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Introduction

The anguish and rage of children with severe personality disorders assail clinicians with uncanny power. Like no other patients, these children challenge the clinician's skill and sensitivity. Although they strain the resources of schools and caregivers, their remarkable determination to survive can be both touching and endearing. Yet they excel at defeating the efforts to help them.

The means these children use to ensure their emotional survival can inflict enormous pain on themselves and their families, and can evoke responses from others that reinforce their maladaptation. Indeed, treatment often fails as clinicians succumb to their own inability to manage the emotional reactions elicited by these children.

On closer examination, these children's disruptive behavior appears to be the manifestation of severe personality disorders that surface in the process of becoming organized and structured. Such patterns of maladjustment span a cluster of conditions encompassing the borderline, histrionic, narcissistic, and antisocial personality disorders, which the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) groups together as the Cluster B, or the "dramatic," personality disorders. I refer to this cluster of disorders as the severe personality disorders because of the enormous personal, social, and financial cost associated with them.

In this book, I examine the processes by which youngsters affected by various combinations of constitutional vulnerability, maltreatment, and specific developmental difficulties generate and organize "dramatic" or severe personality disorders. These personality organizations

ensure these youngsters a semblance of identity, human connection, and sense of control. The harrowing consequences of these efforts at adaptation and the price paid by these children, their families, and society for such precarious adjustment build the rationale for a systematic effort to create more effective therapeutic and preventive approaches. The central premise of this book is that disruptions in the development of the biologically prepared capacity for reflective function (i.e., the moment-to-moment ability to grasp the meaningfulness and intentionality of human behavior, both the child's own and that of others) are the key to understanding personality disorders in children and adolescents. This understanding provides the basis of an effective treatment model.

CAN CHILDREN HAVE A PERSONALITY DISORDER?

"Personality disorders" are defined in DSM-IV (American Psychiatric Association, 1994) as relatively enduring and pervasively maladaptive patterns of experiencing, coping, and relating. Such a definition raises the question: How can children and adolescents, immersed as they are in extraordinarily fluid developmental processes, qualify for such designation? Every aspect of children's bodies and personalities is constantly changing, and at different rates, creating a constantly shifting equilibrium and disequilibrium within themselves and in their relationship with the environment. Maturation and experience provide children with ever-changing tools to cope, perceive, organize their subjective experience, and relate to others, making it difficult, if not impossible, to speak of "rigid and enduring patterns."

Until recently, the question of whether child and even adolescent patterns of experiencing, coping, and relating can indeed become rigidly and maladaptively fixed was largely argued in the arena of theoretical dispute. Over the past 20 years, however, a growing body of developmental research and prospective studies has provided an empirically supported basis for understanding the interactions of genetic and psychosocial factors that create the risk factors and protective influences shaping how children generate, organize, and structure their subjective experiences, coping mechanisms, and relationship patterns (Beeghly & Cicchetti, 1994; Cicchetti & Rogosch, 1997; Cicchetti & Toth, 1995; Fonagy, 2000a; Fonagy & Target, 1997; Perry & Pollard, 1998; Rutter, 1987, 1999; Sroufe, 1997; Wyman et al., 1999).

Such studies support the contention of Paulina Kernberg (1990) and Kernberg, Weiner, and Bardenstein (2000), among others, that children exhibit distinctive traits and patterns of perceiving, relating, and thinking about the environment and themselves, including traits such as impulsivity, introversion, egocentricity, novelty seeking, inhibition, sociability, activity, and many others. Kernberg added that these traits and patterns endure across time and situation, and warrant the designation of personality disorder regardless of the children's age, when they (1) become inflexible, maladaptive, and chronic; (2) cause significant functional impairment; and (3) produce severe subjective distress. Building on this work, I propose that the defining feature of children with a dramatic or severe personality disorder is their "loss" or inhibition of the capacity to maintain a reflective stance, thus replacing the normal grasping and conveying of meaningful mental states, which is the basis of flexible adaptation, with a rigid, nonreflective mode of organizing experience and relating to others. This rigid mode of organization, in turn, evokes interpersonal responses that further reinforce and validate these children's inner organization. Joe, for example (whom I describe in more detail in Chapter 5), responded to feelings of vulnerability and desires for attachment with a rigid and ruthlessly threatening stance, which almost inevitably triggered retaliation by others. In the subsequent chapters, I examine the developmental trajectories that lead to specific patterns of maladjustment in the cluster of the dramatic or severe personality disorders.

