PERSONALITY TRAITS AND DISORDERS IN CHILDHOOD: CLINICAL EVALUATION AND DIAGNOSIS

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Abstract

Objective: Aim of the paper is to examine the controversial issue of personality traits and disorders in childhood.
Method: A literature review of clinical and research data was performed, and a conceptual synthesis was proposed.
Results: Although there are still few longitudinal studies able to clarify the evolution of personality traits from childhood to adulthood, a growing number of studies confirmed emerging personality patterns in childhood and the need for early intervention and prevention. After a discussion of clinical and research data on continuity vs discontinuity in personality disorders, we propose a conceptual synthesis of emerging personality patterns in childhood, conjugating both top-down (theoretical) and bottom-up (research) perspectives.
Conclusions: The literature review showed that a deeper understanding of personality and mental functioning in childhood is still required and that emerging personality patterns and disorders need specific assessment and empirical derived classification that takes into account the developmental perspective.

Key words: childhood personality, personality disorders, diagnosis

Declaration of interest: none

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Introduction

The debate on childhood personality disorders (PDs) still rages, despite a growing number of studies confirming that it is possible to evaluate childhood personality from a developmental perspective (Caspi et al. 2005, Widiger et al. 2009, McAdams and Olson 2010, Trackett et al. 2012). Certain authors (e.g., Shapiro 1990) have inquired whether it is appropriate to evaluate personality in childhood, given the developmental features of mental functioning, but others (Golombeck et al. 1986, Bernstein et al. 1993, Shiner 2009, Tackett 2010, Edmonds et al. 2013, De Clercq and DeFruyt 2012, De Clercq et al. 2009), with the support of empirical and clinical data, confirmed the early structuring of PDs and the need for early intervention and prevention. The *Psychodynamic Diagnostic Manual, Second Edition* (PDM-2; Lingiardi and McWilliams 2017) states that young children do have personalities and traits that may persist over time, and it stresses the importance of assessment even in childhood.

The controversy over the existence of PDs in childhood has continued due to the limitations of studies in this research area and to the reluctance to apply adult personality diagnoses to children. The two main schools of criticism are founded on the contrast of child and adolescent mental functioning and developmental changes with the apparent stability of adult PDs (Tackett 2010) and on the problem of labeling children with stigmatizing diagnoses (Cicchetti and Crick 2009). Both these beliefs have been questioned: personality pathology in adolescence and adulthood is not as unmodifiable (Esterberg et al. 2010) or refractory to intervention as was believed (Chanen et al. 2008, Dweck 2008, Rutter et al. 2006). Moreover, children without diagnosis and treatment are more easily positioned in a shadow area where they can be exposed to a subsequent life of suffering. This danger implies the importance of identifying early risk factors for effective interventions (Tackett 2010).

The study of child and adolescent PDs has come into a significant relief since it moved from the retrospective reconstruction of patients' childhoods to a developmental perspective focusing on the precursors and trajectories of child personality traits and pathologies (Cicchetti and Crick 2009). At the same time, the framework of developmental psychopathology assumes that the study of normality and psychopathology should proceed together, as the same processes are likely to occur in both normal and problematic personality development (Shiner 2009). Recognizing the risk and protective factors within perspectives of multifinality and equifinality could help better understand why personality traits in early and middle childhood are not necessarily predictive of a later personality pathology. The level of continuity in the underlying personality traits is much higher from childhood through adolescence than originally expected (Fraley and Roberts 2004, Roberts and DelVecchio 2000) and significantly increases from adolescence to adulthood (Shiner 2009). The relative modest stability of specific PD diagnoses in adolescence and adulthood (Clark 2007, Zanarini et al. 2003, 2007) can be attributed both to the categorical diagnostic method (in contrast to a dimensional assessment of personality) and

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to the different stability that specific symptoms could have, compared to underlying personality traits (Shiner 2009). In the same perspective, childhood symptoms of personality pathology could appear differently than symptoms manifested in adulthood. Heterotypic continuity explains how an underlying mechanism or trait could characterize the relationship between phenotypically different symptoms from childhood to adulthood in an emerging personality pathology.

In line with this perspective, some researchers (e.g., Kagan and Zentner 1996, Caspi et al 2003, De Clercq et al 2017) have demonstrated a link between early problems in childhood and adult psychopathology. For example, there is a correlation between impulsiveness in preschool children, behavioral problems in school age and antisocial behaviors in adolescence (Bergman et al. 2009, Calkins and Keane 2009, Lahey et al 2003, Moffitt 2003). ADHD, ODD, conduct problems, and antisocial behaviors show continuity and they are serious risk factors for personality development (Caye et al 2016, Moffitt 2018, Wertz et al 2018). There is also a correlation between withdrawal and shyness in early childhood and avoidant personality traits in adolescence (Eggum et al. 2009). Stepp and colleagues (2012) have demonstrated how some structuring features of behavior disorders (i.e., impulsive symptoms, Caspi 2000) could be predictive of borderline personality disorder.

Cohen and colleagues (1993), studying childhood disorders, found that psychiatric disorders in childhood can be as stable as those in adulthood. In the same way, Costello and Angold (1995) have indicated a continuity in the vulnerability of the child through development and that a childhood disorder increases the possibility of having an adolescent disorder. Moreover, some researchers (Levy et al. 1999, Stepp et al. 2012) have shown how personality traits can be detected at a developmental age. For example, Belsky and collegues (2012) indicate that borderline personality related characteristics in children share etiological features with borderline personality disorder in adults and Sharp and Tackett (2014) suggest an early-onset of this disorder.

