



29th May 2024

National Guidelines for Inclusion of Mental Health and Wellbeing in Early Childhood Health Checks

Submitted Online to:

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For:

The National Mental Health Commission

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 9000 people with lived experience of mental health concerns, including suicide and suicidality, across Australia.

All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NIDS, public and private service options, and service provision across urban, regional, rural and remote Australia.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions.

We welcome the opportunity to provide our feedback to this crucially important issue for people with mental health challenges and psychosocial disability, and their families, carers and kin in the Australian community.

Purpose of this Consultation

The Commission is leading the development of National Guidelines for including mental health and wellbeing in Early Childhood Health Checks (ECHCs). The Commission is developing the National Guidelines in consultation with key stakeholders in order to:

- Support national consistency and the early identification of emotional, learning or developmental difficulties in children.
- Expand on the scope of wellbeing aspects covered in existing ECHs.
- Support health professionals to identify current or emerging mental health and wellbeing needs.
- Provide a common framework to discuss child and family health and wellbeing.

This work has been guided by an Advisory Group co-chaired by the Chair of the Commission's Advisory Board, Professor Ngiare Brown and the National Children's Commissioner, Anne Hollonds.

Key findings from the environmental scan included:

- There is broad agreement that ECHCs provide an opportunity to support all aspects of a child's wellbeing, including social needs and parent/carer wellbeing.
- Wellbeing is currently included in ECHCs in all jurisdictions, with variation in scope, timing and screening tools used.
- Family attendance at early childhood health checks drops over time as children grow older.
- When ECHCs result in referral for additional supports, families navigate long wait times and high costs.
- ECHCs could provide an opportunity and mechanism to address national and state-level data gaps that exist around early childhood wellbeing.
- There is an opportunity to align ECHCs with the Australian Government's Early Years Strategy (currently in development).
- It is critically important that the language and framing of wellbeing within ECHCs is sensitive to the needs of all families.

A national consultation was undertaken in 2023. Key areas of focus and need included:

- Increased awareness, value and access to address variability in caregivers' knowledge, awareness and perception of the importance of ECHCs.
- Family and community friendly locations for conducting ECHCs.

- Holistic approaches child and family wellbeing, acknowledging the environments and relationships that influence wellbeing.
- Safe experiences for open and honest conversations about wellbeing to occur.
- Relational experiences as crucial in creating a trusting, safe partnership between practitioners and caregivers.
- System level factors that could better support the inclusion of wellbeing in ECHCs, including the desire for consistent care providers and improved referrals pathways and wait times.

Three key documents as part of this consultation have been reviewed:

- [Consultation Draft - Draft National Guidelines for including mental health and wellbeing in Early Childhood Health Checks.pdf \(961 KB\) \(pdf\)](#)
- [Summary - Draft National Guidelines for including mental health and wellbeing in Early Childhood Health Checks.pdf \(330 KB\) \(pdf\)](#)
- [National Consultation Summary - Draft National Guidelines for including mental health and wellbeing in Early Childhood Health Checks.pdf \(554 KB\) \(pdf\)](#)

The 'Consultation Draft' and 'Summary-Draft National Guidelines' explain the below Conceptual model that is informed by the methods and data outlined in the 'National Consultation Summary' document (links to all documents above).

