Effects of Borderline Personality Traits on the Psychosocial Functioning of Adolescent Girls

by

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Effects of Borderline Personality Traits on the Psychosocial Functioning of Adolescent Girls

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Dedication

To my cousin Bill, my aunt Mary, and my father-in-law Dallas, all of whom passed away during my master's program. You have inspired me, and I keep you close to my heart.

Acknowledgement

Without the support of those around me, I would not have been able to accomplish this master's degree. I would like to thank my husband, who provided me with space, time, understanding, and finances to complete my coursework and capstone. I would like to thank my daughters, who provided technical support when I needed it, my fellow classmates who provided emotional support, and all my instructors at City University of Seattle, who encouraged me and believed in me when I was in doubt. This thesis has been a labour of love and collaborative effort of those in my support system. Thank you, thank you, thank-you.

Abstract

This capstone paper explores the effects of borderline personality traits (BPTs) on the psychosocial functioning of adolescent girls. Drawing on current research, it highlights how BPTs such as emotional dysregulation, identity disturbance, impulsivity, and intense interpersonal difficulties negatively impact key areas of functioning, including social relationships, academic engagement, and mental health. Although borderline personality disorder (BPD) is traditionally associated with adults, emerging evidence supports the validity of diagnosing BPD traits in adolescence, revealing that even subthreshold features are linked to increased distress and impaired functioning. Adolescent girls appear particularly vulnerable due to a combination of biological, psychological, and social factors, including gendered expectations and relational stress. Early identification and intervention are crucial, as adolescence represents a window of opportunity for altering maladaptive trajectories and improving long-term outcomes. This paper concludes with recommendations for developmentally appropriate, evidence-based approaches for whole school and targeted interventions.

Keywords: adolescent girls, Borderline Personality Disorder, borderline personality traits, emotional dysregulation , psychosocial functioning

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Effects of Borderline Personality Traits on the Psychosocial Functioning of Adolescent Girls

Chapter 1: Introduction

"Borderline individuals are the psychological equivalent of third-degree burn patients. They simply have, so to speak, no emotional skin. Even the slightest touch or movement can create immense suffering" -Marsha M. Linehan

Introduction

Adolescence is a pivotal developmental stage characterized by emotional, cognitive, and social changes. For some youth, particularly girls, this period is complicated by the emergence of borderline personality traits (BPTs), such as emotional dysregulation, impulsivity, identity disturbance, and interpersonal difficulties. Although borderline personality disorder (BPD) is traditionally associated with adults, growing evidence supports the validity of identifying BPTs in adolescence, as even subthreshold features are linked to significant impairments in functioning and increased use of mental health services (Chanen et al., 2020). Adolescent girls are especially vulnerable, perhaps due to gendered expectations, heightened sensitivity to relational stress, and greater likelihood of internalizing symptoms.

There is a lack of research exploring the devastating effects of BPT's on adolescent girls' psychosocial development, and there is hesitance to identify and diagnose BPD in youth, with some clinicians citing developmental variability. However, untreated BPTs can severely disrupt social relationships, academic performance, and overall well-being. Early identification and intervention have been shown to alter the trajectory of the disorder and improve long-term outcomes (Chanen & McCutcheon, 2013). Schools play a critical role in the early identification

of mental health disorders in adolescents and offer unique opportunities for support and intervention (Townsend et al, 2018). This capstone paper explores the effects of BPTs on the psychosocial functioning of adolescent girls, with the goal of informing developmentally appropriate approaches to guidance and response strategies in schools.

Background

Borderline personality disorder is a severe and complex mental health condition characterized by emotional dysregulation, unstable relationships, identity disturbance, and self-injurious and impulsive behavior (Kaess et al., 2024). The term *borderline* emerged in the 1930s, when theorists conceptualized the condition as existing on the border between psychosis and neurosis (Stern, 1938, as cited in Stanley & New, 2018). BPD gained formal recognition as a distinct diagnosis in 1980 with the publication of the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; DSM-III), which reflected a growing understanding of its unique clinical profile (Stanley & New, 2018). Since then, research has significantly expanded, revealing that BPD often has an early onset, with precursors observable in childhood and distinct features emerging by early adolescence. When left untreated, BPD can result in chronic impairments throughout the lifespan.

Borderline personality traits in adolescence such as mood instability, intense fear of abandonment, impulsivity, and self-harming behaviors can disrupt healthy development. These traits are associated with poor psychosocial functioning, including academic difficulties, peer conflict, and elevated risk of suicidal behavior, particularly among adolescent girls (Chanen et al., 2020; Sharp & Fonagy, 2015). Despite growing evidence, many clinicians hesitate to diagnose BPD in youth due to concerns about stigmatization or mistaking typical adolescent behavior for pathology. Nevertheless, early detection and intervention are crucial. Emerging

research suggests that adolescence represents a developmental window in which symptoms are more malleable and responsive to treatment (Chanen & McCutcheon, 2013). Understanding the developmental trajectory of BPD and the harmful effects of even subthreshold BPTs empowers educators and school counselors to intervene effectively, thereby improving psychosocial outcomes for adolescent girls.

Statement of the Problem

The resulting problems when adolescent girls suffering from borderline personality traits are not identified and supported are multiple and severe; research shows BPTs are predicative of adult BPD, depression, substance use, and suicidality if left untreated. In addition, these early traits can lead to chronic social, emotional, and occupational impairment (Kaess et al., 2024; Kaess et al., 2014). There is a growing body of research on borderline personality traits in adolescent girls, especially in the last 10-15 years. Historically BPD was viewed as an “adult only” diagnosis, but that has shifted significantly with emerging evidence that BPD symptoms often begin in adolescence, and early traits are clinically significant (Chanen et al., 2020; Kaess et al. 2014; Stepp et al., 2014). However, there is a gap in the literature examining how BPTs specifically affect the psychosocial functioning of adolescent girls.

Studies by Stepp et al. (2014) show that BPTs often emerge early to mid-adolescence, particularly among girls with emotional sensitivity, trauma histories, or insecure attachment, and temperamental traits like affective dysregulation and impulsivity are considered early risk factors. In addition, relational aggression and emotional dysregulation in girls are identified as early signs of emerging BPD (Crick et al, 2005).