Similarities between childhood and adult personality structure were investigated using the Big Five and Big Three Models. Although there are divergences in the interpretation of these factors, there is substantial agreement on how to use the following labels: extraversion, agreeableness, conscientiousness, neuroticism, and intellect (or openness to experience) (John and Srivastava 1999). In her review, Shiner (1998) proposed a theoretical taxonomy for the classification of the childhood personality that includes four general dimensions that are ascribable to four of the Big Five. Continuity between the Big Five in late childhood and adulthood has been established (Kohnstamm et al. 1995, 1998). In the landmark longitudinal study of Caspi et al. (2003), age-3 temperaments and personality traits at age 26 showed a significant association: impulsive, negativistic, and undercontrolled 3-year olds tended to show high levels of neuroticism and low levels of agreeableness and conscientiousness as young adults and inhibited and fearful children tended to show higher levels of constraint and low levels of extraversion. In another longitudinal study (Asendorpf et al. 2008), inhibition in childhood was found to predict, 20 years later, inhibition, internalizing problems, and delay in assuming adult roles for both boys and girls, and aggressive boys showed higher levels of delinquency (McAdams and Olson 2010).

Therefore, it is possible to think that some features related to childhood mental disorders are features of the emerging personality. A main feature of PDs is stable maladjustment over time. Indeed, even if a behavioral trait can change during development, its maladaptive impact tends to persist. This condition can remain hidden when the child or the adult is in structured or predictable situations, but it tends to appear in the stressful period.

Psychodynamic perspective on childhood personality and mental functioning

Children and adolescents are in constant change and they choose different ways of facing difficulties, organizing their subjective experience, and relating to others. It is difficult to imagine that the patterns of experience, adaptation, and relationship of a child can be rigidly fixed. However, over the last 20 years, ever-expanding research has provided an empirical basis for understanding the interaction of genetic and psychosocial factors and the influence of risk and protective factors on personality. These characteristics organize and structure the children's subjective experiences, coping mechanisms, and their relationship patterns (Beeghly and Cicchetti 1994; Cicchetti and Rogosch 1996; Cicchetti and Toth 1995; Fonagy 2000; Fonagy and Target 1997; Perry and Pollard 1998; Rutter 1987, 1999; Sroufe 1997; Wyman et al. 1999). These studies validate Paulina Kernberg's (2000) theory on personality development. She argued that children show traits and patterns of perception, relationship, and thought on the environment and on their own. These include traits such as impulsivity, introversion, egocentrism, novelty, inhibition, sociability, activity, and so on. If these traits exceed an adequate threshold and persist over time, they justify the diagnosis of a PD, regardless the age of the child.

Bleiberg (2001) suggested that a feature that defines children with severe PD is the loss or inhibition of the ability to maintain a significant mental attitude. In such cases, the normal mental state of understand and giving significance to experience is replaced with a rigid and unreflective way of organizing experience and relating to others. These patterns arouse interpersonal responses that tend to strengthen and validate the inner organization of these children.

The awareness of clinicians that PDs do not suddenly appear at 18 years old has led to the spread of the use of some PD diagnoses to define the difficulties of some children and adolescents. It is important to keep in mind, however, that a child is still in developmental, and even if he/she does not fully meet all the criteria for a PD he/she could present a number of pathological personality traits. With the introduction of personality organizations (O. Kernberg 1984, P. Kernberg et al. 2000), the assessment of personality in childhood came to be based on the evaluation of features of mental functioning and behavioral patterns. Persistent personality patterns such as aggression, inflexible coping strategies, and insecure attachment, which can be traced back to preschool, affect the development of personality pathologies and are considered the emergence of the sense of unity, the modulation of affects, the style of thought, the connection with the outside world, and the sense of self, empathy, and impulsiveness.

According to the PDM (PDM Task Force 2006) and PDM-2 (Lingiardi and McWilliams 2017), emerging personality patterns in children exist on a continuum from relatively healthy to compromised. PDM-2 describes personality patterns (the PC Axis) as "the characteristic ways of engaging with others and coping with the opportunities and challenges presented by

the environment. They also include the ways in which strengths are utilized and vulnerabilities are contended with at different stages of life. These patterns or styles begin to form in childhood and continue to develop throughout life" (Lingiardi and McWilliams 2017, p. 501). Epigenetics, temperament, neuropsychology, attachment styles, defense mechanisms, and sociocultural factors, all contribute to understanding the child's emerging personality.

Although PDM-2 does not describe discrete personality diagnoses in childhood, the assessment of emerging personality patterns (healthy, neurotic, borderline, psychotic) from age 4 to 11 is based on the profile of mental functioning for children (MC Axis) that includes a number of capacities, such as regulation, affects, mentalization, identity, relationships, self-esteem, impulse control, and so on.

In line with recent research contributions, the distinction and linkage between the MC and PC axes are the most important aspects of this manual. From a clinical point of view, childhood personality can be evaluated only with the consideration of fundamental aspects of mental functioning. Therefore, we evaluate all these features on two different axes, permitting the consideration of the development of mental functioning and the dimensional nature of personality patterns.

Emerging patterns of childhood personality

Beyond the consideration of whether it is better not to label, avoiding stigmatization and leaving the development to have its course or rather is it higher risk to do so for traits that exist and could lead to a structured pathology without intervention, we would like to consider emerging personality patterns in childhood as developmental trajectories that can be examined. We believe that investigating the precursors and pathways to PDs during childhood, integrating developmental issues, biological vulnerabilities, and problematic environments, has the potential to define a longitudinal developmental approach to personality development and psychopathology (Blatt and Luyten 2009). Our approach tries to address this challenge, conjugating both top-down (theoretical) and bottom-up (research) perspectives, based on research and clinical evidence.

As the first step, we illustrate in a synoptic table (**table 1**) the current classifications of PDs in adulthood, adolescence, and childhood, organized according to O. Kernberg's model of personality organization. This model takes into account the integration of the identity, defense mechanisms, object relationships, and reality testing.

