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‘This is the peer reviewed version of the following article: Wlodarczyk, J., & Lawn, S. (2016). The developmental trajectory of Borderline personality disorder and peer victimisation: Australian family carers’ perspectives. Emotional and Behavioural Difficulties, 22(2), 98–110. https://doi.org/10.1080/13632752.2016.1243360

which has been published in final form at
http://dx.doi.org/10.1080/13632752.2016.1243360

"This is an Accepted Manuscript of an article published by Taylor & Francis in Emotional and Behavioural Difficulties on 12 Oct 2016, available online: http://
www.tandfonline.com/10.1080/13632752.2016.1243360."

Title: The developmental trajectory of Borderline Personality Disorder and peer victimisation: Australian family carers' perspectives

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Abstract (150 words)

Victimisation is a traumatic experience linked to development of Borderline Personality Disorder (BPD). However, there is limited research investigating the developmental journey prior to BPD diagnosis. School environments offer an opportunity for BPD prevention and early intervention. A survey with 19 Australian family carers of people with BPD asked what they noticed during the person's infancy, childhood and adolescence, and their experiences of seeking help during that time. Sensitivity was most noticeable during infancy; difficulty making friends, school refusal/truancy and being bullied were prominent concerns once the child was at school; and concerns about anger, moodiness and impulsivity were the strongest prompts to seek help during adolescence, though doctor or teacher recommendation

to do so was uncommon. BPD family carers' experiences suggest that improved focus on addressing bullying and communication is needed.

Keywords

Borderline personality disorder (BPD); childhood adversity; peer victimization; bullying; family carers

Manuscript Word Count: 6104

Peer victimization and development of Borderline Personality Disorder

Various forms of adverse childhood experiences are thought to be associated with the development of Borderline Personality Disorder (BPD) for many people who experience this mental health diagnosis (Fonagy & Bateman, 2008; Hengartner et al, 2013; Herman, Perry & Van Der Kolk, 1989; Lobberstael et al, 2010; Martin-Blanco et al, 2014; Morandotti et al, 2013; Sansone & Sansone, 2007; Sansone et al, 2013). The aetiological importance of dysfunctional parent-child relationships has been widely emphasized in the literature (Lobbestael et al, 2010; Hengartner et al, 2013) but compelling evidence suggests that being a victim of bullying/violence at school (peer victimization) is also a major predictor of BPD (Arseneault et al, 2009; Sansone et al, 2010; Goodman et al, 2010; Wolke et al, 2011). Peer victimisation has been found to be commonplace among adolescents across Europe and North America (Molcho, et al., 2009). It can take many forms and includes cyberbullying. Peer victimisation has long been understood as a traumatic experience with negative long-term mental health consequences (van Geel, Vedder & Tanilon, 2014). A large UK study investigating frequent and occasional peer victimisation

at age 13 years (n=6719) (Bowes, et al, 2015) found that 29.2% of depression at age 18 years could be explained by peer victimisation and that those who were frequently victimised by peers had over a twofold increase in odds of depression. In fact, recent studies propose that peer victimization is a stronger predictor of BPD than some early adverse experiences that are traditionally considered central to the disorder's aetiology, such as sexual abuse during childhood (Goodman et al, 2010; Hengartner et al, 2013). Ford and Parker (2016) describe Bullying as, "probably the most tractable public mental health problem" (p.3; see also Ford, Mitrofan, and Wolpert 2014; Scott et al. 2014).

The link between peer victimization and BPD symptomatology is consistent with findings that indicate peer victimization has serious consequences for the mental health of victims, who may display anxiety, self-harm, violent behaviour, and psychotic symptoms in response to victimization (Arseneault et al. 2009; Hengartner et al. 2013; Wolke et al. 2012; Sansone et al. 2013). In their study on the relationship between various personality disorder dimensions and different forms of childhood adversity, Hengartner et al. (2013) conclude that peer victimization is a central aspect of every personality disorder listed in DSM-IV-TR. Strong associations were revealed between most dimensions and peer victimization, school-related conduct problems, and emotional abuse. These links were particularly salient in the case of BPD. Interestingly, the authors found that, although sexual abuse influences BPD, the association is weak because of insignificant effect size (Hengartner et al, 2013).