BPTs can severely disrupt psychosocial functioning, manifesting in poor academic performance, strained peer and family relationships, and risky health behaviours. The lack of

identification and tailored interventions for adolescent girls with BPTs leaves a critical gap in mental health services. Chanen and McCutcheon (2013) state BPD should be a focus of prevention and early intervention in clinical practice, as it is the most functionally disabling of all mental disorders, is often associated with help seeking, and it has been shown to respond to intervention. Indicated prevention targeting individuals who display BPTs is the “best bet” for preventing the full development of BPD.

Purpose of the Paper

The purpose of this capstone paper is to examine the effects of BPTs on the psychosocial functioning of adolescent girls. By synthesizing current research, this paper aims to highlight how traits such as emotional dysregulation, identity disturbance, and interpersonal instability impact key areas of adolescent development, including academic performance, social relationships and health behaviors. Through analysis, this paper intends to raise awareness of the unique vulnerability adolescent girls face when exhibiting BPTs, and emphasize the importance of early, developmentally appropriate intervention at the school level. Ultimately, this work aims to contribute to a more informed and responsive approach to supporting girls with borderline traits and to advocate for holistic, research informed intervention strategies that can be used either in a whole school format or as targeted support, which can improve long-term psychosocial outcomes.

Positionality Statement

It is important to acknowledge my history as the writer of this paper. Over the past 20 years, I have taught students in kindergarten through grade 12. Those who stick in my memory are the ones who were particularly sensitive and dysregulated in the elementary years, and who continued to struggle with relationships and academics through middle and high school, even

though they were academically capable. I watched these girls (most of them were girls with difficult home lives), struggle year after year, until they finally either dropped out or barely graduated. These were bright, caring, compassionate girls, and something was going terribly wrong for them. At the time, I was unequipped to fully recognize and address their needs; I came from a middle–class, loving and supportive family, and couldn't conceive of the hardships and mental health issues affecting these girls.

When I started my internship as a school counsellor, I began to see some of these types of girls again, the ones who staff labelled as "attention – seeking drama queens". Only this time I recognized something was wrong, and their behaviour was an expression or symptom of that fact. I began to ask: What is the need that is not being met? What is the homelife like? What is the function of this behaviour? What is the best response? I began by forming relationships and validating feelings. I worked on being present and regulating my emotions, so my calm could become their calm. We coloured and made crafts together and talked about "girl stuff". We talked about feelings and stressors and tools for coping. While all of this was great, and the girls began to trust and confide in me, I knew I could do more, but what?

All of this lead me to research some of the symptoms and traits I was seeing, and I learned about BPD. I began a deep dive into the intricacies of BPD and my curiosity peeked. Researching this paper has allowed me to really get to know and begin to understand borderline personality disorder and it's detrimental effects on the psychosocial functioning of teen girls. In addition, I learned useful, effective strategies I can use in my practice. I am confident, in writing this paper, that I will reflect upon my own privileged upbringing, and appreciate that while I may not share the background of many of my students, I can be a present, caring voice. I plan to

complete this research better equipped to support students (and especially girls), who are displaying borderline traits, in my new role as a counsellor.

Significance of the Study

Understanding the effects of borderline personality traits (BPTs) on the psychosocial functioning of adolescent girls is crucial for supporting early identification and intervention during a key developmental stage. Although BPTs are often dismissed as typical adolescent behavior, research shows that even subthreshold features can significantly impair emotional regulation, peer relationships, academic performance, and overall mental health. This study contributes to the growing recognition that BPTs in youth are not only clinically relevant but also disruptive across multiple areas of functioning. It also addresses a gap in the literature by focusing specifically on how these traits affect adolescent girls. Most importantly, the study emphasizes that BPTs are highly responsive to early, developmentally appropriate intervention.

This research is especially relevant for school counsellors and youth mental health professionals, who are often the first to observe and respond to emotional and behavioral difficulties in students. Adolescent girls with BPTs may exhibit interpersonal conflict, emotional volatility, academic disengagement, or self-harming behaviors, which are issues that frequently arise in the school context. By increasing awareness of BPTs and their psychosocial effects, this study advocates for the implementation of informed, gender-sensitive practices in educational settings. It highlights the need for school counsellors to be equipped with the skills and knowledge to recognize borderline traits, initiate early referrals, and provide appropriate support and accommodations. Ultimately, the study underscores the essential role of school-based mental health services in addressing the needs of vulnerable youth and in mitigating the long-term consequences of untreated personality pathology and its early indicators.

Outline of the Remainder of the Paper

The remainder of this capstone paper is organized into three chapters. The Chapter 2 Literature Review provides an overview of the current research on BPTs in adolescence, with a focus on diagnostic criteria, theories of development of borderline personality disorder, causes of BPD, and the psychosocial impacts specific to adolescent girls. It also explores therapies and intervention strategies at the school level. Chapter 3 will provide a summary, recommendations, and conclusions. It will also synthesize key findings from the literature, highlighting the significance of BPTs on the functioning of adolescent girls and the need for early support. This chapter also offers recommendations for school-based mental health interventions, including a school counsellor-lead girls' group, focused on relationships, identity, self-behaviour, and emotions. Finally, this paper concludes with a comprehensive reference list followed by relevant appendices.

Chapter 2: Literature Review

Introduction

This chapter will answer the research question: How do borderline personality traits affect the psychosocial functioning of adolescent girls? Chapter 2 will further explore the condition of BPD and utilize research gathered to investigate the following themes: The Definition of BPD, Causes of BPD, BPD Effects on Psychosocial Functioning in Adolescence. The first theme, The Definition of BPD, will prepare the foundation for the other themes, with added consideration given to cultural and gender differences as a subtheme. After developing an understanding of what borderline personality disorder is, an examination of the causes can begin. Theories of the development of BPD will be explored along with subthemes of genetic, neurobiological and environmental influences. Next, the theme of BPD effects on psychosocial functioning in adolescence will be addressed, with a particular focus on young girls. Subthemes include borderline personality traits (BPTs) in adolescence, psychosocial functioning in adolescence, and the effects of BPTs on psychosocial functioning.

After examining the themes presented in Chapter 2, Chapter 3 outlines how school counsellors can support adolescents with borderline personality traits. Recommendations include implementing a whole-school social-emotional learning curriculum, introducing a targeted intervention program, and proposing a 10-session group designed to address BPTs by focusing on affect, identity, and relationships.