Undoubtedly, as Shapiro (1990) cautions, only rigorous research can establish the validity of the construct of "personality disorder" in children and adolescents. Today there is relatively scant empirical evidence documenting the clinical and developmental continuities between children labeled as antisocial, narcissistic, borderline, or histrionic, and adults with similar diagnoses. Furthermore, the high prevalence observed in these children of Axis I diagnoses, such as attention-deficit/hyperactivity disorder, developmental reading disorder, eating disorder, somatoform disorder, substance abuse, separation anxiety, mood disorder, and posttraumatic stress disorder, raises the question of whether "dramatic personality disorders" are really atypical, complicated, or severe forms of Axis I diagnoses. In particular, a history of maltreatment—most significantly physical and sexual abuse—in the backgrounds of many of these children prompted some authors (e.g., Herman, 1992a, 1992b; Herman, Perry, & van der Kolk, 1989) to state

that terms such as "borderline" are little more than pejorative designations for people suffering a complex posttraumatic condition as a consequence of protracted abuse and victimization.

ANTISOCIAL, NARCISSISTIC, HISTRIONIC, AND BORDERLINE PERSONALITY DISORDERS IN CHILDHOOD AND ADOLESCENCE

Children appear unfazed by the arguments denying them the capability of creating enduring patterns of maladjustment. Clinicians' awareness that personality disorders do not appear suddenly at age 18 has led to widespread use of the diagnosis of personality disorder—particularly borderline personality disorder—to characterize the difficulties of some children and adolescents. Thus, by 1983, Pine reported that the flow of children given the diagnosis of borderline had reached flood proportions. Eighteen years later, the "flood" has not receded, yet the concept of dramatic personality disorders in childhood and adolescence remains mired in unclarity and controversy.

The effort to make sense of these children's clinical and developmental problems can be traced at least to the late 1940s and early 1950s, when clinicians such as Mahler, Ross, and Defries (1949) and Weil (1954) identified a group of "atypical" children whose disturbance in ego functions and object relations was less severe than that presented by psychotic children, yet more serious than that displayed by neurotic children. Mahler and her colleagues placed these children at the mild end of a clinical and developmental continuum that extends to the most severe and primitive psychotic conditions—the autistic and symbiotic psychoses of childhood. Thus, Mahler and colleagues (1949) articulated the notion of "benign" or "borderline" psychosis, a precursor to the idea of a schizophrenic spectrum in which borderline conditions would represent an attenuated, incipient, or less severe variant.

Ekstein and Wallerstein (1954) proposed the term "borderline" to designate children who were *not* on the way to becoming psychotic but who, instead, presented a "characteristic pattern of unpredictability which is paradoxically one of [their] most predictable aspects" (p. 345), constantly fluctuating between a neurotic and a psychotic level of contact with reality, object relations, and defensive organization. Ekstein and Wallerstein thus advanced the concept of borderline children as a

stable clinical entity defined precisely by ongoing and very rapid shifts in ego functioning.

These pioneer efforts generated a great deal of interest, particularly among psychoanalytically oriented clinicians, leading to a number of attempts to delineate more systematically the developmental and clinical features characteristic of borderline children. Frijling-Schreuder (1969), Geleerd (1958), Marcus (1963), and Rosenfeld and Sprince (1963), among others, described children who presented a wide and fluctuating constellation of problems, including impulsivity; low frustration tolerance; uneven development; proneness to withdraw into fantasy or to regress into primary process in response to stress, lack of structure, or separation from caretakers; pervasive, intense anxiety; multiple neurotic symptoms, such as phobias, compulsions, or ritualistic behaviors; somatic complaints; and sleep problems.