Notably, two separate studies on samples of non-psychiatric individuals from non-psychiatric outpatient clinics found significant relationships between peer victimization and BPD symptomatology (Sansone et al. 2010; Sansone et al. 2013). Studies on clinical but non-psychiatric populations are important for corroborating the association between peer victimization and BPD development because findings in this context are less susceptible to the effects of recall bias attributable to the response of participants who may have active mental health disorders and solicit mental health attention (Sansone et al, 2013).

Peer victimization is one of potentially several adverse experiences that contribute to the psychosocial and environmental aspects of BPD development in certain people with this diagnosis. Accordingly, efforts

to prevent BPD development or intervene once it is recognized must appreciate that peer victimization is a risk factor for BPD symptomatology. Wolke et al. (2012) aptly point out that the concept of childhood adversity should be reworked so that it applies to other distinct forms of non-traumatic childhood adversity (e.g. peer victimization, poverty, divorce) because of the substantive evidence suggesting that they too significantly influence psychopathology. Similarly, Michail (2011) has prompted a pluralist and multifactorial approach to the mental wellbeing of youth, and its deterioration, by referring to the 'whole ecology of the child'. These viewpoints are important for prevention and early intervention because they accommodate the multiplicity of adult roles played by carers, teachers, school counsellor[1] and general practitioners (GPs), and their impact on a child's life. Each of these individuals can be important sources of support and advice for the child who might be unable to cope physically and emotionally with their circumstances.

1. The term 'school counsellor' is a generic term for a person within the school environment whose specific focus and role is to address individual student mental health and wellbeing issues. In some contexts and juridictions, this person is a trained psychologist or other health professional with mental health qualifications. The term used here is commonly used in the literature in Australia, Europe and North America. Similar terms are 'guidance counsellor' and 'pastoral care worker', though these may not have equivalent health qualifications.

BPD is unlikely to emerge in adulthood without earlier developmental antecedents (Fonagy & Bateman, 2008; Baird, Veague and Rabbitt, 2005). Investigations into the relevance of various stages of pre-adulthood have revealed that the effects of peer victimization on BPD development may be especially significant during the stage of pre-adolescence (Helgeland & Togersen, 2004). Longitudinal work by Wolke et al. (2012) showed that exposure to peer victimization in primary school is a predictor of BPD symptomatology at age 11.8 years. Furthermore, in their study of parental viewpoints on children who are following a BPD developmental trajectory, Goodman et al. (2010) found that features consistent with BPD can become detectable within a child's first year of life. Observations of phenomena related to BPD occurring so early on in development are consistent with the possibility that an affective predisposition may be at play in BPD development and underscores the relevance of genetic underpinnings (Lobestael et al, 2013). Studies that enrich our understanding of the timescale involved in BPD development are crucial. They indicate that instituting prevention and early intervention may be possible much earlier in a

child's life. However, there is a dearth of research investigating the developmental journey of the child prior to a BPD diagnosis (Wright et al. 2015).

Prevention and early intervention in schools

A sufficiently broad and inclusive characterization of conditions that enable BPD allows us to consider a significant environmental risk factor (peer victimization) that is profoundly unmanaged. Prevention and early intervention strategies should be informed by the contexts (such as school) that are relevant to adolescence (Helgeland & Togersen, 2005; Sansone et al, 2013; Wolke et al, 2012). To that end, elaborating the 'ecology' that an individual participates in over developmental time requires a wide consideration of the various institutions and adult individuals with whom the child engages (Graham et al, 2011). Schools constitute an important social environment that influences the development of BPD symptomatology. School environment may have a profound effect on which behavioural and experiential pathways are set down in adolescence, a stage that is considered the "tipping point" for the formation of personality disorders (Baird, Veague & Rabbitt, 2005).

The effects of positive and negative school environments on the temporal continuity of BPD symptomatology during adolescence have been demonstrated; in particular, interpersonal conditions that are validating, inclusive, and non-hostile may be closely linked to reductions in symptomatology over time (Kasen et al, 2009). Likewise, superior school performance, which may be promoted by such interpersonal conditions, may be associated with decreased risk of onset of BPD in later life (Kasen et al. 2009; Helgeland & Togersen, 2004).