Theoretical Framework

This paper will utilize research that examines the impact of BPD traits on adolescent girls through several different theoretical perspectives. The first is Attachment Theory, developed by John Bowlby (1969), and later categories into secure and insecure by Ainsworth and Waters

(1972), which examines the impact of parent-child attachment style on the child's future behaviour and relational patterns. We will see that attachment insecurity plays a significant role in the development of BPD and affects one's ability to self-organize and regulate emotions (Fonagy&Bateman, 2007). In examining the environments that influence and contribute to the development of BPD, the Ecological Systems model, developed by Bronfenbrenner (1977) will be utilized. Bronfenbrenner proposed that an individual is influenced by a series of interconnected systems, ranging from the immediate surroundings (e.g., family) to broad societal structures (e.g. culture). Lastly, Erikson's (1950) Psychosocial Development Theory will be employed to investigate how psychosocial functioning is influenced by borderline personality traits. This eight–stage theory of development is concerned with competency and conflict, and how successfully managing challenges at each stage of growth leads to psychological strength.

Attachment Theory

Attachment theory, developed by John Bowlby (1969), and further refined by Ainsworth and Waters (1972), suggests that children are born with an innate need to form attachments. Early interactions with caregivers shape an individual's expectations and behaviours in future relationships. When caregivers are consistently responsive, children develop a secure attachment style, characterized by trust and a sense of safety in relationships. The caregiver's ability to be reflective, responsive, and sensitive to the child's needs fosters the development of trust, confidence, and resilience later in life (Flaherty & Sadler, 2010). Secure attachment can be protective and provide a foundation for normal development. Conversely, inconsistent or unresponsive caregiving can lead to insecure attachment styles, such as anxious, avoidant, or disorganized attachment (Agrawal et al., 2004) A wide range of studies suggest that early attachment difficulties are linked to the development of borderline pathology (Agrawal et al.,

2004; Clarkin & Posner, 2005; Gunderson, 1990; Mosquera et al., 2014). Secure attachment to a caregiver allows a child to explore the world with confidence, knowing the caregiver will be there when needed. This experience helps foster a positive, coherent self-image and a sense of being worthy of love (Agrawal et al., 2004). With this foundation, the child develops a positive expectation that significant others will generally be accepting and responsive (Agrawal et al., 2004).

In contrast, insecure attachments occur when a child's needs are unmet consistently due to neglect, parental stress, or even mismatched child-parental temperaments. Without consistent soothing, the child develops a lack of trust and struggles to form and maintain healthy relationships. Beliefs develop about oneself and others as being unreliable or unlovable (Lee & Hankin, 2009). As previously mentioned, subtypes of insecure attachment include anxious (anxious-preoccupied), avoidant (dismissive-avoidant) and disorganized (fearful-avoidant). When a caregiver is inconsistent, the child may become highly worried and fearful and seek excessive reassurance, leading to an anxious attachment style. When caregivers are emotionally unavailable or rejecting, the child may avoid relationships and emotions altogether and prefer to rely on themselves, leading to avoidant attachment. When children are abused or neglected, they may form a disorganized attachment style, where the child often feels afraid and alone (Agrawal et al., 2004; Atwool, 2006).

Three types of insecure attachment styles are commonly implicated in BPD: avoidant, preoccupied, and fearful (Agrawal et al., 2004; Fonagy, 2000; Levy et al., 2005; Mosquera et al., 2014). Individuals with an avoidant attachment style typically display inappropriate anger, while those with a preoccupied style show heightened concern and behavioural reactions to real or

imagined abandonment. Individuals with a fearful style often exhibit higher rates of identity disturbance compared to controls (Levy et al., 2005).

Individuals with BPD often hold negative views of themselves and others, and they may act needy, manipulative, and angry in relationships (Agrawal et al., 2004). Fonagy and colleagues (2000) found significant distortions in attachment patterns among people with BPD. The core features of BPD, such as unstable and intense interpersonal relationships, feelings of emptiness, bursts of rage, intolerance of aloneness, chronic fears of abandonment, and an unstable sense of self, stem from impairments in underlying attachment systems (Levy et al., 2005).

Children are naturally conditioned to attach to a parent, and when the parent is frightening, the attachment is mediated by fear and anger (Mosquera et al., 2014). When an individual with BPD enters a new relationship, the attachment system is activated, and the new attachment figure is often idealized, much like a parent would be (Mosquera et al., 2014). This relationship is characterized by an intense and overwhelming need for attention and affection, stemming from unmet childhood needs. Although this feeling may seem disproportionate to the current situation, it is rooted in the unmet needs addressed by the original attachment figure (Mosquera et al., 2014). Insecure attachments in infancy and childhood can persist throughout life and may serve as a risk factor for the development of BPD (Agrawal et al., 2004).

Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner's (1977) ecological systems theory proposes that human development is a complex, dynamic process shaped by continuous interactions between the individual and multiple layers of their environment, including biological, interpersonal, societal, and cultural influences (as cited in Tong & An, 2024). This theoretical framework offers significant value to

professionals working with children and adolescents, as it fosters a deeper understanding of the multifaceted nature of human development (Ahluwalia Cameron et al., 2019). By distinguishing and analyzing the various systems that influence an individual, ecological systems theory provides a comprehensive lens through which to assess developmental contexts. The model identifies five interrelated components that together provide an extensive framework for understanding human development. The individual level encompasses personal characteristics, including biological and mental health factors. Surrounding the individual is the microsystem, which includes immediate relationships and settings, such as family, school, and peer groups. The mesosystem refers to the interactions between these microsystems, for example, how a child's home environment influences their school experience. The exosystem consists of broader community influences, such as local institutions and extended family members, which may not involve the individual directly but still impact their development. Finally, the macrosystem represents the overarching societal structures, including cultural values, laws, and policies, which, although more abstract and distant, exert a powerful and pervasive influence on the individual's life (Ahluwalia Cameron et al., 2019). The ecological perspective allows for a holistic view of the factors that influence the development of BPD, as there are many potential causes, and the interplay and bidirectional impacts between systems is central to understanding this disorder.