After reviewing the literature, Bemporad, Smith, Hanson, and Cicchetti (1982) and Vela, Gottlieb, and Gottlieb (1983) reported substantial consensus among clinicians on the diagnostic criteria for borderline children. Bemporad and colleagues (1982) spelled out the following diagnostic criteria: (1) a paradigmatic fluctuation of functioning, with rapid shifts between psychotic-like and neurotic levels of reality testing; (2) a lack of "signal anxiety" (Freud, 1926/1959) and a proneness to states of panic, dominated by concerns of body dissolution, annihilation, or abandonment; (3) a disruption in thought processes and content consisting of rapid shifts between normal and loose, idiosyncratic thinking; (4) an impairment in relationships, with much difficulty, when under stress, in distinguishing self from others, in appreciating other people's needs, or in integrating disparate emotional experiences into a coherent relationship; and (5) a lack of impulse control, comprising an inability to contain intense affects, delay gratification, control rage, or modulate destructive and self-destructive tendencies. Along similar lines, Vela and colleagues (1983) described six features: (1) disturbances in interpersonal relationships; (2) disturbances in the sense of reality; (3) excessive anxiety; (4) severe impulse problems; (5) "neurotic-like" symptoms; and (6) uneven or distorted development.

These clinical criteria closely parallel the adult criteria for borderline personality disorder, as defined in the successive editions of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980, 1987, 1994). The DSM classifications, striving

for an empirically based, atheoretical system, shied away from Kernberg's (1975, 1976) notion of a developmental level of personality organization. Instead, borderline, designated as one of the specific personality disorders—the borderline personality disorder—is one of the Cluster B, or "dramatic," personalities, a group that also includes the histrionic, the antisocial, and the narcissistic personality disorders.

Such differentiation has led to greater diagnostic specificity with borderline children. Petti and Vela (1990) identified the confusion in the literature between children with borderline personality/borderline spectrum disorders and children who, while often referred to as "borderline," are more appropriately described as falling within the schizotypal personality/schizoid spectrum disorders. Both groups of youngsters present transient psychotic episodes, magical thinking, idiosyncratic fantasies, suspiciousness, and a disturbed sense of reality. Yet only schizotypal children have a family history of schizophrenia spectrum disorder or present constricted or inappropriate affect, oddness of speech, and extreme discomfort in social situations, which contrasts with the intense, dramatic affect and hunger for social response of borderline, histrionic, and narcissistic youngsters. Petti and Vela's conclusions are supported by the findings of genetic, epidemiological, and follow-up studies of adult borderline personality disorder that differentiate the borderline spectrum from the schizophrenic–schizotypal spectrum.

Studies such as Petti and Vela's paved the way for more systematic efforts to test empirically the validity and reliability of the borderline personality disorder construct in childhood and adolescence. Although the results of such investigations are far from definitive, several studies (e.g., Goldman, D'Angelo, & Demaso, 1993; Ludolph et al., 1990) conclude that semistructured interviews, such as the Diagnostic Interview for Borderlines (DIB; Gunderson, Kolb, & Austin, 1981), and DSM-III-R criteria (American Psychiatric Association, 1987) can be applied to borderline youngsters. Based on this research, Goldman and colleagues (1993) propose that, with very slight modification, DSM-III-R adult criteria can be applied to youngsters with borderline personality disorder.

In contrast, however, to the lively literature on borderline personality in childhood, there has been a striking paucity of discussion of the other dramatic personality disorders—histrionic, narcissistic, and antisocial—as they develop and crystallize during childhood and adolescence. The relative absence of debate is all the more remarkable considering the interest in the psychiatric and psychoanalytic literature on

these disorders, particularly on the narcissistic personality disorder. Such interest, of course, reflects the prominence of narcissistic features in contemporary life and the frequency with which the complaints heard in clinical practice bear the hallmark of narcissistic disorders: pervasive feelings of unhappiness, inner emptiness, and boredom; dependence on external approval and admiration; fears of closeness and intimacy; exploitativeness and manipulation in interpersonal relationships; intense fears of death and aging; and inability to experience love or meaning in life.

But only a few authors have examined narcissistic traits and narcissistic disorders as they emerge in children (Beren, 1992; Bleiberg, 1984, 1988, 1994; Cohen, 1991; Egan & Kernberg, 1984; Kernberg, 1989; Ornstein, 1981; Rinsley, 1984, 1989), building on models to explain narcissistic psychopathology (i.e., Kernberg, 1975, 1976; Kohut, 1971, 1972, 1977) and focusing on distortions or arrests in early development. Yet support for these models comes largely from the retrospective accounts collected in the treatment of adult patients.