Despite awareness and education initiatives like MindMatters (2015) and HeadSpace (2015), the failure to properly address mental health problems and peer victimization in schools and via social media (either at school or outside of school times) remains systemic in Australia (Bagshaw 2015; Hamm et al 2015; Spears et al 2014; Trudgen & Lawn 2011). Cross et al. (2009) found that peer victimization affects approximately one in four students among the Year 4 to Year 9 (9-14 year olds) Australian student population.

Cyberbullying, in particular, between young people has gained increasing focus, internationally, within the school environment and in the community, more broadly. Hamm et al. (2015) argued that, "Adolescents are connected to social media at a time when their levels of social and emotional development leave them vulnerable to peer pressure and when they have a limited capacity to self-regulate" (p.771). However, in their international review, they found inconsistent links or conflicting results between being bullied and self-harm and suicidality, or between cyberbullying and anxiety. The most common reason for cyberbullying was found to be relationship issues. Girls were most often the recipients or cyberbullying; they were often passive, and lacked awareness or confidence that anything can be done to address the bullying. Of the 10 studies that examined links between social media victimisation and depression, all found a statistically significant connection.

An online study (Australian Communications and Media Authority, 2013) with involving 1,511 interviews with Australian school children (n=604 eight to 11 year olds and n=907 12-17 year olds) concluded that the vast majority of those surveyed had accessed the internet (95% of eight to 11 year olds; 100% of the 16-17 year olds). Home computer access was extremely high (93-97%), as was internet at school (64-75%) and accessing the internet at a friend's house which peaked at 33% for 14-15 year olds (p.6). Spears et al. (2014) in their review of Australian studies and their comparison with international evidence found that "Australia has higher rates of cyberbullying than European countries due to the higher levels of internet use of Australian children"(p.1), and that it is most prevalent among 10-15 year olds. They also found that, "although students who had been victimised by traditional bullying reported that they felt their bullying was harsher and crueller and had more impact on their lives than those students who had been cyberbullied, correlations to their mental health revealed that victims reported significantly more social difficulties, and higher levels of anxiety and depression than traditional victims" (p.50). Similar conclusions have been drawn from international meta-analyses which found that cyberbullying was more strongly related to suicidal ideation compared with traditional bullying (Walker et al., 2012; van Geel, et al., 2014). Spears et al. (2014) outline a comprehensive range of responses internationally to cyberbullying, and the current evidence for their effectiveness.

Sansone et al. (2010) estimate that in the United States, approximately 9% to 14% of individuals experience peer victimization during childhood and adolescence. Despite the recognition that various mental health disorders or types of significant symptomatology affect children and adolescents, peer victimization and mental health problems remain widely unidentified and/or under-reported in schools; an environment where most children and adolescents spend the majority of their time (Bagshaw 2015; Sansone et al 2010; Sayal et al. 2010). In 2014, the Australian Department of Education reported that mental health issues and peer victimization resulted in up to two children per week engaging in explicit suicide threats or self-harming, behaviours that are typical of BPD (Bagshaw, 2015). It is imperative to address the situation in light of such a disturbing statistic but unfortunately there is evidence to suggest that teachers may continue to struggle to recognise and report concerns about students' mental health (Trudgen & Lawn, 2011; Graham et al, 2011). Nevertheless, focusing early intervention efforts on schools should remain a primary goal, as a practical and direct way of mitigating mental health problems. Studies show that early identification and treatment of mental health problems in young people profoundly improves treatment and recovery outcomes (Chanen et al. 2007; Bertolote & McGorry, 2005). Studies also show that untreated mental health problems in children and adolescents pave the way for diagnosed psychiatric disorders among those individuals when they become adults (Ardiles, 2012; Patel et al, 2007; Kasen et al, 2009).