Erikson's Psychosocial Development Theory

Psychosocial development refers to the lifelong process by which individuals grow and adapt psychologically and socially in response to challenges and experiences, as conceptualized by Erik Erikson's (1950) eight-stage model of development (as cited in Sanders, 2013). Each stage presents a developmental crisis, such as identity formation in adolescence or intimacy in

early adulthood, that, when successfully resolved, leads to psychological strengths and social competencies (Rageliene, 2016).

Adolescence is a critical period for psychosocial development. During this time, individuals refine their identity, develop a stable personality, navigate personal relationships, and regulate emotions effectively (Meeus, 2016). Rapid biological, psychological, and social changes also mark this critical phase. Identity formation is central to this process and is influenced by social interactions and environmental feedback (Raufelder et al., 2021). A well-established sense of identity contributes to self-esteem and emotional stability (Sanders, 2013). As adolescents experience significant cognitive, emotional, and social changes, this period lays the foundation for their adult psychosocial functioning.

Psychosocial development is concerned with how people grow emotionally over time, laying the foundation for psychosocial functioning, which describes a person's present ability to manage and maintain emotional, social, and psychological well-being within the context of relationships, daily activities, and life circumstances (Culina et al., 2024). This functioning is essential for mental health and has a significant impact on overall quality of life. These two concepts are inherently interconnected as the outcomes of the psychosocial development stages directly influence psychosocial functioning. For example, successful navigation of Erikson's (1950) stage of "autonomy vs shame and doubt" fosters a sense of self-control and confidence that supports healthy functioning in school-age years and beyond. Similarly, unresolved conflicts during critical periods, such as failure to establish a stable identity during adolescence, can impair functioning later, leading to issues with emotional regulation, relationships, or self-esteem (cited in Sanders, 2013). Moreover, psychosocial functioning serves as a real-time indicator of how well someone has resolved or is navigating their psychosocial development. For example,

impaired psychosocial functioning such as social withdrawal or occupational struggles, is often traced back to disrupted or incomplete psychosocial development (Sanders, 2013). This dynamic relationship underscores the importance of viewing psychosocial functioning not as isolated behaviour, but as the expression of a developmental history shaped by biological, relational, and environmental factors.

Key dimensions of psychosocial functioning include emotional well-being, which involves regulating emotions, managing stress, and maintaining stability (Gross, 2015); social relationships, which refer to the ability to form and sustain positive connections with family, peers, and colleagues, providing essential emotional support and validation (Heinrich & Gullone, 2015); coping mechanisms, which are effective strategies for managing stress and challenges, aiding in adaptation to life's demands (Lacomba-Trejo et al., 2020); and role fulfillment, which entails navigating and fulfilling societal roles, such as being a student, parent, or employee, while maintaining responsibilities within these roles (Taylor, 2010).

Understanding psychosocial functioning in adolescence is particularly valuable, as it provides insight into identity formation, personality development, and the challenges adolescents face in processing stressors and social feedback, all of which are compromised by borderline pathology.

Adolescent Girls

While adolescent girls move through stages of development in relatively the same way boys do, there are some significant differences. According to the American Psychological Association (2008), during adolescence, and compared to boys, girls are more anxious and stressed, experience diminished academic achievement, suffer from increased depression and lower self-esteem, experience more body dissatisfaction and distress over their looks, suffer from

greater number of eating disorders and attempt suicide more frequently. Leventhal et al. (2015) also state that globally, girls are at higher risk than boys for many psychological disorders, particularly anxiety and depression. The reasons for this are not clear, although a combination of biological, psychological, and societal factors are likely responsible (Leventhal et al., 2015).

The developmental tasks of adolescence are vast, including negotiating puberty and completion of growth, developing new cognitive skills (e.g. abstract thinking), developing a clearer sense of personal and sexual identity, and developing emotional, individual, and financial independence from parents. Girls typically grow and mature faster than boys, with growth spurts occurring early in puberty (approximately 11-12 years) compared to later in puberty for boys (approximately 14 years) (Christie & Viner, 2005; Kaess et al., 2024). In addition, girls tend to develop stronger empathy than boys and are more highly attuned to social cues, making them more responsive to the emotional states of others (Li et al., 2018).

Adolescent girls tend to be more prosocial than boys (Bergin et al., 2003). Prosocial behaviour is generally defined as voluntary actions aimed at benefiting others, such as sharing, helping, comforting and showing empathy (Li et al., 2018). From childhood to adulthood, prosocial behaviour is associated with positive developmental outcomes such as happiness, emotional well-being, and peer acceptance (Li et al., 2018). It is positively related to psychosocial functioning, leading to higher self-esteem, lower internalizing problems such as depression and anxiety, better peer relations, enhanced emotional regulation skills, and increased resilience (Bergin et al., 2003).

In adolescent girls specifically, given the developmental importance of close friendships and emotional connections, disruptions in prosocial behaviour and psychosocial functioning can

worsen borderline personality traits, which leads to less prosocial behaviour, creating a vicious cycle (Stepp et al., 2016).

Borderline Personality Disorder (BPD)

Borderline Personality Disorder (BPD) is a complex and highly impairing condition. Recent evidence indicates that even subthreshold features (those that fall below the diagnostic threshold of the DSM-5), are linked to poor outcomes for adolescents (Chanen et al., 2020). Traits such as impulsivity, identity disturbance, substance use, and risky sexual behaviour can disrupt the transition to adulthood by delaying the development of essential life skills. Long-term consequences for adolescents with BPD include difficulties forming meaningful peer and romantic relationships, challenges in completing education, barriers to employment, and impaired ability to function independently in society (Chanen et al., 2020). These effects are particularly severe in adolescent girls, for whom borderline personality traits (BPTs) are strongly associated with worsening social, academic, and mental health outcomes (Wright et al., 2016). Four key characteristics are cited: the definition and development of BPD, the expression of BPTs during adolescence, and their effects on psychosocial functioning.