From a different perspective, an extensive literature has examined delinquent youth. A tremendous catalyst to explore the development of delinquents was August Aichhorn's (1935) bold proposal to apply psychoanalytic principles to create a human relationship as a vehicle for understanding and caring for "wayward," hateful, impulsive youngsters and for helping them resume their thwarted development.

Rutter and Giller (1983) and Rutter, Giller, and Hagel (1998), attempting to make sense of the various combinations of biological and psychosocial vulnerabilities displayed by delinquent youngsters, concluded that the most meaningful dimension determining outcome is the children's capacity to form enduring affectionate bonds and to experience concern for others. Almost in passing, Rutter and Giller wondered whether the truly significant differentiation is between *degrees or types of personality disturbance*.

This line of thinking is supported by the factor-analytic studies of delinquent youth carried out by Marohn, Offer, Ostrov, and Truillo (1979), which revealed four psychological subtypes: (1) the impulsive, (2) the narcissistic, (3) the empty-borderline, and (4) the depressed-borderline. Each of these types of delinquency encompasses specific but overlapping maladaptive patterns of experiencing, coping, and relating, whose features seem strikingly similar to the personality disorders in the dramatic cluster. These dramatic personality disorders represent

overlapping developmental paths, leading to a cluster of enduring patterns of maladjustment that reflect various combinations of constitutional vulnerability and psychosocial misfortune.

CLINICAL PRESENTATION OF CHILDREN WITH DRAMATIC PERSONALITY DISORDER

"Dramatic" children indeed create drama and stir up turmoil around them, but they vary greatly in their adjustment and behavior at any given moment. Specific triggers—changes in children's subjective experience linked to interpersonal or internal cues—bring about prototypical modes of rigidly organizing their subjective experience, coping mechanisms, and relationship patterns.

By school age, most children with a dramatic personality disorder meet diagnostic criteria for one or more Axis I diagnoses, more commonly a disruptive behavior disorder, an anxiety disorder, or a mood disorder. I propose that the two modal types within this cluster are the narcissistic and the borderline. Some narcissistic youngsters present a more malignant ruthlessness linked to the antisocial disorders, while others are more dramatic in their communication, impressionistic in their cognitive style, and hungry for attention, shading into the histrionic personality. Some children—predominantly those who are narcissistic or narcissistic–histrionic—are cool and canny far beyond their age. They appear well controlled and capable, and they impress people with their remarkable strength, charm, and charisma, their ability to place themselves at the center of everyone's attention, and their shrewd awareness of how to elicit specific responses from the environment. Other narcissistic or narcissistic–antisocial youngsters can be relentlessly destructive, defiant, and apparently lacking in remorse, concern, or constraints.

THE PROTOTYPE OF THE NARCISSISTIC PERSONALITY DISORDER

The prototypical response of narcissistic children—whether "malignant" or histrionic—to threats of vulnerability, humiliation, or lack of attention is first to organize their sense of self around an illusory con-

viction of perfection, power, or control. Arguably, the developmental antecedent of this response is the dismissive/avoidant attachment pattern, which, as I discuss later, is a coping strategy against attachment disorganization.

These children disown those aspects of themselves that fail to measure up to such standards of perfection or simply to their expectation to be "cool," "tough," and self-sufficient. In particular, they reject experiences of helplessness, vulnerability, pain, dependency, and—for narcissistic–histrionic children—the dreaded experience of being ignored. Subsequently, they project these unbearable aspects of the self onto others, who they then perceive as helpless, worthless, or insignificant, mere tools to manipulate or props to help them achieve acclaim, power, or satisfaction. At the same time, they require from others an ongoing confirmation of their perfection, magnificence, and power. Yet no matter how much adulation or confirmation, or how much success they achieve, they are haunted by the possibility that their shortcomings will be exposed. Shame and the fear of ridicule and humiliation loom as ever-present threats throughout their lives. For example, Elliot, a 10-year-old boy whom I describe in more detail in Chapter 6, shared, with just a hint of condescension, his plans to become a Nobel Prize–winning nuclear physicist, the best neurosurgeon in the world, and a future President of the United States. Yet when I—mistakenly—inquired about his feelings of uncertainty or bafflement, the very feelings that may underlie the behavior that brought him to treatment, he became anxious, provocative, and even more determined to make me feel stupid and helpless.