As stated above, there are several individuals that play important roles in a child's social and emotional development. Family carers can engage with teachers and schools to form a powerful communication network around the child focused on supporting the child's achievement and wellbeing whilst at school. Yet, communication that would facilitate psychosocial and/or clinical interventions is often compromised among these individuals for multiple reasons and may enable and exacerbate the child's problems. Ongoing teacher-parent-child communication allows for concerns about peer victimization to be shared and for necessary actions to be taken in a timely fashion. It is likely that multiple conditions are necessary for effective communication. An adequate level of mental health literacy among teachers and family carers facilitates the recognition and understanding of a child's mental health struggles. However, prevention and early intervention can be facilitated by improvements in communication networks even in

the absence of adequate mental health literacy. With a competent communication network in place, basic vigilance and recognizing that something is 'not quite right' may go a long way in the process of initial help-seeking, referral, and intervention.

The systemic occupational difficulties and limitations that are reported by teachers in schools prevent them from appropriately addressing a child's mental health issues because it is often thought that such concerns will fall on deaf ears in administrative mechanisms, unless they involve imminent and significant harms (Trudgen & Lawn, 2011). The role of is also commonly influential during a child's development, and parent-GP dialogue is another element of a communication network that protects against development of mental health disorders. For example, inadequate consult time lengths often prevent proper communication when parents approach primary healthcare providers with complaints concerning their child's mental health (Sayal et al, 2010). Another related factor shown to be vital this process is the effectiveness of carers in knowing how to respond and how to access appropriate assessment and support services when they begin to recognize that their child is struggling (Sayal et al, 2010).

The current study used the approach taken by Goodman et al. (2010) by analyzing the Australian family carer perspective in order to map out a pattern of behavioural, interpersonal, and affective qualities that were noticed in the child during different stages of life prior to a diagnosis of BPD. It simultaneously explored the difficulties surrounding the mental health of children that stem from communication deficits in their relationships with others in their immediate and regular environment such as parents, teachers and peers. To that end, the current study aimed to elaborate family carers' recognition that something was 'not quite right', with a focus on their ability and attempts to communicate their concerns with others in order to seek help for their child.

Methods

The data reported here form part of a larger survey with 121 carers, involving 84 survey questions covering carer and cared for persons' demographic details, BPD diagnosis and treatment from the carers'

perspective, impacts of BPD on the person and the carer; contact with GPs, mental health services, hospitals, and other supports including carer support groups, and suicide/self-harm from the carers' perspective. The survey was developed by the Private Mental Health Consumer Carer Network (Australia) (PMHCCN) National Committee in consultation with a reference group of national BPD clinical, research and lived experience experts who, together, endorsed its use. The survey's purpose was to understand the perspectives of family carers of people diagnosed with BPD seeking and receiving support from public and private health systems. It was delivered online via Survey Monkey across all Australian States and Territories (6 weeks in May-June 2011). The advertised link to the online survey was distributed through 29 consumer and carer mental health network electronic and paper-based communications, included 20 clinical mental health and non-government community organisations. Participation was open to any person who identified as a person providing informal care to a family member diagnosed with BPD. The findings of that larger survey and a companion survey with 153 people diagnosed with BPD are reported elsewhere (blinded). Approval to conduct the larger survey was gained through the national committee of the PMHCCN and its auspice organization - the Private Mental Health Alliance. Ethical considerations were informed by consultation with the PMHCCN National Committee and expert reference group drawn together specifically for this research. The specific data reported here relate to 6 questions within the larger survey about carers' perspectives on the person's childhood development and the carers' parenting experiences during that time. These questions (See Box 1) were drawn from BPD online surveys that were run by the National Education Alliance for Borderline Personality Disorder in the United States of America (USA), conducted by Goodman et al (2010). The developmental periods are: infancy (0-4 years), childhood (5-12 years) and adolescence (13-18 years). Ethical approval to undertake this further analysis was granted by the University's Social and Behavioural Research Ethics Committee (No.6891). Informed consent for participation was assumed by completion of the anonymous online survey.

[Box 1 here]

Results

Between 17 and 19 carers responded to the survey questions; this variability being due to some

respondents electing to not answer some questions. The small sample size precluded analysis beyond presentation of descriptive statistics.