As we can see from the synoptic table, a degree of homogeneity in adult classifications can be observed. Even if some classifications, such PDM-2, incorporate some developmental aspects more than other. With SWAP-200-A, Westen and colleagues (2005) proposed an empirically based adolescence classification in which they claim that:

- Avoidant and dependent personalities are not present. These are difficult to locate in childhood too. Both may be a trait of development and are partly overlapping. Possibly for this reason, only the "peer rejection" factor is found in adolescence. The antecedent of this factor may be a unique childhood pattern that can lead to a different outcome in adulthood.
- Obsessive and dysphoric factors show continuity and a similar manifestation during development

Table 1. *Synoptic table of current classifications of personality disorders in adulthood, adolescence and childhood and a proposal for emerging personality patterns in childhood (last column)*

PERSONALITY ORGANIZATION	DSM-5	DSM-5 Alternative Model	PDM-2 – PA Axis (adolescence)	SWAP-200-A – Factor (adolescence)	P. Kernberg et al. (2000) (childhood and adolescence)	Emerging Personality Patterns in childhood
NEUROTIC	Dependent		Dependent/ Victimized	Peer rejection		Inhibited/ Withdrawn
	Avoidant	Avoidant	Anxious/ Avoidant		Avoidant	
	Obsessive-Compulsive	Obsessive-Compulsive	Obsessional	Anxious obsessionality	Obsessive-Compulsive	Pathological Obsessiveness
			Depressive	Dysphoria/ Inhibition		Dysphoric
BORDERLINE	Borderline	Borderline	Borderline	Emotional dysregulation	Borderline	Dysregulated
	Histrionic		Impulsive/ Histrionic	Histrionic sexualisation and Sexual conflict	Histrionic	
	Narcissistic	Narcissistic	Narcissistic	Psychopathy/ Malignant Narcissism and Delinquent behaviour	Narcissistic	Pathological Narcissism
	Antisocial	Antisocial	Antisocial/ Psychopathic		Antisocial	
PSYCHOTIC	Paranoid		Paranoid		Paranoid	Suspicious
	Schizoid		Schizoid		Schizoid	Schizoid
	Schizotypal	Schizotypal		Schizotypy	Schizotypal	

from adolescence to adulthood. Thus, it is possible to hypothesize a homotypic continuity from childhood.

- Borderline/dysregulated and histrionic factors show continuity, but the sexual conflict of the histrionic disorder is centered on the pubertal body. Clinical manifestations of these disorders, such as instability, reactivity, and dysregulation are common elements. These manifestations partly overlap, and they are difficult to distinguish in childhood.
- Narcissistic and antisocial factors are aggregated into one unique factor. These disorders have distinctive features, especially in guilt and socialization, but they share early childhood aggressiveness and destructive behaviors as antecedents. This may be because the differences between the disorders become clearer in adulthood, whereas common features such as fragility of self-esteem and grandiosity are common. This makes possible to hypothesize that these disorders begin in a similar condition in childhood, becoming distinguished during development.
- No paranoid factor is present in this classification, possibly because it is difficult to evaluate in development. Despite the scarcity of research on this disorder, paranoid construction certainly takes place during development. It is possible to hypothesize that there is a specific emerging pattern of personality, although attenuated, and with less serious features than adults. That pattern would lead with homotypic continuity to adult disorder.
- A schizotypal factor is present in adolescence, not a schizoid one. However, these two disorders, which partly overlap, seem in continuity, and one can evolve from the other. A schizoid factor can be an attenuated manifestation of a schizotypal one.

In the last column of **table 1**, we propose a theoretical approach to conceptualizing the classification of emerging patterns of personality in childhood, noting that these emerging patterns of personality are not disorders but the results of an attempt to conceptualize the developmental pattern of personality that may vary during development.

After a description of the organization, we try to define the emerging pattern of personality in terms of mental functioning and behavior, relying on clinical and research data.

Healthy personality organization

This organization has high cognitive and affective functioning and processes such as regulation, attention,

Table 2. *Mental Functioning and other significant factors of the Emerging Personality Patterns in Neurotic Personality Organization*

	NEUROTIC		
MENTAL FUNCTIONING (MC) AND OTHER FACTORS	**INHIBITED/WITHDRAWN**	**PATHOLOGICAL OBSESSIVENESS**	**DYSPHORIC**
Cognitive and Affective Processes	Inhibition, constraint, difficulty to express negative emotions, inadequate feelings and depression. Empathy.	Limited affective range: embarrassment for positive emotions, fear for negative emotions. Bizarre thought, obsession and compulsion. Lack of empathy.	Anhedonia, depression, inhibition and constraint. Difficulty with positive feelings.
Identity and Relationships	Too dependent to adults, problems with peers. Shame and fear of intimacy in relationships. Poor self-esteem.	Constraint and rigid, prefers activities to people. Self-esteem depends on production. No intimacy.	Passive and needy with adults. Difficulty with peers. No intimacy and social withdraw. Poor self-esteem.
Defense and Coping	Adaptability, resilience, strength and impulsivity control. Need others for regulation.	Routine, rituals, competitive, suffer when losing control.	Passivity
Self-Awareness and Self-Direction	Self-observation, ethical and moral standard but very self-critical.	Self-critical, unrealistic internal standard, hate for flaw, sensitive to criticism.	Guilt, self-critical and self-punishment.
Temperament	Irritable, anxious, stubborn, sullen, very shy, avoidance.	Stubborn, hypervigilant, high arousal and low threshold of pain.	Apathetic, excess response to stimuli.
Neuropsychology	No learning problem or deficit.	Compromised learning due to rituals and obsessions.	Compromise learning due to fear to appear and fear of others.
Attachment Style	Anxious/ambivalent. Very attentive to adults. Anxious, scared, and very critical caregivers.	Caregivers influence fear and behaviors and the need of control.	Caregivers repress anger. Need others and fear of rejection. Very attentive to adults.
Defense Mechanisms	Mature defences	Rigid defences	Mature defences
Sociocultural Factors	Traumatic and stressor events	The environment increases symptoms and punctuality.	