As Egan and Kernberg (1984) pointed out, narcissistic youngsters contrast with normal children, who "do not need to be unusually admired as sole owners of everything enviable and valuable" (p. 42) and who make demands that are related to real—and realistic—needs. The demands of children with a narcissistic personality are "excessive, can never be fulfilled, and are in fact secondary to an ongoing angry denigration" (p. 42) of those who attempt to care for them. Whereas small children can be warmly grateful, narcissistic youngsters are cool and aloof, and show disregard for others, except for momentary idealization.

The hallmarks of the prototypical narcissistic personality in childhood are grandiose fantasies, excessive demands, intense self-absorption, grandiosity that defensively reverses overwhelming feelings of inadequacy and helplessness, and inability to experience genuine attachment, trust, and interest in others.

THE PROTOTYPE OF THE BORDERLINE PERSONALITY DISORDER

As infants, borderline children often burden their caregivers with their high activity level, poor adaptability, negative mood, and problems settling into predictable sleep–wake and feeding patterns. They are, in short, temperamentally "difficult" babies. *Some* of these children, as I discuss later, will form attachment bonds that foster the selective inhibition of reflective function, a developmental feature that appears to be signaled by the presence of a disorganized pattern of attachment (Main & Solomon, 1990). Infants with a disorganized attachment respond to the presence of their caregivers with a chaotic mix of approach–avoidance and "trance-like" behaviors. Clinginess, vulnerability to separations or hyperactivity, and proneness to tantrums are also common features of their early development.

Many of these youngsters appear hyperactive, moody, irritable, and explosive. Minor upsets or frustrations trigger intense affective storms, episodes of uncontrolled emotion that are wholly out of proportion to the apparent precipitant. Other youngsters are anxious, hypersensitive to the comings and goings of their caregivers, impossible to comfort after separations, and demanding of constant attention and reassurance against abandonment. One moment they may feel elated and expansive, blissfully connected with a protective caregiver. But the next moment they plunge into bitter disappointment and rage, coupled with self-loathing and despair.

As with narcissistic youngsters, self-centeredness is a striking characteristic of these children, who also crave attention and respond with rage or despair to rejection or indifference. But in prototypical borderline youngsters, such events trigger profound feelings of subjective dyscontrol, hyperarousal, loneliness, and a fragmented sense of self and others. These feelings bring about rigid patterns of coping, experiencing, and relating. As a result, borderline children seductively strive to coerce others into providing them with emotional "supplies" because they are unable, under specific stressors, to evoke images of other people as soothing and comforting. Instead, they find themselves swept away by the feelings and needs of the moment, and they experience utter chaos, both in their inner world and in the world around them.

By adolescence, they often find that they can modulate their vulnerability to hyperarousal and subjective dyscontrol by deliberately

seeking thrills, by desperately attempting to numb themselves, by actively pursuing self-victimization, and by manipulatively striving to prevent abandonment. Food binges, promiscuous sex, or drug abuse become key strategies to achieve these aims. Self-mutilation and suicidal gestures are more common among girls, whereas aggression covering hidden fears of vulnerability is more typical of boys. Unstable relationships with peers and adults become more prominent as transient idealization and clingy overdependence alternate with rage, devaluation, and feelings of abandonment and betrayal. Although they can derive some feelings of nurturance from food, drugs, or sex, they are soon left with only shame, guilt, and a sense of inner deadness.