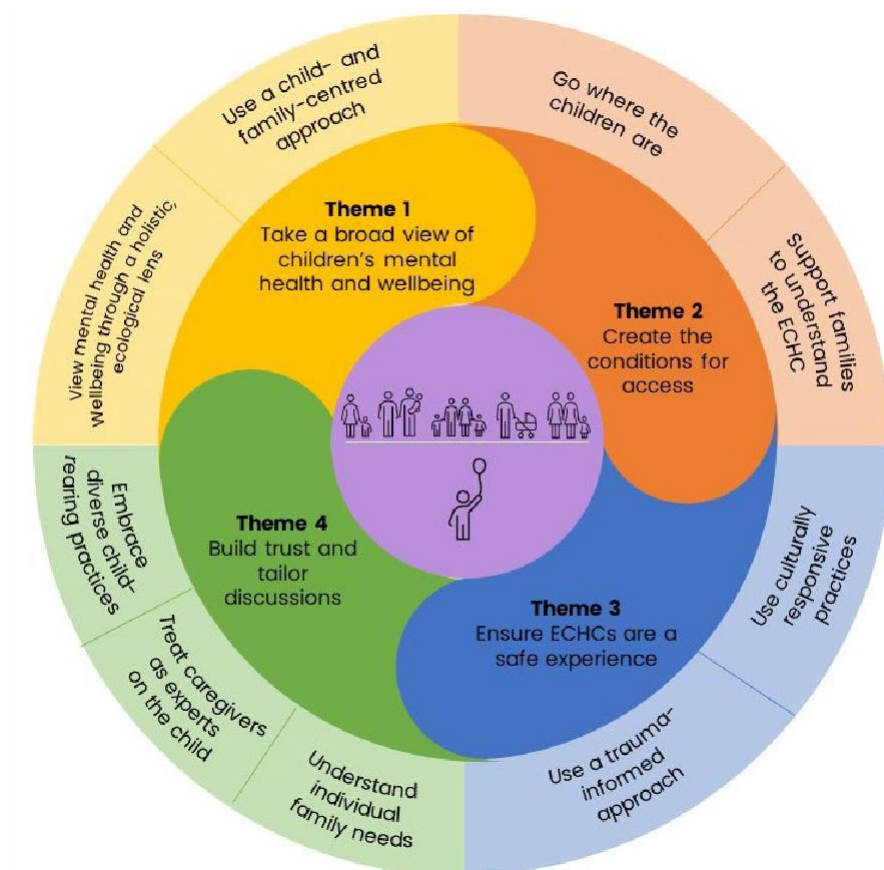


Figure 1: Conceptual model for including mental health and wellbeing in ECHCs.

Our Response to the Review

We strongly support the aims and purpose of this guideline. Many people who currently and/or formerly received contact and/or support from mental health service systems have had adverse childhood experiences that have contributed to the development of serious mental health challenges. Many can identify that their struggles with emotional and mental health began in childhood but were not identified or addressed until much later. For many, these childhood experience have had adverse impacts on their health and wellbeing across the life course, well beyond childhood. Earlier identification and support to children and their families may have made a significant positive difference for them, preventing adverse impacts on relationships with peers and family/kin, education, employment, community connection, and so forth. For many, it may have prevented or ameliorated the development of psychosocial disability, and experiences of trauma that many of the people we advocate for have carried into their adolescence and adult lives. It may also have prevented or ameliorated secondary trauma, burden and a broad range of adverse impacts for families and carers. Ultimately, earlier identification and support may help people to thrive. It is a positive investment in healthy families and communities.

We have a small number of comments to make in response to the National Consultation Summary.

1. Language used throughout the draft

We would like to see a slight shift in the tone and focus of the draft, towards intent that truly is about increasing the capacity and autonomy of families to support their children early. For example, the key findings of the environmental scan resonate, so long as the lessons from this evidence support families (parents, other supportive relatives/kin, older siblings and young children) to avoid 'capture' by systems once concerns about mental health and wellbeing are identified. We would hope that the overall goal is prevention and early support that empowers families (including children) rather than disempowers, discriminates, negatively frames and labels, and sets up a process of dependence on systems. Whilst we understand that the purpose of a guidelines document is to inform the workforce in its interactions with people who may use a service, the Draft Guidelines Document is very much frames with language that is about practitioner hegemony. The rhetoric of inclusion is there, but it feels like some of the intent articulated in the 6 areas present in the National Consultation Summary have not fully translated across to the Draft Guidelines.

2. Whether the structure and narrative of the draft is logical and clear

We thought the structure and narrative of the draft was logical and clear. As per above, the overall framing of the issues within the 6 areas of focus and need reported in the National Consultation Summary seemed to be clearer than in the Conceptual model's 4 areas. It was more useful in capturing the diversity of issues and unpacking the potential complexities. Though we do note that there seemed to be a focus on 'feeding practices' at the expense of a focus on other issues of importance too (please see below for examples of these).

3. Anything not included that you think should be

We felt that there is an implicit sense that the draft does not capture the notions of family and wellbeing beyond Western cultural assumptions of family. Family and community approaches need to also include culture more explicitly.

In the 'Increasing awareness, value and access' section, we felt that challenges associated with rurality could have been mentioned too. This is because there are not only significant access issues for families in rural areas to basic services and supports that metropolitan families may take as given, but rural areas are also disproportionately impacted by natural disasters such as bushfires, floods and drought which impact the very structures of families in which young children are raised.

We also felt that the 'Holistic experiences' section did not adequately capture sibling dynamics that families must often navigate which can have lasting impacts on young children as they grow and develop. No child is the same and supporting the individual emotional needs of each child within a family can be demanding and complicated for any parent/adult kin in the child's life. There is also to potential issue of bullying and challenges as children grow and develop that can occur between siblings. These memories and their

impacts are long lasting. We would argue that families need more support, not less support, where there are more children in the family. In this section, there could also be more directly said about family violence and the complexities of families where parents have separated and may have shared care/access, and where children can be used as weapons.