learning, movement, and language. The ability to express, communicate, and understand emotions is good. These children show good adaptation, an integrated identity, and intact reality testing. In relationships, they can show intimacy, mutual exchange, and good friendship. They can regulate their self-esteem. Defenses and coping strategies can handle aggressive impulses without passivity. They can compete and have normal ambitions. They can handle anxiety and negative affect without disorganizing, and they can be reassured by their parents. These children are adaptable, flexible, resilient, and strong (Lingiardi and McWilliams 2017).

Neurotic personality organization

The PC axis of the PDM-2 (Lingiardi and McWilliams 2017) describes these children as logical and thoughtful, well enough adapted to new and stimulating circumstances. They can also be impulsive, opposing or destructive, but when faced with sensitivity they can regain control, reflect on what they have done, and appreciate another's perspective. They are capable of empathy, remorse, and guilt. They maintain reality testing, and they have a pretty good sense of who they are. They tend to have close relationships with both their peers and adults. Relational difficulties that arise are often resolved without excessive effort. Their affective range is wide and appropriate to the context.

According to O. Kernberg (1975, 1976, 1978, 2005), the neurotic personality organization present the lowest level of pathology. The DSM-5 (APA 2013) describes Cluster C in a similar way. This cluster is called anxious and includes: dependent personality disorder (DPD), avoidant personality disorder (AvPD), and obsessive–compulsive personality disorder (OCPD).

Table 2 shows a synthetic description of the emerging patterns of personality that we hypothesize are included in neurotic organization in childhood.

Inhibited/withdrawn emerging personality patterns

An inhibited/withdrawn emerging personality is characterized by an excess of shyness, insecurity, self-criticism, general inhibition, and shame. Children fitting this profile have difficulty expressing their internal states, especially negative ones, which they tend to deny. Their feelings of inadequacy lead to social avoidance, excessive dependence on their caregivers, withdrawal from their peer group, and a general inhibition in interaction, and emotional constraint. School and social functioning may be affected by these aspects and they can fail to pass certain developmental stages. This can be a quite high functioning type of personality, but in its severe forms, it can be seriously compromised. In some cases, it could be hypothesized a continuity with DPD and AvPD in adulthood.

Clinical and research data on DPD in developmental ages are scarce. This deficiency may be because dependence is considered part of typical development. A person with DPD shows a submissive and dependent behavior, self-perceives as incapable, cannot be without others, has difficulty to expressing his or her disagreement or hostile impulses, and shows pessimism and a lack of self-confidence (APA 2013). DPD people often come from dysfunctional families with dominant, untrustworthy, and intrusive caregivers. These parents suggest the idea that autonomy is full of dangers. To grow up and diversify is like betraying the parents (Masterson and Rinsley 1975). A direct consequence of this is that being dependent is the only way to keep the bond with parents and that growing up means losing parental love. The dependent style can also be found in subjects with caregivers that treat them as worthless things of little value. Their role in relationships is to be a victim. Another feature of DPD is an ambivalent insecure attachment pattern. The DPD is the only PD essentially defined by a single trait: pathological dependence. However, it could be divided in two related factors: passive-submissive and active-emotional (Morgan and Clark 2010). This diagnosis, such as AvPD, is often in comorbid with depression or anxiety.

AvPD is a pervasive pattern of social inhibition, feelings of inadequacy, hypersensitivity to negative judgment, and low self-esteem (APA 2013). The DSM-5 (APA 2013) indicates that the onset often occurs in infancy or childhood with extreme shyness, isolation, and fear of strangers or new situations. These children are characterized by the avoidance of school, extracurricular activities, and relationships with peers. Friendships are influenced by the need to be unconditionally accepted.

P. Kernberg (2000) defines the people with AvPD as anxious, irritable, and with a poor self-image. The irritable and anxious temperament (Rothbart and Bates 2006), behavioral inhibition, and shyness (Geiger and Crick 2010, Rettew 2000) play a crucial role in this pattern of personality. Excessive rigidity, hypersensitivity, fear of novelty, avoidance, and withdrawal are risk factors. Relations of AvPD with shyness and inhibition suggest that withdrawal is a precursor of AvPD (Eggum et al 2009).

These children have a temperament that is slow to warm, and they are overwhelmed by environmental stimuli (PDM Task Force 2006). Obviously, family risk factors, stress, and trauma also contribute to the development of avoidant behaviors. Children can be programmed to be afraid and avoid people and situations that most persons consider innocuous. Stone (1993) included traumatic environmental factors such as physical and sexual abuse and incest in childhood as causes. Schaefer and Milman (1994) also include other parental factors such as excessive criticism, perfectionism, and neglect or role reversal.

Among the clinical conditions relevant to this pattern of personality, social phobia must be taken into account. According to several studies, the diagnoses of avoidance and social phobia overlap considerably (Boone et al. 1999, Marteinsdottir et al. 2003, Rettew 2000, LaFreniere 2009), but social phobia describes a more intense anxiety syndrome and is linked to specific situations, whereas avoidance is more pervasive and serious (Hummelen et al. 2007, Widiger 1992, Rettew 2000). Positive associations between anger and low impulsivity and avoidance were found (Meyer 2002, Warner et al. 2004).