INTEGRATING POINTS OF VIEW: THE PERSPECTIVE OF DEVELOPMENTAL PSYCHOPATHOLOGY

Faced with the bewildering challenges posed by children with dramatic or severe personality disorders, clinicians have searched through a variety of theoretical roadmaps for signposts to guide their interventions. In this book, I seek to demonstrate that in the development of children with severe personality disorders, specific genetic vulnerabilities find expression in the context of attachment relationships that predispose children to inhibit selectively a key processing mechanism, that of reflective function. This perspective is embedded in the contemporary framework of developmental psychopathology. That framework is built on the assumption that the relationship environment equips children with psychological mechanisms of appraisal and processing, in turn regulating gene expression and having an impact on the environment (Elman et al., 1996; Emde, 1989; Fonagy, 2000a; Rutter, 1999). The central point of these perspectives is that developmental outcomes are generated by the action of psychological, mediating functions that determine whether specific environmental factors, such as trauma, trigger the expression of genetic vulnerabilities.

This perspective is based on multiple contributions from various viewpoints. The early efforts to make sense of these children were rooted in the soil of psychoanalytic theory, including Aichhorn's previously mentioned efforts to understand and treat young delinquents. Aichhorn's ideas were based on the underlying premises of psychoana-

lytic theory: an appreciation of the power and significance of unconscious motivation, and a belief in the centrality of early development and early relationships in shaping psychic experience.

By the early 1950s, Aichhorn's seminal work had inspired a number of important contributions to the psychoanalytic understanding of delinquency. Redl and Wineman (1951, 1957) described the failure of ego controls underlying the difficulties of "children who hate." Johnson and Szurek (1952) examined adolescents' enactments of their parents' unconscious delinquent tendencies. Winnicott (1958) interpreted the antisocial tendency as an effort to test and establish relationships.

Two decades later, Mahler, Pine, and Bergman (1975) and Otto Kernberg (1975) produced a set of key concepts that were to become the fundamental framework for the psychoanalytic understanding of how severe personality disorders are generated.

According to Mahler's concept of *separation–individuation*, during the first 3 years of life, children normally go through a series of developmental stages in which they (1) internalize some of the soothing, equilibrium-maintaining functions initially performed exclusively by caregivers—what Winnicott (1965) called "the holding environment"—and acquire the capacity to carry out these functions with some degree of autonomy; (2) practice ego skills and use them to expand their knowledge of themselves and the world, while figuring out how to evoke desired responses from the environment; and (3) integrate the "good"—pleasurable and safe—and the "bad"—unpleasant and unsafe—representations of the self and others. These achievements subsequently permit children to accept the reality of their existence as separate individuals and to develop object constancy, which is the ability to maintain relationships and evoke loving and comforting images of their caregivers even when absent or when the children are upset with them.

Otto Kernberg (1967, 1975), through his influential contributions, sought to define "borderline" as a level of development in personality organization. The developmental markers of the borderline level of organization, according to Kernberg, are the differentiation of the self-representation from the representation of the object—which he believes is the basis of the capacity for reality testing—but without integration of the "good" and the "bad" aspects of the self and the object. For Kernberg, the crux of the borderline personality is the ongoing defensive need to retain an internal split between two sets of self–object units: a "good" self-representation linked to a "good" object-representation by

libidinal affects of pleasure, safety, and satisfaction on the one hand, and a "bad" self-representation linked to a "bad" object-representation by affects of tension, distress, pain, anger, and frustration on the other.

According to Kernberg, the defensive need for splitting derives from the burden of excessive aggression that children carry as a result of either genetic loading or inordinate frustration. Heightened aggression, in turn leading to a predominance of "bad" introjects, fosters the defensive need to protect the "good" sense about the self and the object from the unremitting attacks from the bad introject. Splitting, however, precludes a real integration of the self- and the object-representation, and thus interferes with the achievement of both cohesive identity and object constancy.

For Kernberg, a number of personality disorders, including the narcissistic, the schizoid, the paranoid, and the antisocial, generally function at this borderline level of personality organization. This broad use of the term "borderline" resonated with clinicians working with children. Pine (1974), for example, defined the "borderline" condition of children and adolescents as a group of disorders with common developmental and structural features, although substantially different clinical manifestations.

