PATHWAYS TO THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER

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The available empirical evidence concerning the etiology of borderline personality disorder is reviewed. A tripartite model of the development of BPD is then presented. This model has three elements: a traumatic childhood (broadly defined), a vulnerable (hyperbolic) temperament, and a triggering event or series of events. The authors conclude that each borderline patient has a unique pathway to the development of BPD that is a painful variation on an unfortunate but familiar theme.

The place of borderline personality disorder (BPD) in psychiatric nosology has long been a point of contention. Stern (1938) was the first author to use the term borderline to describe a specific pathological condition—a condition that he thought had both neurotic and psychotic features.

Since that time, there have been six main conceptualizations of this term. The first of these conceptualizations is based on the work of Kernberg (1975). In this view, the term borderline is used to describe most serious forms of character pathology. The second conceptualization reflects the work of Gunderson (1984). In this view, the term borderline describes a specific form of personality disorder that can be distinguished from a substantial number of other axis II disorders, particularly those in the "odd" and "anxious" clusters of DSM-III and DSM-III-R. The third conceptualization, which flourished in the 1960s and 1970s, focused on the propensity of borderline patients to have transient psychotic or psychotic-like experiences. In this view, borderline personality was thought of as being a schizophrenia spectrum disorder (Wender, 1977). The fourth of these conceptualizations, which organized much of clinical care and empirical research in the 1980s, focused on the chronic dysphoria and affective lability of borderline patients. In this view, borderline personality was thought of as being an affective spectrum disorder (Akiskal, 1981; Stone, 1980).

Both the fifth and sixth theories of borderline psychopathology have arisen during the 1990s. Zanarini and her colleagues (1993) have proposed...
that borderline personality disorder is best conceptualized as an impulse spectrum disorder (i.e., a disorder related to substance use disorders, antisocial personality disorder, and perhaps eating disorders). In this view, BPD is not seen as an attenuated or atypical form of one of these impulse spectrum disorders. Rather, these authors suggest that BPD is a specific form of personality disorder that may share a propensity to action with other disorders of impulse control.

At about the same time, Herman and van der Kolk (1987) suggested that BPD might better be conceptualized as a chronic form of PTSD. This theoretical observation led, in part, to the view that BPD is a trauma spectrum disorder, related to PTSD and dissociative disorders, including dissociative identity disorder.

While the validity of BPD is now generally accepted, the etiology of the disorder is still in the process of being uncovered. The first attempt to explain the development of BPD came from the psychoanalytic community, and over the years, three major psychodynamic theories of the pathogenesis of the disorder have been proposed.

**PSYCHODYNAMIC THEORIES OF THE PATHOGENESIS OF BPD**

In the first of these theories, Kernberg (1975) suggests that excessive early aggression has led the young child to split his or her positive and negative images of him or herself and his or her mother. This excess aggression may have been inborn, or it may have been caused by real frustrations. In either case, the preborderline child is unable to merge his or her positive and negative images and attendant affects to achieve a more realistic and ambivalent view of him or herself and others.

In the second of these theories, Adler and Buie (1979) suggest that failures in early mothering have led to a failure to develop stable object constancy. Because the preborderline child’s mothering was inconsistent, and oftentimes insensitive and nonempathic, the child fails to develop a consistent view of him or herself, or of others, that he or she can use in times of stress to comfort and sustain him or herself.

In the third of these theories, Masterson (1972) suggests that fear of abandonment is the central factor in borderline psychopathology. He believes that the mother of the future borderline patient interfered with her child’s natural autonomous strivings by withdrawing emotionally when the child acted in an independent manner during the phase of development that Mahler (1971) has termed “separation-individuation.” Later experiences that require independent behavior lead to a recrudescence of the dysphoria and abandonment panic that the borderline patient felt as a child when faced with a seemingly insoluble dilemma (either continue to behave dependently or lose needed emotional support).