Pathological obsessiveness emerging personality patterns

Emerging personality with pathological obsessiveness is characterized by excessive precision, attention to detail and rules, preference for productive activities, and obsessive thoughts not attributable to the typical events of the latency age. Children with pathological obsessiveness have little empathy, are a bit bizarre, and have difficulty in intimacy and in the expression of negative internal states. They are rigid, hypervigilant, and stubborn with their peculiar

thoughts. They often have a sequence of rituals related to very precise ideas about how certain things must be done. They have fears of dirt that often come from overprotective and anxious parents. They do not have friends because they do not feel the need. Their school performance can be affected by the need to follow exhausting rituals. This is the most compromised type of neurotic personality. In some cases, it could be hypothesized a continuity with OCPD in adulthood.

The features of OCPD appear persistent from childhood to adulthood, so it is possible to hypothesize that there is a specific pattern in childhood in homotypic continuity with adulthood. The obsessive aspect is central, because the compulsive aspect may not be always present in the developmental age (Westen et al. 2005). With obsession, these children maintain a sense of control to the point of losing the main purpose of the activity. They may be overly conscientious, scrupulous, and uncompromising in terms of morality, ethics, or values. They can also be very self-critical and rigidly submit to authority. They may be incapable of throwing away objects that are consumed or valueless, even when they have no affective meaning. In these children, the expression of the emotions is compromised. They have difficulty with empathy and recognition of others' points of view as well as in relationships generally (Kernberg et al. 2000).

P. Kernberg and colleagues (2000) also observed that hyper-control, inhibition of aggression, magical thinking, concern with rules, and hypersensitivity to criticism can be present in healthy development but obsessive children show hypersensitivity to these aspects. Schaefer and Millman (1994) hold that children who develop compulsive personalities are those whose fussiness, order, punctuality, intolerance to confusion and dirt, and attention to detail take too much time and interfere with their ordinary activities.

Obsession can be imagined on a continuum. At the most disturbed end, obsessed children cannot defend themselves from overwhelming anxiety, regression, or loss of reality testing. To the healthiest end of continuum, there are obedient children who follow rules and are very diligent. Obsessive children handle the anguish with defenses such as the isolation of affect, compartmentalization, and intellectualization. Compulsive children handle the anxiety through perfectionist and repetitive behaviors that may have the meaning of canceling fantasies (PDM Task Force 2006). The superego is rigid and strict, derived from the interiorization of an always-unsatisfied caregiver. This drives obsessive individuals to seek perfection, searching for satisfaction when real self-satisfaction is foreclosed.

The etiology of the disorder is familiar (Andrews et al. 1990). Stone (1993) noted that although genetic factors predispose the structure of the personality, OCPD is modeled by caregiving patterns. Parker and Stewart (1994) have noted that some OCPD traits in children have a negative impact on school performance but also that the educational system applauds some features, such as cleanliness, precision, competitiveness, self-criticism, and the need to maintain control.

Obsessive-compulsive disorder (OCD) is a clinical condition that must be taken into account; its important difference with OCPD is the egodystonic of symptoms. Diaferia and colleagues (1997) analyzed the relationship between OCPD and OCD, concluding that the two entities may share phenomenological characteristics but do not belong to the same genetic spectrum.

Dysphoric emerging personality patterns

A dysphoric emerging personality is characterized by a depression and an excess of inhibition. They are passive children, with frequent somatizations and difficulties in expressing their internal states, and they have feel strong guilt. They have difficulty interacting with their peers. At school their performance can be affected by self-devaluation and their fear of appearances. It is a middle–high functioning typology of personality but in its most severe forms it can seriously compromise the sufferer. In some cases, it could be hypothesized a continuity with depressive personalities in adulthood.

In the literature, a pattern emerges of a depressive personality that is never present in the classifications but is often reported in appendices or as a further subject of study. Rudolph and Klein (2009) supported the thesis that this PD exists and that its traits show continuity over time. Therefore, it is important not to omit this kind of emerging personality pattern in childhood, which shows homotypic continuity in adulthood.

Borderline personality organization

The PC axis of PDM-2 (Lingiardi and McWilliams 2017) argues that children with a borderline personality organization are characterized by rigid and inflexible thought. They may also show difficulty in differentiating what is coming from within them and what from the other. Under stress, they tend to become disorganized and show breaks with reality. These children show little capacity for self-reflection. Histories of maltreatment, including neglect and abuse, are not uncommon. They tend to show intense shifts in emotion, with acting out. They can be truly empathic at one moment and callous at the next. The functioning and the adaptation of these children are very variable.

According to O. Kernberg (1975, 1978), the borderline is a quite compromised personality organization. DSM-5 (APA 2013) describes Cluster B, called dramatic-impulsive, in a similar way. This cluster includes: borderline personality disorder (BPD), histrionic personality disorder (HPD), narcissistic personality disorder (NPD), and antisocial personality disorder (ASPD). These PDs are the most complex and well-studied in development. Often, they are included in other clinical conditions.

Table 3 gives a synthetic description of the emerging patterns of personality that we hypothesize are expressed in borderline organization.

Dysregulated emerging personality patterns

The dysregulated emerging personality is characterized by mood instability, impulsivity, anger, identity disorders, primitive defenses, theatricality, and somatization. Children with a dysregulated personality engage in unstable, intense, but superficial relationships with peers and adults. They are dependent and require constant attention but at the same time tend to deny their need. They may use seduction, are less empathic, tend to act out, and have a fragile self. Several clinical conditions may be present related to feeding, sleep, behavior, and regulation. School functioning can be severely compromised, in spite of the fact that they may have good intelligence. This is a kind of personality that is rather compromised. In some cases, it could be hypothesized a continuity with BPD and HPD in adulthood.