BPD is characterized by robust and extensive dysregulation of emotion, behaviour, and cognition, and includes a pattern of volatile personal relationships. It is persistent, complex and highly impairing. BPD is marked by affective instability, stormy, enmeshed relationships, unrealistic fears of abandonment by loved ones, dissociated thoughts, chronic feelings of emptiness, impulsivity, paranoid thoughts and suicidal ideation or gestures (Crick et al., 2005). To be diagnosed, a person must show at least five of the following (evident across various situations and beginning in early adulthood): efforts to avoid abandonment, whether real or imagined, unstable and intense relationships, where they shift between idealizing and devaluing

others, unstable self-image or sense of identity, impulsivity in areas that could harm oneself (such as spending, sex, substance abuse), self-harming behaviours, including suicidal gestures or threats, emotional instability, with mood swings that are intense but short-lived, chronic feelings of emptiness or a persistent feeling of being empty inside, intense or uncontrollable anger, paranoia or dissociation, typically triggered by stress (APA, 2022; Sharp & Fonagy, 2015). BPD is often comorbid with mood and anxiety disorders, bipolar disorder, schizotypal and narcissistic personality disorders (Fonagy & Luyten, 2009).

The risk of death by suicide in individuals with BPD is exceptionally high, with some estimates putting it at ten percent, which is fifty times higher than the suicide rate in the general public (O'Grady & Hinshaw, 2023). Although BPD is not typically diagnosed in individuals under the age of 18, there is solid evidence that suggests it can be reliably identified in adolescents (Kaess et al., 2014; Sharp & Fonagy, 2015; Winsper et al, 2016), and BPD features can be identified in children (Bozzatello et al., 2019; Crick et. al, 2005).

Cultural and Gender Considerations

Prevalence rates of borderline personality disorder in the general population typically range from 0.3% to 1% (Clarkin & Posner, 2003; Munson et al., 2022), with some studies reporting rates as high as 2% (O'Grady & Hinshaw, 2023). In contrast, BPD is observed in 10-12% of individuals in psychiatric outpatient settings and 20-22% in psychiatric inpatient settings (Clarkin & Posner, 2003; Munson et al., 2022).

However, it's important to note that these prevalence estimates are primarily based on research conducted in Western countries (Munson et al., 2022). Neacsiu et al. (2017) specify that approximately three-quarters of the research done on BPD has been done in North America and Western and Northern Europe. There are varying opinions as to whether the DSM-5 takes

cultural perspectives into account when diagnosing BPD. Some literature suggests that variations between cultures are not considered in the DSM-5 diagnosis (Munson et al., 2022), while others explicitly state that cultural perspectives in assessment have been taken into account (Ronningstam et al., 2018). In the section of the DSM-5 that describes BPD, it does caution the diagnostician to consider cultural differences when observing symptoms or traits that suggest the presence of BPD. There is a "Cultural Formulation Interview" (CFI) one can use as a guide to develop a cultural specific understanding of the problem (DSM, 2022, p.860). This indicates that there is a lack of research on BPD in non-Western cultures (Munson et al., 2022; Neacsiu et. al, 2017; Ronningstam et al., 2018). Despite these hurdles, there is agreement that the pattern of BPD traits has been seen in many settings around the world, although there are culture-specific variations in symptoms (Neacsiu et al., 2017; Ronningstam et al., 2018; Munson et. al). There needs to be further research done on the presentation of BPD in non-Western cultures, so that prevalence rates and diagnoses are accurate when cultural context is considered.

In addition to questions around the cultural expression of BPD symptoms, numerous studies have cited research indicating BPD is more prevalent among females than males (Clarkin & Posner, 2003; Crick et al., 2005; Sansone & Sansone, 2011). Some literature suggests women outnumber men by a ratio of 3:1 in the diagnosis of BPD (Bjorklund, 2006). Many of these findings appear to come from research conducted more than twenty years ago, and it has been proven that clinicians have an indirect female gender bias concerning the diagnosis of BPD (Sansone & Sansone, 2011).

Another factor contributing to the gender gap in BPD diagnosis is that females are more likely to seek out treatment than males, and the presentation of symptoms may also vary by gender. The DSM-5 confirms this hypothesis as it addresses gender-related diagnostic issues by

noting that BPD is identified in women more often in clinical settings (DSM, 2022). In contrast, in community settings, the prevalence rates are the same. One reason given for this discrepancy is that women may be more likely to seek help. Females with BPD typically display internalizing symptoms such as sadness, anxiety, and loneliness, whereas males usually present with externalizing symptoms such as aggression and impulsivity (Qian et al., 2022). Females are more prone to express and talk about their emotions, which may magnify usual sex-based distinctions. Another interesting note is that males who present with similar symptoms to females (who are diagnosed with BPD) are more likely to be diagnosed with antisocial personality disorder (Qian et al., 2022). Qian et al. (2022), also state these sex differences could be explained by the DSM diagnostic criteria for BPD itself, as there are more internalizing symptoms than externalizing symptoms listed. The widely held myth that more women present with BPD is based on old, biased data, and new research shows that the gender gap in prevalence rates does not exist (Neacsiu et al., 2017).

Research has found that BPD can be reliably diagnosed in adolescents, with BPD traits identifiable in children (Chanen et al., 2020; Stepp, 2012). As much as 2% of the general population (of Western nations), is diagnosed with BPD, with ten to twenty times that amount found in psychiatric outpatient and inpatient settings, and the suicide risk for people with BPD is 50 times higher than that of the general public.

Diagnosis in Adolescence

Multiple studies confirm that clinicians can reliably and validly diagnose borderline personality disorder (BPD) during adolescence. Even subthreshold symptoms, those falling below the DSM-5 diagnostic threshold, correlate with poor outcomes, including increased use of mental health services and impaired functioning (Chanen et al., 2020; Gupta et al., 2023; Kaess

et al., 2014; Sharp & Fonagy, 2015; Stepp, 2012). Despite this evidence, many clinicians hesitate to diagnose BPD in youth, often viewing the symptoms as part of typical adolescent development or the normative "storm and stress" phase (Chanen et al., 2020; Kaess et al., 2014).