Family Carers' Reflections on the Person's Infancy and Toddlerhood

On reflection, the most common unusual behaviour or sign of future problems with mental health that carers (n=19) noticed about the consumer during infancy or toddlerhood was sensitivity (57.9%, n=11) (Table 1). Moodiness (42.1%, n=8), excessive separation anxiety (42.1%, n=8) and social delay (36.8%, n=7) were also highlighted. Further features such as picky eating, poor temperament and inability to be consoled can also be understood as associated with sensitivity.

[Table 1 here]

Family Carers' Reflections on the Person's Childhood

Participants also reflected on whether they noticed anything unusual in the person they cared for during their childhood (n=19) (Table 2). At this development stage, the school context is an important environment in which the child interacts and learns about themselves and others. Therefore, several issues in the table are associated with the school environment. Again, sensitivity rated highly (63.2%, n=13), along with difficulty making friends (63.2%, n=13), school refusal/truancy (52.6%, n=10) and being a victim of bullying (47.4%, n=9). An increasingly concerning picture of the child struggling with a range of issues, occurring directly or indirectly in relation to the school context, is apparent from participants' reports.

[Table 2 here]

Family Carers' Reflections on the Person's Adolescence

Participants also reflected on whether they noticed anything unusual in the person they cared for during their adolescence (n=19) (Table 3). At this stage, anger was the most prominent issue that carers reported noticing (68.4%, n=13), followed by moodiness (63.2%, n=12), impulsivity (57.9%, n=11), body image issues (52.6%, n=10) and sensitivity (52.6%, n=10). Of note were increased rates of sexual abuse reported by participants about their child during adolescence. Whilst sensitivity received the highest rating during infancy and childhood, by adolescence, participants rated it behind the overt issues of anger,

moodiness and impulsivity. Also of note, in contrast to the issues rated as prominent in childhood, the issues that participants rated highly during the person's adolescence now appear to reflect internal behaviours within the person, rather than interpersonal behaviours arising from or associated with interactions within their school environment. The young person's responses seem to reflect more internal emotional processes, and movement towards symptomatology associated with illness.

[Table 3 here]

Further behavioural issues that carer participants noticed during the person's adolescence were elicited (n=16) (Table 4). Difficulty making friends was noted by 62.5% of carers (n=10), followed by promiscuity (56.3%, n=9) and verbally abusive outbursts (50%, n=8).

[Table 4 here]

Family Carers' Help-Seeking Efforts

Carers sought an evaluation of their child's problems from health professionals mainly as a result of concern about their child's behavioural problems (70.6%, n=12 of 17 respondents) and mood disturbances (58.8%, n=10) (Table 5). Of note, doctor and teacher recommendation was not often the reason for seeking an evaluation (17.6% - n=3). This paints a picture of a young person rapidly losing control of their life and circumstances, and their parents impacted increasingly by multiple issues beyond that expected of childhood and adolescence, but with little outside professional recognition of the problems or support available, prior to the BPD diagnosis.

[Table 5 here]

Once a clinician evaluation was undertaken, carers (n=17) reported that therapy was the main treatment recommended for their child (64.7%, n=11), followed by medication (58.8%, n=10), with 17.6% (n=3) of carers reporting that hospitalisation was recommended.

Discussion

This is the first study that uses the carer perspective of an Australian sample to consider sequential snapshots of the BPD developmental pathway. Though the sample is small, results suggest systemic communication gaps experienced by family carers in their attempts to receive help for their child at each point in the child's development, despite being aware that 'something was not quite right' for their child. We suggest that improved earlier communication between carers, teachers, school counsellors and children about these emerging concerns may offer greater opportunities for prevention and early intervention for BPD developmental outcomes. What this study and others suggest about early intervention may be especially pertinent to disorders such as BPD because they seem to develop and 'happen' over such long stretches of time from the perspective of carers, as demonstrated by the pattern of behaviours and experiences this study has collated. The findings indicate that basic ongoing communication between parents, teachers and school counsellors may play a large role in prevention and treatment, because ongoing communication facilitates the exchange of observations and concerns over time and may enable proactive measures during the early stages of child development. Although the survey questions did not specifically ask about the trajectory of attempting to seek help from GPs during the person's childhood, it is likely that GPs are also pivotal players in the family carers' help-seeking journey. However, research has shown that many parents seeking support for their child's mental health may have their concerns dismissed by GPs (Sayal et al, 2010).