**PREVIOUSLY STUDIED ETIOLOGICAL FACTORS**

Six factors that may have etiological significance for the development of BPD have been studied empirically. Three of these factors are environmental in nature. These factors involve, at a propensities to c and 3) subtle factors.

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nature. These factors are: 1) early childhood separations, 2) disturbed parental involvement, and 3) childhood experiences of abuse. The other three factors are probably more constitutional in nature. These factors are: 1) familial propensity to certain psychiatric disorders, 2) temperamental vulnerabilities, and 3) subtle forms of neurological and/or biochemical dysfunction.

The first studies of the environmental factors that might be of etiological significance for borderline personality disorder focused on issues raised in the psychodynamic theories reviewed above. Two topics were studied with particular care: parental separation or loss and disturbed parental involvement.

STUDIES OF PARENTAL SEPARATION OR LOSS
Six studies have assessed the prevalence of prolonged early separations and losses in the childhood histories of borderline patients (Akiskal et al., 1985; Bradley, 1979; Links, Steiner, Ossoff, & Eppel, 1988; Soloff & Millward 1983a; Walsh, 1977; Zanarini, Gunderson, Mariko, Schwartz, & Frankenbach, 1989). Two conclusions have emerged from these studies. First, prolonged early separations and losses are common among borderline patients; being reported by 37% to 64% of the borderline patients in these studies. Second, prolonged early separations and losses are highly discriminating for borderline patients; being reported by a significantly higher percentage of borderline patients than psychotic, affective, or personality-disordered controls.

STUDIES OF DISTURBED PARENTAL INVOLVEMENT
Eight studies have assessed the type of relationships that borderline patients report having had with their parents (Frank & Hoffman, 1986; Frank & Paris, 1981; Goldberg, Mann, Wise, & Segall, 1985; Grinker, Werble, & Drye, 1968; Gunderson, Kerr, & Englund, 1980; Paris & Frank, 1989; Soloff & Millward, 1983; Walsh, 1977). Three conclusions emerged from these studies: 1) patients with BPD usually see their relationships with their mothers as highly conflictual, distant, or uninvolved; 2) the father’s failure to be present and involved is an even more discriminating aspect of these families than a problematic relationship between a preborderline person and his or her mother; and 3) disturbed relationships with both parents may be both more specific for BPD and more pathogenic than those with either one alone.

STUDIES OF CHILDHOOD ABUSE
Nine studies have assessed the childhood histories of physical and/or sexual abuse reported by borderline adolescents or adults (Herman, Perry, & van der Kolk, 1989; Links, Steiner, Ossoff, & Eppel, 1988; Ogata et al., 1990; Paris, Zweig-Frank, & Guzder, 1994a; Paris, Zweig-Frank, & Guzder, 1994b; Salzman et al., 1993; Shearer, Peters, Quaytman, & Ogden, 1990; Westen, Ludolph, Misler, & Ruffins, & Bold, 1990; Zanarini, Gunderson, Mariko, Schwartz, & Frankenbach, 1989). Four main findings have emerged from these studies. First, both physical and sexual abuse are relatively common in the childhood histories of criteria-defined borderline patients. Second, physical abuse is generally not reported significantly more often by borderline patients than controls. Third, sexual abuse is consistently
reported significantly more often by borderline patients than depressed or personality-disordered controls. Fourth, a quarter of borderline patients report a history of parent-child incest; the other 25% to 30% with histories of sexual abuse report being abused by other types of perpetrators, such as other relatives, neighbors, or peers.