Guile et al. (2018) explain that to diagnose BPD in adolescents, clinicians must observe traits that persist for at least one year, deviate from developmental norms, and cause significant distress or impair functioning in social or academic settings. Although BPD affects males and females at similar overall rates, adolescent girls appear to experience more severe impacts. From 2000 to 2012, a Canadian study reported a rise in BPD diagnoses among girls aged 14–17 (Guile et al., 2018). While researchers have not fully explained this gender disparity, U.S. data show that 3.8% of girls met criteria for severe BPD, compared to 2.8% of boys. For moderate BPD, the rates increased to 11.5% in girls and 8.3% in boys. Adolescent's typically begin to show symptoms of BPD during early teenage years. Clinicians have diagnosed the disorder reliably in individuals as young as 12 (Chanen et al., 2020; Guile et al., 2018; Stepp, 2013). During this developmental phase, young people are expected to gain independence in emotional regulation and behavioral control, which makes any difficulties in these areas more visible. Chanen et al. (2020) describe adolescence through young adulthood (ages 10–25) as a particularly vulnerable period that coincides with peak onset of major mental health disorders, including BPD. Research has shown that childhood externalizing disorders such as attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) predict the development of BPD symptoms. Specifically, girls diagnosed with ODD between ages 8–10 and with ADHD between ages 10–13 often develop BPD symptoms by age 14 (Chanen et al., 2020; Guile et al., 2018).

Wright et al. (2016) report that many adolescents with BPD begin seeking treatment in late adolescence. These youth represent about 30% of patients in adolescent clinical settings.

Additionally, adolescents with BPD frequently meet diagnostic criteria for mood, eating, dissociative, and substance use disorders (Kaess et al., 2012).Adolescence presents a critical opportunity for early identification and intervention (Kaess et al., 2024). Kaess et al. (2014) emphasize growing support for diagnosing and treating BPD during this time, as even subclinical traits can interfere with the transition to adulthood. Chanen et al. (2020) found that adolescents who show elevated BPD traits at age 14 tend to experience reduced functioning for up to two decades. More recent findings from Kaess et al. (2024) indicate that adolescent girls are more likely than boys to meet multiple BPD criteria, and Stepp et al. (2010) note that girls often face more pronounced challenges related to the disorder.

The Etiology of Borderline Personality Disorder

Given the complexity of BPD, it's not surprising that no single cause has been identified. Theories suggest that BPD is primarily a disorder of emotional dysregulation, resulting from a combination of genetic, neural, behavioural, familial, and social factors (Crowell et al., 2009). Although BPD has been studied more extensively than other personality disorders (Kulacaoglu & Kose, 2018), empirical research on its development remains limited (Crowell et al., 2009).

Genetic Influences. The genetic influence on BPD remains poorly understood; however, researchers agree that it is moderately to highly heritable (Amad et al., 2014; Kaess et al., 2014; Nia et al., 2018; Winsper et al., 2016). Familial and twin studies suggest genetic factors contribute to the development of BPD symptoms in adolescents and children. However, experts generally believe that BPD behaviours arise from an interaction between genetic and environmental factors (Amad et al., 2014; Nia et al., 2018). Kaess et al. (2014) note that while no specific genes have been definitively linked to BPD, research points to variations in serotonin transporter genes as playing a role in adolescent BPD. Specifically, studies have found an

association between the serotonin transporter gene 5-HTTLPR and BPD traits in children and adolescents aged 9-15 years (Winsper et al., 2016). These transporter genes are frequently identified as markers of sensitivity, indicating that affected children may be genetically more susceptible to environmental influences such as parenting (Amad et al., 2014).

Genetic factors strongly influence the stability of BPD traits, while non-shared environmental factors have a moderate influence, suggesting a significant gene-environment correlation (Amad et al., 2014). Amad and colleagues (2014) argue that genes involved in BPD development should not be labelled as "vulnerability genes" but rather as "susceptibility to the environment" genes. These genes likely function as plasticity genes, making individuals more responsive to both positive (e.g., environmental support and enrichment) and negative (e.g., childhood maltreatment) environmental influences. This perspective aligns with the biosocial development model of BPD, which emphasizes the complex interaction between biological vulnerability and environmental risk factors. In addition to genetic influences, neurobiological factors also play a role, which will be discussed in the next section.

Neurobiological Influences. Evidence clearly shows that BPD is at least moderately heritable, with several brain regions and neurotransmitter systems implicated in the emotional dysregulation, impulsivity, and interpersonal difficulties characteristic of the disorder. Although no single brain region has been definitively linked to BPD development, structural MRI studies reveal reduced brain volume in areas associated with emotional processing and regulation, such as the amygdala, hippocampus, orbitofrontal cortex, and anterior cingulate cortex (Perez-Rodriguez et al., 2018). Additionally, dysfunction in the frontolimbic network and the hypothalamic-pituitary-adrenal (HPA) axis has been proposed as central to BPD development (Kulacaoglu & Kose, 2018). Neuroimaging studies of adolescents with BPD show

structural alterations in frontolimbic regions, along with neuropsychological abnormalities like impaired executive functioning and social cognition difficulties (Winsper et al., 2016). These structural and functional abnormalities contribute to emotional hyperarousal and are associated with reduced top-down regulatory control.

Top-down regulation, primarily mediated by the prefrontal cortex, is essential for cognitive control and emotional regulation. In BPD, hypoactivity in the prefrontal cortex combined with hyperactivity in the amygdala leads to intense emotional reactions and difficulties in stress management. This imbalance leads to impulsivity, mood swings, and increased sensitivity to perceived rejection or criticism (Perez-Rodriguez et al., 2018). Essentially, the "brakes" (top-down regulation) are too weak to control the "accelerator" (amygdala activity). While the top-down system is underactive, the bottom-up system, which triggers immediate responses for survival, is overactive. This imbalance leads to an overactive amygdala and an underactive prefrontal cortex, overwhelming logical thinking and self-regulation (Kulacaoglu & Kose, 2018; Perez-Rodriguez et al., 2018).

Additionally, individuals with BPD show smaller hippocampal volume, which may contribute to difficulties in emotional memory processing, heightened stress sensitivity, and dysfunction in the anterior cingulate cortex. The anterior cingulate is linked to impaired conflict resolution and emotional regulation (Winsper et al., 2016). Research also suggests that abnormalities in the hippocampal and amygdala regions may appear early in BPD development, with neurobiological markers observable from childhood (Kaess et al., 2014). These factors, combined with environmental influences, may increase the risk of BPD in young populations.

Studies have also identified changes in neurotransmitter systems, including serotonin, glutamate, and GABA, as well as dysregulation in neuropeptides like opioids, oxytocin, and

vasopressin (Perez-Rodriguez et al., 2018). Some researchers argue that alterations in opioid receptor sensitivity in the brain contribute to the alarming symptoms and self-destructive behaviours seen in BPD individuals (Bandelow et al., 2010). These behaviours may be unconscious, desperate attempts to stimulate a malfunctioning neurochemical system that regulates pain, mood, stress, and reward receptors throughout the central and peripheral nervous systems (Bandelow et al., 2010).