Increasing the involvement of family carers, as well as GPs, in continuous communication with teachers might decrease the demands on each of these individuals with respect to ensuring child welfare. This might be particular pertinent to their combined efforts to address cyberbullying which can occur at between young people at school, but also outside of school hours and therefore be difficult for both teachers and parents to address without a coordinated effort. It is recognized that the overcrowded and overburdened status of school systems is a barrier to an adequate response to mental health concerns among students; likewise, short appointment times with GPs and the consequent inability to observe behavioural issues in young consumers over long periods of time is a related barrier stemming from the deficits of primary care systems (Bagshaw, 2015; Sayal et al, 2010). A further barrier found to be present in primary care is a perception that the family environment has somehow caused the child's problems

(Hoffman, Buteau & Fruzetti, 2007). Similar perceptions may be held by teachers and school counsellors and may therefore constrain their level of engagement with the child, with family and with reporting their concerns.

Spears et al. (2014) have stressed that responses to address traditional bullying at the whole-school level are also relevant to reducing risks associated with cyberbullying. These include broad school policies around safe internet use; social skills training, focusing on improving overall school climate and building teachers' capacity to respond. In Australia, these responses, by the nature, extend and reach beyond the classroom to also include students' behaviours towards their peers outside the classroom and outside the school environment.

By virtue of their position in the school social environment, teachers appear to be indispensible to successful early intervention. Trudgen and Lawn (2011) point out how the role of teacher uniquely lends itself to the effective identification of mental health problems. In most cases, a teacher knows their student better than any other adult, with the exception of the student's parents; familiarity with student behaviour and personality traits over long durations of time informs judgment on student wellbeing. The school setting is also conducive to teacher vigilance: their observations are enhanced by an ability to pick out high-risk students in real-time by using their peers as a basis for comparison for assessing concerning behaviours; an opportunity that is mostly only available to teachers. The authors also remind us that adolescent individuals commonly lack the knowledge and insight to recognize that their painful experiences are linked to a mental health problem (Trudgen & Lawn, 2011). The student-teacher relationship can work to mitigate this reality because the teacher should be acquainted with student behaviour on a continuous basis and is mature enough (even if they lack adequate mental health literacy) to detect the existence of significant mental health issues. However, in order to perform a greater role in supporting the mental health of their students, teachers need greater support and training to do so. Given the many tasks expected of teachers and the social complexities that exist in the lives of their students, Graham et al. (2011) argue that, "it is not difficult to conclude why some teachers find themselves ill-

prepared professionally and personally for the complexity of children's lives and the possibilities and constraints this places on their work"(p.482).

The potential for successful school-based intervention is reinforced by findings related to the putative dose-response relationship between BPD symptomatology and exposure to peer victimization. The childhood bullying study by Wolke et al. (2012) distinguished between the effects of different types of peer victimization (overt v. relational) on BPD symptomatology as well as considering the effects of varying severity and varying duration of peer victimization on BPD symptomatology. They found that children exposed to chronic, severe, or combined (both overt and relational) peer victimization were at much greater risk of demonstrating BPD symptomatology in comparison to other categories of victims (Wolke et al. 2012). Hengartner et al. (2013) found that distinct forms of childhood adversity have additive effects, as revealed by score increases on every personality disorder dimension in association with combinations of various childhood adversities. Sansone et al. (2013) also found that duration of peer victimization has some statistical association with BPD symptomatology, while the number of victimizers (bullies) had no effects.

Intervention strategies can be substantially informed by these dose-response findings, especially in light of the pluralist approach to the mental wellbeing of youth that is now becoming widely endorsed. The multiple angles from which to address and mitigate BPD symptomatology and development suggest that intervention strategies can be successful in previously unforeseen ways, as the many studies now suggest. For instance, by only reducing the duration of peer victimization rather than eliminating it completely (a less realistic goal), a teacher can still make a tangible impact on the victim's mental health and potential trajectory toward BPD. Likewise, in cases where multiple adversities coexist in a student's life, addressing only the current bullying-related issues that affect them means that there is one less form of childhood adversity available for the BPD developmental recipe.