**BPD AND FAMILY HISTORY OF PSYCHIATRIC DISORDER**

To date, ten studies that have assessed a range of psychiatric disorders in the first-degree relatives of borderline patients meeting modern research criteria for BPD have been published [Akiskal et al., 1985; Andrulonis & Vogel, 1984; Baron, Gruen, Asnis, & Lord, 1985; Loranger, Oldham, & Tullis, 1982; Loranger & Tullis, 1985; Links, Steiner, & Huxley, 1988; Pope, Jonas, Hudson, Cohen, & Gunderson, 1983; Schulz et al., 1989; Soloff & Millward, 1983b; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1988]. Taken together, the results of these studies, which vary considerably in their methodology, are very consistent in indicating little if any familial link between BPD and schizophrenia and/or schizotypal personality disorder. They are also very consistent in indicating that affective disorder, particularly unipolar affective disorder, is very common among the first-degree relatives of borderline probands. However, unipolar depression was also found to be common among the relatives of controls. In addition, the results of these studies suggest a strong familial link between BPD, substance use disorders, and antisocial personality disorder. Perhaps most importantly, all four studies that have assessed the familial risk of developing BPD have found that BPD “breeds true” (i.e., is significantly more common among the first-degree relatives of borderline patients than of controls).

Clearly, only twin studies or adopted-away studies can definitively address the issue of the genetic heritability of BPD. Thus, the results of the studies reviewed above may indicate the environmental stress of being raised by a psychiatrically disturbed caretaker or living with a psychiatrically ill sibling as much as they indicate an underlying biological propensity to develop any of these disorders.

**TEMPERAMENTAL CONCERNS**

Recent research has found that borderline personality disorder is associated with a temperament characterized by a high degree of neuroticism (i.e., emotional pain) as well as a low degree of agreeableness (i.e., strong individuality) [Clarnk, Hull, Cantor, & Sanderson, 1993; Soldz, Budman, Demby, & Merry, 1993; Trull, 1992]. BPD has also been found to be the only axis II disorder that is associated with a high degree of both harm avoidance (i.e., compulsivity) and novelty seeking (i.e., impulsivity) [Svrakic, Whitehead, Przbeck, & Cloninger, 1993].

**NEUROLOGICAL AND/OR BIOCHEMICAL DYSFUNCTION**

Andrulonis and his colleagues [Andrulonis et al., 1981; Andrulonis, Glueck, Stroebel, & Vogel, 1982; Andrulonis & Vogel, 1984] were the first to propose that at least a subset of borderline patients could best be conceptualized as having some type of head trauma, end deficit disorder and/or schizophrenia. Surprisingly, this hypothesis has not been widely accepted.

The results of other studies have suggested that patients with BPD have a history of an abnormally high number of EEG abnormalities [Cornellius, Kimble, & Williams, 1991]. Four studies conducted. Two of these studies showed EEG abnormalities that were essentially normal. Two others found EEG abnormalities, rates that differed from rates found in patients with BPD [Lucas, 1990; Williams, 1991].

To the best of our knowledge, no studies have found consistent results. However, it is clear that borderline personality disorder is associated with a high degree of both harm avoidance and novelty seeking, which suggests a neurobiological basis for the disorder.

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Stone (1980) was the first to propose that a person is at risk for developing borderline personality disorder if they have been exposed to psychological trauma early in life. This risk increases if the trauma is related to sexual abuse. The development of borderline personality disorder is then thought to be influenced by a combination of genetic and environmental factors.

**CONCLUSION**

In summary, the evidence suggests that borderline personality disorder is a complex disorder that is influenced by both genetic and environmental factors. Further research is needed to better understand the underlying mechanisms that contribute to the development of this disorder.
as having some type of organic impairment. They based this conclusion on their finding that 14% of the borderline patients they studied had a history of head trauma, encephalitis, or epilepsy, and 26% had a history of attention deficit disorder and/or a learning disability.

Surprisingly, this hypothesis has received relatively little empirical investigation until quite recently. One study (Van Reekum, Conway, Gansler, White, & Bachman, 1993) found that 44% of a sample of mostly male borderline inpatients had a history of a developmental deficit and 58% had a history of an acquired brain insult—figures which were significantly higher than for gender matched general psychiatric controls. However, two other studies failed to find any significant differences in developmental deficits or acquired brain insults between borderline inpatients and axis II controls (Kimble, Oopen, Weinberg, Williams, & Zanarini, 1996; Zanarini, Kimble, & Williams, 1994).