Neurobiological evidence highlights the complexity of BPD, suggesting that genetic and environmental factors interact to shape the disorder. Abnormalities in brain structure and function, along with neurotransmitter dysregulation, contribute to the emotional instability, impulsivity, and interpersonal difficulties defining BPD. Ongoing research into these neurobiological mechanisms will be essential for developing more targeted treatments that address the disorder's root causes, ultimately improving outcomes for those affected by BPD. An individual's environment, along with genetics and neurobiology, plays a key role in the development of BPD, which will be discussed further next.

Environmental Influences. Environmental risk factors for the development of BPD include social, emotional, behavioural, and societal influences. These factors can be categorized into adverse childhood experiences and maladaptive parenting.

Adverse Childhood Experiences. A strong link exists between BPD and adverse childhood experiences (Kaess et al., 2014; Sharp & Fonagy, 2015). Individuals who have experienced abuse or neglect are at a higher risk of developing BPD, and those diagnosed with BPD report more childhood traumas compared to individuals with other personality disorders (Keinanen et al., 2012). Identified types of traumas include neglect, emotional abuse by a parent, verbal abuse, physical abuse, emotional withdrawal by a parent, inconsistent treatment by a

caretaker, denial of the child's feelings, caretakers placing the child in a parental role, and failure to protect the child (Keinanen et al., 2012).

While some research suggests that trauma related to sexual abuse is the strongest predictor of psychosocial difficulties in individuals with BPD (Al-Alem & Omar, 2008; Volkert et al., 2024), other studies argue that sexual abuse is a weak predictor (Cavicchioli et al., 2024; Sharp & Fonagy, 2015; Winsper, 2018). In contrast, Cavicchioli and colleagues (2024) highlight a robust correlation between childhood emotional abuse and neglect and BPD psychopathology, emphasizing that childhood traumatic experiences are among the most significant environmental influences in the development of BPD.

Bullying in childhood, particularly when chronic, severe, or involves a significant power imbalance, can have lasting effects on mental health. Wolke and colleagues (2012) found that any form of peer victimization in elementary school predicted BPD symptoms by age 11.8 years. They also discovered that children exposed to chronic victimization, especially at ages 8 and 10, were at a much higher risk of developing BPD symptoms (Wolke et al., 2012). In addition, difficulties with peer relationships might contribute to or accelerate the development of BPD in adolescence and increases the risk of self-harm in late adolescence (Kaess et al., 2014). Victims of bullying often report feelings of betrayal by peers, loneliness, anger, and a loss of trust. These experiences can lead to mistrust in others, unstable relationships, biased perceptions, and emotional dysregulation (Wolke et al., 2012). Such experiences contribute to the negative relational patterns seen in BPD, as identified by Keinanen and colleagues (2012).

Individuals with BPD often report perceiving themselves as hostile in relationships, and they tend to be critical and rejecting of others (Keinanen et al., 2012). These negative relational patterns are supported by Kaess et al. (2014), who found that adolescents with BPD show a

strong tendency to focus on negative emotional stimuli. They struggle to disengage their attention from negative facial expressions when in a bad mood. Interestingly, BPD was not linked to a specific focus on positive stimuli (von Ceumern-Lindenstjerna et al., 2010). Additionally, adults with BPD demonstrate hypervigilance to negative emotional words (von Ceumern-Lindenstjerna et al., 2010).

***Maladaptive Parenting*.** Maladaptive parenting is another identified risk factor in the development of BPD. Adverse parental behaviours and low parental affection are linked to BPD in adulthood, along with childhood verbal, emotional, and physical abuse (Keinanen et al., 2012). Parents who deny children the right to have their own thoughts and feelings, fail to protect them, treat them inconsistently, or display outward hostility contribute to what Linehan (1993) describes as an "invalidating environment" (Kaess et al., 2014). Negative, invalidating parenting behaviours are associated with social and emotional difficulties throughout childhood, and maternal inconsistency, emotional overinvolvement, low warmth, and harsh punishment predict BPD symptoms in adolescence and adulthood (Stepp et al., 2014). Additionally, adults with BPD often report their parents as neglectful, invalidating, overinvolved, and indifferent, with household environments characterized by conflict and inconsistency (Stepp et al., 2014). Understandably, maladaptive parenting can lead to attachment insecurity. Individuals with BPD often hold negative views of themselves and others, and they may act needy, manipulative, and angry in relationships (Agrawal et al., 2004). Fonagy et al. (2000) found significant distortions in attachment patterns among people with BPD. The core features of BPD such as unstable and intense interpersonal relationships, feelings of emptiness, bursts of rage, intolerance of aloneness, chronic fears of abandonment, and an unstable sense of self stem from impairments in underlying attachment systems (Levy et al., 2005).

Understanding another person’s thoughts and feelings, or “mentalizing”, is a key developmental milestone, facilitated by attachment relationships (Fonagy & Bateman, 2007). Individuals with BPD have a limited ability to label, identify, and express their thoughts and feelings (Keinanen et al., 2012). This leads to altered social cognition and a tendency to “hypermentalize”, or over-attribute intentions to others (Winsper et al., 2017). To develop a coherent sense of self, an infant needs their emotional signals to be accurately reflected back to them by an attachment figure. If this process is disrupted, the consequences for self-organization and emotional regulation can be severe (Fonagy & Bateman, 2007).

The quality of a child’s primary attachment relationship is a strong predictor of mentalization ability (Fonagy & Bateman, 2007). Goueli et al. (2019) found that early adversity, such as emotional neglect or abuse, blocks access to the mentalization system, which may serve as a protective mechanism against intolerable psychological pain. However, this disruption leads to deficits in social cognition. Studies have shown that adolescents with BPD have altered social cognition, struggling to label facial expressions accurately compared to healthy controls. They also demonstrate a negativity bias, as previously mentioned (Goueli et al., 2019). The inability to accurately perceive others' likely thoughts and feelings, coupled with a tendency to over-interpret social cues, plays a role in the development and maintenance of BPD.

BPD is complex and influenced by numerous neurobiological, genetic, and environmental factors. These risk factors interact in ways that vary for each individual. BPD often emerges during adolescence, making this a crucial period for identification and intervention, as even the presence of borderline traits can hinder a successful transition to adulthood.