Stopping peer victimization early can reduce the costs inflicted by BPD on people with this diagnosis, carers, and healthcare systems (Ball et al. 2009; Lester & Cross, 2014; Scott et al. 2001). Moreover, these efforts may enhance teachers' experiences of and satisfaction with teaching by improving the

overall home, community, schoolyard and classroom milieu in which student behavioural issues can interfere with their teaching role and with students' wellbeing. Focusing on the mental wellbeing of student populations may directly or indirectly alleviate some of the common complaints of school teachers: job stress, overcrowded classrooms, and the repetitive/reemerging nature of behavioural issues that 'tire out' many teachers (Bernard & Milne, 2008).

Limitations

This study had several limitations. It drew on the perspectives of a small sample of family carers in the Australian context only and therefore may not reflect the experiences of family carers of people diagnosed with BPD elsewhere, or the health and education systems of other countries. The data was also retrospective and this may create a bias in reporting, given the expected benefit of hindsight, and current circumstances of participants and confirmed diagnosis of BPD for the person. Further research to elicit a deeper understanding of the interpersonal and affective dynamics involved the development of BPD is needed (Wright et al. 2015). This includes further research with a larger sample that also seeks the perspectives of teachers, school counselors, GPs and students would provide a more comprehensive picture of the developmental path of BPD.

Conclusion

This study has drawn a picture of the trajectory of childhood development towards a diagnosis of BPD from the perspective of the family carer. The results reveal a stark picture of early identification by parents that their child is struggling with a range of emotional and behavioural issues at all childhood developmental stages. These issues appear to persist and escalate as the child ages, with little sense of redress throughout these formative years. The results suggest a trajectory in which there is limited effective early intervention by others in the environment of the child; in particular, there is limited evidence of teacher, school counsellor or GP intervention to assist the parent or child to prevent further decline in the child's mental health. This represents a missed opportunity to provide prevention and early

intervention. In order to help address this situation, teachers, school counselors, GPs and parents are likely to need significant support to respond to the mental health needs of these young people.

Acknowledgements

We thank Ms Janne McMahon OAM and the Private Mental Health Consumer Carer Network (Australia) for providing permission to use this data, and the National Education Alliance for Borderline Personality Disorder (the original developers of the six survey questions) who provided permission to the Private Mental Health Consumer Carer Network (Australia) for that survey. This research did not receive any specific funding.

Conflicts of Interest: The authors have declared that they have no competing or potential conflicts of interest.

Contributions: JW conceptualized the focus of this paper on victimization/bullying and led the writing of the draft manuscript as part of their Advanced Studies work within their medical degree. This included investigating and synthesizing the literature. SL conceptualized the focus on BPD and childhood development and provided access to subset of data within the original larger survey with BPD carers. SL had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis. Both JW and SL reviewed the final draft prior to submission.

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Box 1: Survey Questions (Source: Goodman et al, 2010)

1. **Did you notice anything unusual in infancy or toddlerhood?**		1. **Did you notice anything unusual in childhood?**	
Colic Excessive separation anxiety Inability to be consoled Inability to self-soothe Sensory problems Picky eating Poor temperament Sensitivity	Moodiness Motor delay Cognitive delay Social delay Verbal delay Physical abuse (of this child) Sexual abuse (of this child)	Poor temperament Anger Sensitivity Moodiness Impulsivity Difficulty making friends or few friends Conflict with authority figures School refusal or truancy Frequent lying or deception	Bully perpetrator Victim of rape Poor grades Learning disability or special education Body images issues Emptiness Boredom Verbal abusive outbursts Alcohol abuse Substance abuse Physical abuse (of