The results of electroencephalographic studies among criteria-defined borderline patients have also been mixed. Two studies have reported a significantly higher rate of abnormal EEG findings among borderline patients than depressed controls (Cowdry, Pickar, & Davies, 1985-1986; Snyder & Pitts, 1984). However, two other studies have found that the rate of abnormal EEG findings in borderline patients and axis II controls is about the same (Cornelius, Brenner, Soloff, Schulz, & Tumuluru, 1986; Zanarini, Kimble, & Williams, 1994).

Four neuroimaging studies of borderline patients have also been conducted. Two of these studies found that the CT results of borderline patients were essentially normal (Schulz et al., 1983; Snyder, Pitts, & Gustin, 1983). Two others found that 13%-39% of borderline patients had abnormal CT findings—rates that did not distinguish them from healthy normal or axis II controls (Lucas, Gardner, Cowdry, & Pickar, 1989; Zanarini, Kimble, & Williams, 1994).

To the best of our knowledge, no study has systematically assessed the results of routine neurological examinations of criteria-defined borderline patients. However, the one relevant study (Gardner, Lucas, & Cowdry, 1987) found that borderline patients had a significantly greater number of soft sign neurological abnormalities than normal controls had.

In addition, the results of biochemical studies have typically been consistent with reduced serotonergic activity being found in criteria-defined borderline patients (Coccaro et al., 1989; Hollander et al., 1994). This deficit is believed to be partially responsible for the problematic impulsivity of these patients.

PATHWAYS TO THE DEVELOPMENT OF BORDERLINE PERSONALITY DISORDER

Stone (1980) was the first to suggest that the development of BPD might best be accounted for by a diathesis-stress model. In this view, the more vulnerable a person is to the development of BPD, the less environmental stress would be needed to develop a full-blown case of BPD. Conversely, the less innately vulnerable a person is, the more environmental stress it would take to develop BPD.
This theory makes intuitive sense, and it allows for the importance of each of the environmental and constitutional factors reviewed above. However, our group and others have suggested that the model of the development of BPD that best captures the complexity of borderline psychopathology is multifactorial in nature (Zanarini & Frankenburg, 1994). This model suggests that borderline symptomatology and its comorbid manifestations are the final end product of a complex admixture of innate temperament, difficult childhood experiences, and relatively subtle forms of neurological and biochemical dysfunction (which may be sequelae of these childhood experiences or innate vulnerabilities). It also suggests that there may be subgroups of borderline patients, due to differing combinations and/or interactions of these various risk factors.

Consistent with this multifactorial model, we believe that three factors—one environmental in nature, one constitutional in nature, and one representing the interaction of the other two or a triggering factor—are necessary (but perhaps not sufficient) for the development of BPD.

The first of these factors is a home environment that is traumatic in a broadly defined sense. In some cases, the trauma might be confined to the types of childhood experiences that can be categorized as unfortunate but not totally unexpected. These experiences, which we call Type I Trauma, would include prolonged early separations, chronic insensitivity to the preborderline child’s feelings and needs, and serious emotional discord in the family, perhaps leading to separation or divorce. Type II Trauma would include experiences of verbal and emotional abuse, neglect of age-appropriate physical needs, and circumscribed episodes of parental psychiatric illness. Type III Trauma would include experiences of frank physical and sexual abuse, chronic types of caretaker psychiatric illness, particularly axial II psychopathology and substance abuse, and a generally chaotic and dysfunctional home environment (e.g., parents repeatedly engage in shouting matches, the children physically assault one another, no one abides by family rules or honors other family members’ personal boundaries).