There is also no mention of the impact of technology and social media on early childhood mental health and wellbeing and how ECHCs might provide support to families in this regard.

The section on 'Relational experiences' is good but could perhaps be stronger in highlighting the experiences of families in attempts to seek help when they notice 'something is not quite right' for their developing child. We know from a national survey that we have conducted twice in 2011 and then again in 2017 with families of people with a diagnosis of borderline personality disorder that parents sometimes spent years having their concerns brushed aside by professionals. We have attached a published paper on this data to this submission. The experiences of these parents are compelling, traumatising and extremely concerning to say the least.

The section on 'System level factors' notes issues with territorialism and mistrust between service providers and organisations. We feel that actions to address this must be strengthened in the guidelines.

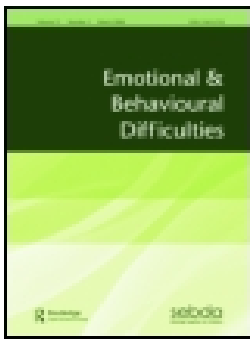
Contact

We thank the Mental Health Commission for the opportunity to put our views forward. We wish Advisory Group co-chairs, Professor Ngiare Brown and National Children's Commissioner Anne Hollonds well with the next steps and would be pleased to contribute our lived experience perspectives to any future discussions about this important topic.

Your sincerely

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The developmental trajectory of Borderline personality disorder and peer victimisation: Australian family carers' perspectives

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To cite this article: Julian Wlodarczyk & Sharon Lawn (2016): The developmental trajectory of Borderline personality disorder and peer victimisation: Australian family carers' perspectives, Emotional and Behavioural Difficulties, DOI: [10.1080/13632752.2016.1243360](https://doi.org/10.1080/13632752.2016.1243360)

To link to this article: <http://dx.doi.org/10.1080/13632752.2016.1243360>



Published online: 12 Oct 2016.



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The developmental trajectory of Borderline personality disorder and peer victimisation: Australian family carers' perspectives

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ABSTRACT

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

Peer victimisation 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 and Bateman 2008; Hengartner et al. 2013; Herman, Perry, and Van der Kolk 1989; Lobbestael, Arntz, and Berstein 2010; Martin-Blanco et al. 2014; Morandotti et al. 2013; Sansone and Sansone 2007; Sansone et al. 2013). The aetiological importance of dysfunctional parent-child relationships has been widely emphasised in the literature (Lobbestael, Arntz, and Berstein 2010; Hengartner et al. 2013) but compelling evidence suggests that being a victim of bullying/violence at school (peer victimisation) is also a major predictor of BPD (Arseneault, Bowes, and Shakoor 2010; Sansone, Lam, and Wiederman 2010; Goodman et al. 2010; Wolke et al. 2012). 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 include cyberbullying. Peer victimisation has long been understood as a traumatic experience with negative long-term mental health consequences (van Geel, Vedder, and Taniol 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 victimisation 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' (3; see also Ford, Mitrofan, and Wolpert 2014; Scott et al. 2014).

The link between peer victimisation and BPD symptomatology is consistent with findings that indicate peer victimisation has serious consequences for the mental health of victims, who may display anxiety, self-harm, violent behaviour and psychotic symptoms in response to victimisation (Arseneault, Bowes, and Shakoor 2010; 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 victimisation is a central aspect of every personality disorder listed in DSM-IV-TR. Strong associations were revealed between most dimensions and peer victimisation, 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 victimisation and BPD symptomatology (Sansone, Lam, and Wiederman 2010; Sansone et al. 2013). Studies on clinical but non-psychiatric populations are important for corroborating the association between peer victimisation 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 victimisation 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 recognised must appreciate that peer victimisation 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 victimisation, poverty, and 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 well-being 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 counsellor¹ 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 jurisdictions, 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 and Bateman 2008; Baird, Veague, and Rabbitt 2005). Investigations into the relevance of various stages of pre-adulthood have revealed that the effects of peer victimisation on BPD development may be especially significant during the stage of preadolescence (Helgeland and Torgersen 2004). Longitudinal work by Wolke et al. (2012) showed that exposure to peer victimisation 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 (Lobbestael et al. 2010). 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, Hopwood, and Simms 2015).

Prevention and early intervention in schools

A sufficiently broad and inclusive characterisation of conditions that enable BPD allows us to consider a significant environmental risk factor (peer victimisation) that is profoundly unmanaged. Prevention and early intervention strategies should be informed by the contexts (such as school) that are relevant to adolescence (Helgeland and Torgersen 2004; 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, and 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 and Torgersen 2004).