		Suspension or expulsion Multiple schools Bully victim	this child) Sexual abuse (of this child)
2. Did you notice anything unusual in adolescence?		**3. Did you notice anything else unusual in adolescence?**	
Moodiness Sensitivity Poor temperament Anger Impulsivity Recklessness Property destruction Arrests Theft Alcohol abuse Anorexia Bulimia	Body image issues Emptiness Boredom Hallucinations Delusions Homicidal ideation Paranoia Odd thinking or perceptions Physical abuse (of this child) Sexual abuse (of this child)	Violence victim Aggression Frequent lying or deception Verbally abusive outbursts Difficulty making or few friends	Promiscuity Pregnancy STDs Rape victim Fights
4. What first prompted you to seek evaluation? Anger problems Temper tantrums Behaviour problems Teacher recommendation School refusal Doctor recommendation Mood disturbances Eating disorder Substance abuse Police intervention or legal issues Promiscuity		**5. What treatment was initially recommended?** Therapy Medication Hospitalisation Day treatment Alcohol/drug rehabilitation Halfway house	

Table One: Issues Noticed in the Person's Infancy and Toddlerhood by their Family Carers (n=19)

Issue	Response percent	Response count	Issue	Response percent	Response count
sensitivity	57.9%	11	inability to self-soothe	21.1%	4
moodiness	42.1%	8	physical abuse (of this child)	15.8%	3
excessive separation anxiety	42.1%	8	sexual abuse (of this child)	15.8%	3
social delay	36.8%	7	cognitive delay	15.8%	3

verbal delay	26.3%	5	motor delay	15.8%	3
picky eating	26.3%	5	colic	15.8%	3
poor temperament	21.1%	4	sensory problems	5.3%	1
inability to be consoled	21.1%	4			

Table Two: Issues Noticed in the Person's Childhood by their Family Carers (n=19)

Issue	Response percent	Response count	Issue	Response percent	Response count
sensitivity	63.2%	12	Anger	36.8%	7
difficulty making friends or few friends	63.2%	12	frequent lying or deception	31.6%	6
school refusal or truancy	52.6%	10	suspension or expulsion	31.6%	6
bully victim	47.4%	9	sexual abuse (of this child)	31.6%	6
moodiness	42.1%	8	learning disability or special education	26.3%	5
multiple schools	42.1%	8	poor temperament	26.3%	5
poor grades	42.1%	8	victim of rape	15.8%	3
conflict with authority figures	36.8%	7	physical abuse (of this child)	10.5%	2
impulsivity	36.8%	7	bully perpetrator	5.3%	1

Table Three: Issues Noticed in the Person's Adolescence by Family Carers (n=19)

Issue	Response percent	Response count	Issue	Response percent	Response count
Anger	68.4%	13	emptiness	31.6%	6
moodiness	63.2%	12	property destruction	31.6%	6
impulsivity	57.9%	11	theft	26.3%	5
body image issues	52.6%	10	arrests	26.3%	5

sensitivity	52.6%	10	paranoia	26.3%	5
odd thinking or perceptions	42.1%	8	delusions	21.1%	4
recklessness	42.1%	8	physical abuse (of this child)	10.5%	2
alcohol abuse	42.1%	8	anorexia	10.5%	2
substance abuse	42.1%	8	bulimia	10.5%	2
boredom	42.1%	8	hallucinations	10.5%	2
sexual abuse (of this child)	36.8%	7	homicidal ideation	5.3%	1
poor temperament	36.8%	7			

Table Four: Further Issues Noticed in the Person's Adolescence by Family carers (n=16)

Issue	Response percent	Response count	Issue	Response percent	Response count
difficulty making or few friends	62.5%	**10**	aggression	37.5%	6
promiscuity	56.3%	**9**	rape victim	31.3%	5
verbally abusive outbursts	50.0%	**8**	fights	31.3%	5
frequent lying or deception	43.8%	7	pregnancy	25.0%	4
violence victim	37.5%	6	STDs	12.5%	2

Table Five: Carer's Reasons for Seeking Health Professional Evaluation of their Child (n=17)

Issue	Response percent	Response count	Issue	Response percent	Response count
behavioural problems	70.6%	12	temper tantrums	23.5%	4
mood disturbances	58.8%	10	eating disorder	23.5%	4
anger problems	47.1%	8	doctor recommendation	17.6%	3
substance abuse	41.2%	7	teacher recommendation	17.6%	3

police intervention or legal issues	29.4%	5	promiscuity	11.8%	2
school refusal	29.4%	5			