While for heuristic purposes we have defined three different types of environmental trauma that we have found are common in the histories of borderline patients, these types of trauma often occur sequentially or co-occur in the childhoods of many borderline patients. Recent research results from our group and others (Paris, Zweig-Frank, & Guzder, 1994a, 1994b; Zanarini, Dubo, Lewis, & Williams, 1996) have found that about half of borderline patients report a childhood characterized by Type I and/or Type II Trauma. These same studies have also found that the remaining half of borderline patients report a childhood characterized by all three types of trauma that we have described.

The second factor necessary for the development of BPD is a vulnerable temperament. Previously, we have described emotional hypochondriasis as the primary defense of borderline patients, and a hyperbolic stance as the behavioral manifestation of this defense (Zanarini & Frankenburg, 1994).

In this view, emotional hypochondriasis is defined as the transformation of unbearable feelings of rage, sorrow, shame, and/or terror into unremitting affect, the emotional process and involve a core “insensitivity.”

The outward manifestations of borderline patients dramatically is severe and unrelenting. In the case of the Death of a Son, the author’s deteriorating health and perception of his own worth over a period of years is dramatized by the suicide efforts engendered by the sacred history of the world. Deliberately physised, suicide efforts engender stress and feeling of hopelessness.

While anyone may demonstrate typical of borderline patients, their pain is not their own. The role of the therapist is to help the patient recognize and eventually accept his or her feelings and situations, thus having his or her feelings.

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importance of each described above. However, the development of psychopathology is ill. This model suggests that manifestations are late temperamental symptoms of neurological childhood that there may be combinations and/or

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different types of experiences in the histories of our sequential or recent reports, Guzder, 1994a, found that about 80% of the remaining cases are classified as Type I, and/or Type II. All three types

PD is a vulnerable psychosis as a result as the vulnerability to the patient's innate vulnerability, which we have conceptualized as traumatic events. Without such an event or series of events, which remind the patient of old feelings of rage, despair, and may represent the final degree of frustration that he or she can bear, such a person might be viewed as intense and demanding but not clearly ill or impaired. Or he or she might be viewed as having a mild outpatient case of BPD. In our experience, these “borderline trait” patients display the same symptoms but in a milder form than the more severe BPD group.

Thus, the model of the development of BPD that we have proposed is tripartite and can be characterized as the transformation of terror into unremittent attempts to get others to pay attention to the enormity of the emotional pain that one feels. These attempts are usually indirect, and involve a covert reproach of what is perceived as the listener’s “insensitivity,” “stupidity,” or “malevolence.”

The outward manifestation of this defense is the hyperbolic stance of the borderline patient. To put it most succinctly, nothing that can be stated dramatically is said simply, and nothing that can be stated once goes unreported. In other words, much as the wife of Loman’s in Arthur Miller’s The Death of a Salesman (1949) believed that “attention must be paid” to his deteriorating situation, borderline patients insist that attention be paid to the enormity of their subjective pain—pain that is often consciously perceived and openly discussed as “the worst pain anyone has felt since the history of the world began.” Perhaps most prototypic of this behavior is the deliberately physically self-mutilative acts and manipulative (help-seeking) suicide efforts engaged in by borderline patients when under interpersonal stress and feeling alone.

While anyone would be in pain, given the traumatic childhood environment, the manner in which borderline patients handle their pain is both characteristic and distinguishing. They insist that their pain be recognized and they present it in a difficult-to-identify manner, due to a combination of habituation and shame. Transforming our dynamic considerations into descriptive terminology, we would characterize the temperament of borderline patients as hyperbolic.

The third factor necessary for the development of BPD is a triggering event or series of events. The experiences that we would describe as triggering can be normative in nature, such as moving away from home to attend college or starting an intimate relationship. They also can be traumatic in nature, such as being injured in a car crash or being date raped. In either case, such an event seems necessary to propel a borderline person toward the full expression of his or her psychopathology and/or to enter treatment, and thus have his or her condition noticed for the first time.