Despite awareness and education initiatives like MindMatters (2015) and HeadSpace (2015), the failure to properly address mental health problems and peer victimisation 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 and Lawn 2011). Cross et al. (2009) found that peer victimisation affects approximately one in four students among the Year 4–9 (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' (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 of 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 1511 interviews with Australian school children ($n = 604$ 8–11-year olds and $n = 907$ 12–17-year olds) concluded that the vast majority of those surveyed had accessed the internet (95% of 8–11-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 (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'(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' (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, Craven, and Tokunaga 2012; van Geel, Vedder, and Tanilon 2014). Spears et al. (2014) outline a comprehensive range of responses internationally to cyberbullying, and the current evidence for their effectiveness.

Sansone, Lam, and Wiederman (2010) estimate that in the United States, approximately 9% to 14% of individuals experience peer victimisation during childhood and adolescence. Despite the recognition that various mental health disorders or types of significant symptomatology affect children and adolescents, peer victimisation 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, Lam, and Wiederman 2010; Sayal et al. 2010). In 2014, the Australian Department of Education reported that mental health issues and peer victimisation 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 and 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 improve treatment and recovery outcomes (Chanen and McCutcheon 2008; Bertolote and 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 victimisation 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 recognising 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 and 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 health-care providers with complaints concerning their child's mental health (Sayal et al. 2010). Another

related factor shown to be vital in 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 recognise that their child is struggling (Sayal et al. 2010).

The current study used the approach taken by Goodman et al. (2010) by analysing 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 organisation – 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 six 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.

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.

Box 1. Survey questions (Source: Goodman et al. 2010).

1. Did you notice anything unusual in infancy or toddlerhood?

- 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)

1. Did you notice anything unusual in childhood?

- Poor temperament
- Anger
- Sensitivity
- Moodiness
- Impulsivity
- Difficulty making friends or few friends
- Conflict with authority figures
- School refusal or truancy
- Frequent lying or deception
- Suspension or expulsion
- Multiple schools
- Bully victim
- 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 this child)
- Sexual abuse (of this child)

2. Did you notice anything 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)

3. Did you notice anything else unusual in adolescence?

- Violence victim
- Aggression
- Frequent lying or deception
- Verbally abusive outbursts
- Difficulty making or few friends
- Promiscuity
- Pregnancy
- Sexually transmitted diseases (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 1. Issues noticed in the person's infancy and toddlerhood by their family carers (n = 19).

Issue	Response (%)	Response count	Issue	Response (%)	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			

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

Table 2. Issues noticed in the person's childhood by their family carers ($n = 19$).

Issue	Response (%)	Response count	Issue	Response (%)	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

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.

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.

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

Table 3. Issues noticed in the person's adolescence by family carers ($n = 19$).

Issue	Response (%)	Response count	Issue	Response (%)	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 4. Further issues noticed in the person's adolescence by family carers ($n = 16$).

Issue	Response (%)	Response count	Issue	Response (%)	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 5. Carer's reasons for seeking health professional evaluation of their child ($n = 17$).

Issue	Response (%)	Response count	Issue	Response (%)	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			

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.

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%, $n = 8$).

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.

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 that 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 not only 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 recognised 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, and 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 indispensable 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 recognise that their painful experiences are linked to a mental health problem (Trudgen and 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' (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

victimisation. The childhood bullying study by Wolke et al. (2012) distinguished between the effects of different types of peer victimisation (overt vs. relational) on BPD symptomatology as well as considering the effects of varying severity and varying duration of peer victimisation on BPD symptomatology. They found that children exposed to chronic, severe or combined (both overt and relational) peer victimisation 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 victimisation has some statistical association with BPD symptomatology, while the number of victimisers (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 victimisation 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 towards 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 victimisation early can reduce the costs inflicted by BPD on people with this diagnosis, carers and health-care systems (Ball and Link 2009; Lester and 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/re-emerging nature of behavioural issues that ‘tire out’ many teachers (Bernard and 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 were 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 in the development of BPD is needed (Wright, Hopwood, and Simms 2015). This includes further research with a larger sample that also seeks the perspectives of teachers, school counsellors, 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 counsellors, GPs and parents are likely to need significant support to respond to the mental health needs of these young people.

Acknowledgments

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.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributors

Julian Wlodarczyk conceptualised the focus of this paper on victimisation/bullying and led the writing of the draft manuscript as part of their Advanced Studies work within their medical degree. This included investigating and synthesising the literature.

Sharon Lawn conceptualised the focus on BPD and childhood development and provided access to the 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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