Psychoanalytic clinicians seeking to understand the developmental and clinical problems of youngsters with dramatic and severe personality disorders conceptualized these problems in terms of splitting and the derailment of Mahler's separation–individuation. The psychoanalytic literature soon came to ascribe such developmental problems to parental—particularly maternal—failure. Adler (1985), for example, postulated that the central feature of borderline psychopathology is the patient's inability to evoke the memory of a soothing, comforting object when faced with separation or distress. He attributed this defect of internalization to a parental failure in providing an adequate "holding environment." The consequence of such failure for the child is an inner state of emptiness, reliance on angry, manipulative efforts to secure involvement and attention from others, and use of drugs or food to soothe and comfort. This dependence on external supplies is similar to the reliance of young children on transitional objects and experiences described by Winnicott (1953).

Along similar lines, Masterson (1981), Masterson and Rinsley (1975), and Rinsley (1980a, 1984, 1989) claimed that specific patterns of mother–infant interaction thwart the separation–individuation pro-

cess and lead to borderline or narcissistic psychopathology. In their view, the mothers of future borderline individuals take pride in, and find gratification in, their children's dependency. These mothers, claim Rinsley and Masterson, reward children's passive–dependent, clinging behavior while withdrawing or otherwise punishing them when they strive for autonomy. These mothers are sensitively attuned to and exquisitely responsive to their children's pain, helplessness, and proximity-seeking behavior, but they subtly or overtly rebuff their children when they exhibit activity, mastery, or independence. According to these authors, the central message that mothers of future borderline individuals communicate to their children is, as Rinsley (1984) said, that to grow up is to face "the loss or withdrawal of maternal supplies, coupled with the related injunction that to avoid that calamity the child must remain dependent, inadequate, symbiotic" (p. 5).

Future *narcissistic* individuals, according to Rinsley (1984), receive a different message. Their mothers communicate to them that they are loved and cherished, maybe more than anyone is or ever has been, *because* they are special people. It is as if they are told: "I love you, but to keep my love, you *must* grow up and be wonderful, so that everything you accomplish is a reflection of me, your mother." This selectivity of maternal attunement and response is not, as in the case of mothers of borderline individuals, to the child's deflated and pained states, but to the child's competent, attention-getting aspects that best enhance the mother's self-esteem and prevent her narcissistic collapse.

This focus on maternal responsibility in conceptualizing the development of both borderline and narcissistic personality disorders, however, served mostly to expose the limitations of prevailing psychoanalytic formulations. The emphasis on the mother's failure ignored the growing evidence about the critical role of maltreatment—particularly sexual abuse—often perpetrated by fathers and other caregivers in the pathogenesis of severe personality disorders.

As Gabbard (1994) points out, psychoanalytic formulations overemphasize *early* development, notably the separation–individuation process, at the expense of other sensitive developmental stages—times when critical events such as sexual abuse may occur. But perhaps more significantly, these formulations focus largely on only *one* developmental stage and assume an *arrest* in development at that stage. Last, but certainly not least, psychoanalytic formulations—with the exception of those by Kernberg—move away from consideration of the significance

of constitutional factors. This neglect made it difficult for these perspectives to explain why *some* children exposed to, for example, dependency-rewarding and autonomy-punishing mothers did *not* grow up to become borderline, while other children, clearly *not* exposed to such an environment, did develop a borderline personality.

A similar wave of criticism turned the early enthusiasm for psychoanalytic models of delinquency into widespread disillusion with the explanatory power of psychoanalysis in general, and with the effectiveness of psychoanalytically oriented approaches to the treatment of delinquent youth in particular.

By the early 1990s, competing theoretical models sought to explain the problems of delinquent youth:

1. Sociocultural models (see, e.g., Cloward & Ohlin, 1960; Wichstrom, Skogen, & Oia, 1996) identified the significance of socioeconomic class; ethnicity; family size; access to social, medical, and psychiatric services; child-rearing and socializing practices; and modes of exposure to alcohol and drugs.
2. Family interaction models (see, e.g., Patterson, 1982; Patterson, DeBaryshe, & Ramsey, 1989) emphasized the importance of parental violence, severe marital discord, and parental inadequacies in providing children with structure, supervision, and emotional involvement.
3. Neurobiological models stressed genetic influences (Brennan, Mednick, & Jacobsen, 1995; Christiansen, 1977), neuropsychiatric vulnerabilities (Lewis, 1983; Lewis, Shanok, & Balla, 1979), attentional deficits (Cantwell, 1981), and depression (Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984a; Kovacs et al., 1984b; Riggs, Baker, Mikulich, Young, & Crowley, 1995).