The role of this triggering event seems to be that of a bridge between the intense dysphoria and frustration resulting from traumatic childhood experiences and the preborderline person’s innate vulnerability, which we have conceptualized as a hyperbolic temperament. Without such an event or series of events, which remind the patient of old feelings of rage, despair, and may represent the final degree of frustration that he or she can bear, such a person might be viewed as intense and demanding but not clearly ill or impaired. Or he or she might be viewed as having a mild outpatient case of BPD. In our experience, these “borderline trait” patients display the same symptoms but in a milder form than the more severe BPD group.

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experiences, which tend to occur within the family and out of public view, interact with a preborderline patient's innate hyperbolic temperament to create an inner sense of emotional misery and almost total frustration. A normative or traumatic triggering event then occurs which reminds the preborderline person of earlier stress or trauma. This event, or series of events, acts as a catalyst for the fruition of a full-blown borderline condition with its characteristic symptom pattern (i.e., chronic, intense dysphoria: transient paranoid or dissociative experiences; impulsivity in a number of self-destructive areas; troubled interpersonal relationships marred by problems such as demandingness, manipulation, and extreme dependency).

It is tempting to describe different subtypes of borderline patients with correspondingly different pathways to the development of BPD. It is particularly tempting to describe borderline patients who have a childhood history of sexual abuse as one subtype, and those who have no such history as being another subtype. Unfortunately, for all its heuristic value and clinical interest, this view is not consonant with the facts. First, recent research has found that borderline patients, with and without comorbid PTSD, have almost identical subsyndromal phenomenology (Zanarini et al., 1995). Second, recent research has also found that the childhood sexual abuse reported by borderline patients almost always occurs in a context of biparental abuse and neglect (Zanarini, Dubo, Lewis, & Williams, 1996). Thus, it is almost never alone among environmental factors as being both necessary and sufficient for the development of BPD. Third, recent research has also found that not all sexually abused borderline patients report being sexually abused in the same way (Paris, Zweig-Frank, & Guzder, 1994a, 1994b). Some report very severe forms of abuse, and others report less severe forms of abuse.

Subdividing borderline patients along the lines of their history of sexual abuse may also have deleterious consequences for those in both groups. Borderline patients without a history of childhood sexual abuse may be seen by other patients, and by inexperienced therapists alike as being "second class" borderlines. Clearly, this is both an unhelpful and unrealistic attitude that interferes with treatment by fostering the view that pain is a competitive sport.

Conversely, borderline patients with a history of childhood sexual abuse may be seen by inexperienced therapists as not really being borderline, but as having some chronic form of PTSD. This too is an unfortunate view, in that it can lead to a too intensive, or even exclusive, exploration of memories of childhood abuse. This may continue even though the patient's condition is deteriorating, or even though it is not what the patient sees as most relevant and pressing to his or her current situation. This reframing of BPD can also lead to an unwillingness to deal with the more characterological aspects of BPD (e.g., acting in a very demanding or controlling manner when most angry or afraid).

When all of these matters are considered, we believe that there are as many pathways to the development of BPD as there are borderline patients. Each pathway is poignant in its uniqueness and agonizing in its similarity. Each is a painful variation on an unfortunate but familiar theme.

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Just as there are a myriad of ways to become borderline (although each shares certain factors in common), there are a wide variety of ways of being borderline. Some common differences are the different patterns of comorbidity found in male and female borderline patients (Zanarini & Dubo, 1995). Additionally, there are a number of different pathways to health for borderline patients. Many of these pathways (e.g., sustained educational performance, finding a mentor, becoming involved in an emotionally sustaining intimate relationship) are heavily influenced by aspects of one’s natural endowment and normative aspects of temperament. For example, some borderline patients are highly intelligent, while others are not. Some borderline patients are very likeable, while others are less so. Some borderline patients are very active and determined, while others are more passive.

In the end, studying children at high risk for developing BPD will best explain the etiology of BPD. Currently, we have such a study underway. However, until the results of such studies are known, it is important to remember that all pathways to the development of BPD are long, complicated, and painful.

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