Table 3. *Mental Functioning and other significant factors of the Emerging Personality Patterns in Borderline Personality Organization*

	BORDERLINE	
MENTAL FUNCTIONING (MC) AND OTHER FACTORS	**DYSREGULATED**	**PATHOLOGICAL NARCISSISM**
Cognitive and Affective Processes	Intense emotions, rapidly shifting emotions, and mood instability. Attention difficulties, anhedonia. Needy and dependent, regressive, theatrical, little tolerance of frustration. Anxiety and depression. Little empathy.	Abstract thought, no psychological mentality and pseudo-insight. Arrogant, scornful and superb. Spirals of negative emotions. Little tolerance of frustration, no empathic.
Identity and Relationships	Sense of loneliness and need to control relationships. Fragile Self. Unstable self-image, body-image and identity. Unstable relationships, quickly attachments and fast changes.	Grandiose Self. Cruel, others are objects. No intimacy and need of admiration. Manipulator, difficult to regulate self-esteem, envious, jealous and dissatisfied. Disturbed self-image and body-image.
Defense and Coping	Impulsiveness, lack of control, dissociation, somatization.	Impulsiveness, lack of control.
Self-Awareness and Self-Direction	Self-critical, lack of judgment, unreachable standards, guilt.	Unrealistic or very low standard, not follow the rules, use the others, no remorse or guilt. Retreat and indifference after causing damage. No respect for rules.
Epigenetics		Environmental psychological deficit. Antisocial families.
Temperament	Reactive and immature.	Numbness and self-hypnosis, stubborn, immature. Difficult to regulate arousal.
Neuropsychology	Possible cognitive deficits and compromise learning.	Possible cognitive deficits and compromise learning for need of admiration and not acceptance of limits.
Attachment Style	Disorganization, parents unable to support development. Sensibility to environment.	Avoidant or disorganized. Neglecting caregivers who reject dependence or are scared and terrified.
Defense Mechanisms	Primitive defenses	Primitive defenses
Sociocultural Factors	Trauma and abuse	Environment and devious people

Some attempts have been made to evaluate BPD and HPD in childhood. Bleiberg (2001) defines children with these disorders as difficult because they are overactive, capricious, and irritable. They may make desperate efforts to avoid real or imaginary abandonment, and they are very sensitive to their environment. Sometimes they do not need anyone; sometimes they try to control someone else or submit themselves to achieve a sense of self (Kernberg 1983). They can be afflicted by chronic empty feelings. They are unable to express a various range of feelings, and when they express emotions they may be superficial and rapidly change. They often show an age-inappropriate maturity. They fail to control their impulses and do not show pleasure in peer interactions (Bleiberg 2001). Their level of ego functioning, with sudden regression, explains their cognitive deficits, attention and memory problems, and delay in verbal and motor development.

Emotional dysregulation is considered central in BPD (Berenbaum et al. 2003; Cicchetti et al. 1995; Cole et al. 1994, 2009; Gross and Muñoz 1995; Kring and Werner 2004). It is characterized by sudden, intense, and unpredictable changes (Siever and Davis 1991) and is context dependent, especially in relation to the caregiving relationship (Gunderson 2007). Emotional dysregulation rather than impulsivity is able to predict BPD symptoms in adulthood (Tragesser et al. 2007). Affective dysfunction, disinhibition (in the form of sensation seeking), and self and emotion regulation deficits also have a role in childhood BPD (Gratz et al 2009).

With regard to the etiology, it has been conceptualized as a product of specific traumas (Herman et al. 1986, Carlson et al. 2009, Crawford et al. 2009), genetic and temperamental predispositions (Svrakic et al. 1993, Carlson et al. 2009), and environmental experience (Crowell et al. 2009, Fonagy et al. 2002, Gunderson and Lyons-Ruth 2008, Putnam and Silk 2005). Dysfunctional, abusive, and neglected patterns in parent–child interactions lead to the development of the disorganized attachment often presented by BPD people (Agrawal et al. 2004). For these reasons, children with BPD mothers are more at risk of developing the same disorder (Lenzenweger and Cicchetti 2005). Difficulties in emotional regulation seem to overlap with those found in maltreated children with dissociation states (Macfie et al. 2001).

Instead, children identified with HPD show an anxious–insecure attachment that consists in an insatiable search for attention that is always frustrated. This frustration has the paradoxical effect of increasing that specific behavior rather than extinguishing it. Abse (1974) emphasizes that these children's caregivers are often negligent and show more care when children are sick. Such parents can suggest the idea that they are the only source of support, encouraging their children to be

dependent and passive (Sperling 1973). Moreover, they can have an inappropriate and sexualized relationship. A main feature of these children is their sensitivity to their caregivers' mood and unexpressed thoughts.

Pathological narcissism emerging personality patterns

An emerging personality with pathological narcissism is characterized by a grandiose self, difficulty in self-esteem regulation, excesses of anger, need for admiration, and splitting and devaluation defenses. Such children are without friends and they use others as a public or as objects for their personal profit. They have no empathy, tend to act out, and they show an early self-sufficiency. Their school functioning can be severely compromised by the difficulty of getting involved, by little respect for others and rules, and by excessive suffering from criticism. They often present other clinical manifestations, especially related to behavioral disorders. This is a rather compromised kind of personality. In some cases, it could be hypothesized a continuity with NPD and ASPD in adulthood.

Bleiberg (2001) emphasizes two basic features of pathological narcissistic regulation. The first is that these children are trapped in a pattern of discontinuous experience, with the impossibility of use the reflective function. The other is that unreflective models are projected to the outside. These children inspect the world to find something wrong and they force other people to act as they expect. For these children, the reflective function increases rather than decrease psychological vulnerability. These children find themselves able to actively trigger an auto-hypnotic state to escape pain, terror, and impotence.