In a similar fashion, a number of alternative perspectives were proposed to explain the pathogenesis of personality disorders, particularly borderline personality.

A decade earlier, empirical studies had already helped to detach borderline personality disorder from schizophrenia, which, at least in the child arena, was a notion derived from Mahler's "mild or incipient psychosis" model. A shift in focus to the affective lability and dysphoria of borderline patients led to the concept of borderline as an affective

disorder spectrum condition. Klein (1977), for example, proposed that a subgroup of borderline patients, whom he referred to as "hysteroid dysphorics," suffer from a problem in affective regulation that gives rise to emotional lability and heightened sensitivity to rejection. According to Klein, manipulative relationships and other maladaptive interpersonal tactics *result from* rather than cause the affective dysregulation. This view gained strength after studies by Stone (1979), Stone, Kahn, and Flye (1981), and Akiskal (1981) found a high prevalence of affective disorders in the relatives of borderline patients and identified features suggestive of borderline personality in the offspring of affectively ill patients.

As evidence mounted, however, that a linkage between affective disorder and borderline personality was neither uniform nor especially strong (Gunderson & Zanarini, 1989), a number of authors proposed instead that borderline personality could best be conceptualized as an impulse spectrum disorder—that is, as a disorder linked to attention-deficit/hyperactivity disorder, substance abuse, episodic dyscontrol, and cognitive processing difficulties, such as developmental reading disorder and other problems sharing a propensity for the immediate discharge of affect in action (e.g., Andrulonis, 1991).

Yet again, prospective studies pointed out that, just like most children with an affective disorder or the psychosocial "vulnerabilities" associated with delinquency (e.g., poverty, parental discord), many, if not most, impulsive children manage to survive childhood without developing severe personality disorder or manifesting serious delinquency problems.

The search for an alternative explanation brought the focus to maltreatment, particularly sexual abuse. A number of studies found a very high incidence of sexual abuse in the background of adolescents and adults with borderline personality (Famularo, Kinscherff, & Fenton, 1991; Goodwin, Cheeves, & Connell, 1990; Herman et al., 1989). Indeed, when clinicians focused on the possibility of sexual abuse, an astonishing number of borderline adolescents were found to be marred by abuse, their lives appearing to be not an empty house devoid of sufficient internalization of parental functions, but rather a haunted house (Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989) filled with the terrifying ghosts of caregiver brutality and boundary violations. In Terr's (1991) view, exposure to repeated traumatization—such as physical and sexual abuse—evokes defensive operations and experi-

ential distortions that lead to severe personality disorders. Still, as a number of studies demonstrate (e.g., Paris & Zweig-Frank, 1992, 1997; Zanarini & Frankenburg, 1997), although sexual abuse seems to be an important factor in the etiology of borderline personality disorder, abuse alone is neither necessary nor sufficient to develop borderline or other severe personality disorders.

The time seems ripe to consider an integrative perspective (Cicchetti & Cohen, 1995), the point of view of developmental psychopathology. This framework considers how the full array of biopsychosocial factors interact with one another to generate both the *protective* and the *risk* factors that shape the direction of adaptive or maladaptive developmental trajectories. From this perspective, all behavior, including maladaptive behavior, is evaluated not simply from the standpoint of what a person does, but also in reference to how behaviors are organized in respect to one another and in reference to context. Likewise, development is not regarded as the *addition* of new capacities but as an unfolding *organization* of capacities. Finally, personality is conceptualized not as a collection of traits but as the organization and structuring of attitudes, values and goals, coping strategies, relationship patterns, modes of feeling and response, and ways of processing experience across contexts (Sroufe, 1989).

In particular, the point of view of developmental psychopathology allows us to investigate the protective mechanisms bestowed by the evolution of the human species to cope with biological vulnerability and environmental misfortune. Examining these children against the background of developmental psychopathology offers the promise of a framework that integrates psychoanalytic, cognitive, social–cultural, family systems, and neurobiological perspectives in a new paradigm that can serve as the basis of better understanding and more effective treatment.

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