Locating pathological narcissism in infancy is very complex, though in the developmental age, it tends to deviate toward becoming a disorder (Bardenstein 2009; Barry et al. 2003; Thomaes et al. 2008, 2009). Children need confirmation from their caregivers during development, but narcissistic children need them more than others (Baumeister and Vohs 2001). Narcissists are continually looking for situations where they can obtain a benefit (Morf and Rhodewalt 2001). Moreover, narcissists are more interested in establishing their superiority and dominance over others to feel good about themselves (Campbell et al. 2002) than in building social relationships.

Adult NPD is rooted in infancy, influenced by biology, temperamental features, and motivational systems (Elliot and Thrash 2001, Paulhus 2001). Self-esteem and aggressiveness are central in NPD. The covert or low-self-esteem variety of narcissism appears not to foster aggressive responding. In contrast, narcissists with high self-esteem, the so-called overt narcissists, appear to be exceptionally aggressive when criticized (Bushman et al. 2009).

Early dysfunctional interactions with caregivers can be an important predictor of pathological narcissism development. These caregivers may become offensive because they are frightened from their children's vulnerabilities, which they find unbearable in themselves. These children suffer from a twofold deficit: caregiver failure of their attachment needs and being the recipient of the projection of vulnerabilities denied by their parents (Bleiberg 2001).

In adolescent or adult with ASPD, early and chronic behavioral problems are present. Caregivers can be exhausted and can experience real fears for their children's behaviors (Frick and White 2008). There are also neuropsychological, executive and attention deficits, and impulsiveness. The heterogeneity of these issues, the early onset, and risk factors suggests many significant precursors (Dodge and Pettit 2003, Moffitt 2003, Willoughby et al. 2001). There are at least two subgroups of precursor signals: too-high or too-low levels of arousal and parenting interactions (Frick and Dickens 2006, Frick and White 2008, Frick and Viding 2009). Moreover, children with early antisocial behaviors differ for the presence or absence of callous-unemotional traits: in the first group, temperamental difficulties in processing emotional stimuli and responding to punishments could interfere with the normal development of empathy, guilt, and other aspects of conscience; in the other group, cognitive deficits and ineffective socialization lead to behavioral and emotional dysregulation (Frick and Viding 2009).

Etiology is attributed to environmental, genetic, temperamental, peer-relationship, and social-skill factors (Calkins and Keane 2009, Lahey et al. 2003, Olson and Sameroff 2009). The development of emotional regulation development is also implicated. A very important connection has been identified between self-regulation and antisocial behavior (Rothbart et al. 1994, Kochanska 1995, Oldehinkel et al. 2004). During childhood, success in emotional self-regulation largely depends on parental support and responsiveness of caregivers (Calkins and Fox 2002). Preschool children show aggressive, opposing, and impulsive behavior when their parents are not good resources for emotional care and education (Campbell 1995, Pettit et al. 1993). These children have disharmonious parent–child relationships characterized by low levels of affectivity, positive involvement, and support (McFadyen-Ketchum et al.1996).

At school, peers, such as caregivers, provide support in the development of regulatory functions. The expression of anger, aggression, and impulsivity leads to difficulties in establishing positive peer relationships (Eisenberg et al. 1993, Keane and Calkins 2004, Hubbard 2001). These children can be coercive and controlling and may be even ready to deceive, exploit, and abandon their friends as if they never mattered to them. However, peers' refusals may have negative consequences in the child's emotional development. Refusal, victimization, or exclusion are related to subsequent aggressive behaviors and high levels of delinquency (Deater-Deckard 2001, Rubin et al. 1998). Children who establish relationships with deviant peers show more deviant attitudes (Dishion and Piehler 2007).

Psychotic personality organization

On the PC axis of PDM-2 (Lingiardi and McWilliams 2017), this organization is conceptualized as strange verbal productions, changes in cognitive functioning, breaks with reality, somatization, and worries about the body. Affective reactions and behaviors may be a child's response to internal rather than external stimuli. Such children sometimes lose the boundary between themselves and the other and between play and reality. They may be bullied or avoided by other children because they are considered "weird" or "crazy." There is a little capacity of self-reflection. These children will frequently have significant family mental disorders.

O. Kernberg (1975, 1978) argue that the psychotic personality organization represents the highest level of pathology. DSM-5 (APA 2013) describes Cluster A in a similar way, defining them as bizarre and eccentric; this cluster includes paranoid personality disorder (PPD)

Table 4. *Mental Functioning and other significant factors of the Emerging Personality Patterns in Psychotic Personality Organization*

	PSYCHOTIC	
MENTAL FUNCTIONING (MC) AND OTHER FACTORS	**SUSPICIOUS**	**SCHIZOID**
Cognitive and Affective Processes	Jealous, suspicious, cold, detached and too self-sufficient. No empathy. No positive feelings. Thought disorders.	Bizarre and peculiar thought, eloquence and behavior. Constraint, no empathic and psychological mentality, cold and detached. Restricted feelings, depression and distractibility.
Identity and Relationships	Hypersensitive, no intimacy for fear of being betrayed and humiliated. No pleasure with others.	No intimacy, passive, strong withdraw, no need of others.
Defence and Coping	Reticent, megalomania and persecution.	Reacts badly to criticism
Self-Awareness and Self-Direction	Moralistic, rigid and strict.	Strange and peculiar
Epigenetics		Parents with possible affective disorders
Temperament	Hypervigilant and anxious	Anxious
Neuropsychology	Learning difficulties	Learning difficulties
Attachment Style	Humiliating, sadistic and violent caregivers.	Environmental failure
Defence Mechanisms	Primitive defenses	Primitive defenses
Sociocultural Factors	Trauma	

and schizoid personality disorder (SPD) or schizotypal personality disorder (StPD).

The diagnostic criteria for each PD in adulthood are similar to the childhood ones (Kernberg et al. 2000). In this cluster, the etiology is affected by biological more than other factors, and social factors have a role in determining the evolution of these PDs.

Table 4 presents a synthetic description of the emerging patterns of personality that we hypothesize are included in psychotic organization.

Suspicious emerging personality patterns

The suspicious emerging personality is characterized by mistrust, jealousy, and a tendency to interpret reality as malevolent. Children do not feel pleasure in being with others and often feel persecuted and victimized. They are more self-sufficient than is typical for their age because they cannot accept being dependent. They are hypervigilant and controlling. Moreover, they are hypersensitive and easily feel embarrassed and ashamed. They do not like to share things or emotions. School and social functioning are severely compromised. It is a highly compromised personality type with a possible continuity with PPD in adulthood.

There have not been many studies on the constitution of PPD. In adults with this disorder, however, it has emerged that it has its origins during development. People with PPD have a pattern of diffidence and suspicion, fear of intimacy, rancor, less humorous, inability to express strong positive emotions, excessive seriousness, coldness, detachment, moralism, and envy; they are also easily frightened and shy (APA 2013). The principal defensive mechanisms are splitting, projection, projective identification, denial, and omnipotent control. The inner world of these people is divided into an idealized self and a persecutory self, in relation to idealized and persecuted objects. The self with persecutory objects is projected onto external objects, whereas the self with idealized objects is introjected. In this way, there is a good self-image (megalomania) and a bad representation of others (persecution). Moreover, the use of projective identification leads paranoids to have attitudes and behaviors that provoke into aggressiveness and hostility, thus confirming their expectations. The utmost control is exerted used to keep this reality alive as malevolent. For these reasons, they tend to be hypervigilant and to keep away from others.

From an affective point of view, there are prevailing feelings of hostility, resentment, and vengeance. That is the result of infantile experiences of being overwhelmed and humiliated. Experiences of overwhelming frustration, early trauma or loss, and/or sadistic and violent caregivers together with constitutional aspects prevent the development of basic trust. Traumatic events such as child abuse or victimization by peers are highly correlated with the development of PPD (Natsuaki et al. 2009).

Schizoid emerging personality patterns

The schizoid emerging personality is characterized by peculiar thoughts, expressions, and behavior. They are not empathic children. They are closed to the world and present a strong social withdrawal driven by a great mistrust and lack of pleasure in being with others. They are bizarre and very anxious children. They are immersed in their world, reality testing can be compromised, and their school performance is severely deficient. This is a highly compromised personality type, showing a possible continuity with SPD or StPD in adulthood. Some attempts to evaluate the developmental features of these disorders have been done.

Studies on SPD show that the schizoid adult is dominated by a chronic dilemma about relationships: they cannot have it but they are not able to be alone.

The fantasies most commonly encountered in these patients are embedded in interpersonal relationships; such fantasies are often associated with early relational traumas that seem to justify these fears. Therefore, the failure of the primary environment is central (APA 2013). With regard to the defensive processes, the most important for SPD and StPD are splitting, projection, projective identification, and retreat into fantasy. Such mechanisms help them to escape from social or interpersonal situations, confusing the stimuli of their inner world with external reality. In these children, there is a profound contradiction between what they manifest, detachment, and indifference, and what they live in fantasy, where they often build a private world full of omnipotence and aggression. The almost absence of any form of expression of emotions creates the impression of a general coldness and detachment and of almost total affective flattening (Bernstein et al. 2009).

The longitudinal course of SPD is still unknown. This disorder is heterogeneous and in constant evolution with some remissions or improvements (Seivewright et al. 2002). It seems reasonable to say that SPD shows a high degree of plasticity over time, probably due to variability in temperament (Lenzenweger and Willet 2009). Therefore, some subjects with SPD may not show symptomatic patterns anymore or may shift to a more serious form of disorder (schizotypal or psychotic symptoms) (Wolff et al. 1991).

A study of StPD by Olin and colleagues (1997) confirmed that late-age children diagnosed as schizotypal were passive, socially disengaged, hypersensitive to criticism, and nervously reactive to events. The authors claimed that this disorder can be diagnosed in children and that its manifestations are similar to adulthood one. The strong hypersensitivity to the criticism found in schizotypal children is a precursor to social anxiety and it reduces their socialization opportunities (Olin et al. 1997).

Studies on adopted children suggest a genetic relationship between this disorder and schizophrenia, of which StPD seems to be a mitigated variant. Kendler and Walsh (1995) argue that schizotypal traits are not specific to schizophrenia but reflect a broad vulnerability to non-affective psychoses. Likewise, some authors report that StPD is more frequent in children whose parents have an affective disorder (Squires-Wheeler et al. 1989).

StPD and SPD share many traits, but StPD has more pronounced psychotic features and is stable over time (Squires-Wheeler et al. 1992). Some schizoid children develop StPD in adulthood (Ellison et al. 1998).

Conclusions and future directions

Using the literature data, this study defined possible developmental pathways for emerging personality patterns in childhood. We argue that it is possible to define emerging patterns that may lead to PDs in adolescence and adulthood. The study of childhood personality can inform us about mental functioning, precursors and pathways of development. The emergence and the developmental course of personality pathology could be confirmed by longitudinal studies that describe both the pathological developmental trajectories and the recovery of children due to protective factors.

In conclusion, it seems to us that certain fundamental things are missing:

- A complete tool that allows the investigation of the developmental personality. We think it is important to evaluate risks and protective factors and, where necessary, diagnose.
- A better understanding of mental functioning and aspects of the personality of children.
- A specific classification, empirically derived, that takes into account developmental age, with special attention to continuity and change.

Childhood personality disorders have already been discovered in literature and are a challenge for clinical treatment.

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