BPD Theories

Models of BPD emphasize the interaction between biological vulnerabilities and stressful life events. Linehan's biosocial theory (1993) is perhaps the most influential to date (Al-Alem & Omar, 2008; Winsper, 2018). Her theory posits that individuals with BPD experience biologically based emotional dysregulation and are exposed to invalidating environments. Other notable theories include the Biosocial Development Model (BDM), an extension of Linehan's model; Selby's (2009) Emotional Cascades Model (ECM); Fonagy et al.'s (2017) Socially Oriented Model; and the Developmental Model proposed by Hughes et al. (2017).

Biosocial Development Model (BDM)

Linehan's biosocial theory is the most comprehensively defined causative model of borderline pathology (Crowell et al., 2009). It identifies BPD primarily as a disorder of emotion regulation that results from interactions between individuals with biological vulnerabilities and specific environmental influences, particularly an invalidating environment, where the individual's feelings, thoughts, and behaviours are repeatedly dismissed, undermined, or devalued. The Biosocial Development model extends and elaborates on Linehan's original theory by adopting a lifespan developmental approach. In this model, BPD is viewed as the outcome of interacting risk factors, precipitating events, and ongoing processes.

The BDM proposes five hypotheses (based on theoretical and empirical evidence) (Crowell et al., 2009). The first is that genetic risk factors of poor impulse control and emotional sensitivity predispose a child to the development of BPD. The second is that wide-ranging emotional dysregulation is encouraged and sustained within a caregiving environment that is dismissive or invalidating. Therefore, an emotionally sensitive child, whose experiences are rejected or not tolerated, does not learn how to understand or accept their own emotional

experiences. The third hypothesis is the mutual interactions between biological predispositions and environmental risks. These interact to amplify emotional dysregulation, resulting in more severe behavioural control issues. For example, when a parent is repeatedly invalidating and cannot model appropriate expressions of emotion, over time the child may develop heightened impulsivity, aggression, and interpersonal difficulties (Crowell et al., 2009). In turn, the child's tendencies to be impulsive and overly emotional can have evocative effects on parenting style. The fourth hypothesis is there are early behavioural indications of risk for BPD. Biologically driven temperamental vulnerabilities lay the foundation for later development of BPD by shaping how individuals respond emotionally and behaviorally to their environment (Crowell et al., 2009). For example, when emotional dysregulation and impulsivity combine, the risk for suicidal and nonsuicidal self-injury increases. Crowell et al. (2009) state that research indicates there is an association between adolescent self-injury and borderline pathology. Finally, the fifth hypothesis is that traits and behaviours of BPD emerge earlier (perhaps as soon as birth) than a full diagnosis (Crowell et al., 2009; Stepp et al., 2014; Winsper et al., 2017). The interactions between the child and an overburdened caregiving environment perpetuates emotional and behavioural dysregulation in the biologically vulnerable child. An example of this might be that significantly dysregulated behaviours such as self-injury or disordered eating impact the parent-child relationship by lessening trust and increasing conflict and rigidity.

The BDM highlights poor impulse control as an early trait associated with difficulties in emotion regulation. Impulsivity and emotional dysregulation are believed to emerge independently and sequentially, with environmental risk factors amplifying them through a cycle of mutual exchanges (Crowell et al., 2009; Winsper, 2018). For instance, a child with impulsive tendencies in a high-risk environment may struggle to regulate intense emotions due to

inconsistent parenting. Over time, these harmful exchanges lead to negative interpersonal and cognitive outcomes. By mid-adolescence, the individual has developed dysfunctional coping strategies, which increases the risk of BPD by eliciting negative responses from others and disrupting healthy social development.

Emotional Cascade Model (ECM)

The Emotional Cascade Model posits that the relationship between emotional and behavioural dysregulation in BPD is explained by rumination (Selby et al., 2009). Rumination is the tendency to continuously think about the same (often negative thoughts) without reaching a resolution. According to the ECM, rumination may be a process that contributes to the heightened sensitivity, increased intensity, and extended duration of emotions seen in BPD (Winsper, 2018). The interwoven relationship between negative emotions and ruminative thinking leads to an “emotional cascade,” usually triggered by an event that evokes strong emotions (Selby et al., 2009). As the intensity of feelings rises, the individual focuses more on their emotions, therefore resulting in a positive feedback loop between rumination and negative affect. These emotional cascades magnify negative affect, causing the individual to resort to extreme behaviours such as self-injury, substance abuse, binge-eating, and aggression (Selby et al., 2009; Winsper, 2018). Selby and colleagues also discovered that in BPD, emotional dysregulation is not only influenced by the experience of upsetting interpersonal interactions or other problems, but even just thinking about something upsetting might be enough to trigger an emotional cascade, further providing evidence of the emotional “hypersensitivity” of individuals with BPD (Selby et al., 2009). The ECM complements the BDM by clearly explaining the proposed processes that contribute to the intensification of emotional, cognitive, and behavioural dysregulation.

Socially-Oriented Model

Fonagy and colleagues (2017), consider BPD as developing from a lack of epistemic trust in social knowledge. The theory follows that epistemic trust is created in infants within the context of early attachment relationships, where they are open and receptive to social communication from their primary caregivers. If, however, there is a lack of social smiling, eye contact, and turn-taking from the caregiver, epistemic trust will not be stimulated. In such situations, the infant becomes hypervigilant or closed off to the communication of social knowledge (Fonagy et al., 2017; Winsper, 2018). In families with abusive or hostile caregivers, epistemic mistrust becomes an adaptive process. It leads to overinterpretation of motives or "hypermentalisation", where the individual will assume malicious motives behind another person's actions. In this way, personality dysfunction will be maintained in a cycle of social dysfunction and mentalization difficulties (Fonagy et al., 2017). This may manifest as chronic interpersonal paranoia or a defensive reaction to perceived slights. In essence, BPD is thought of as the outcome of how an individual has learned to respond to the transmission of social knowledge within their social environment.

Developmental Model

Hughes and colleagues (2017) combine emotional and social domains by considering the role of frontolimbic dysfunction within the context of social baseline theory (Winsper, 2018) Social baseline theory suggests that human brains are wired to expect social relationships as the baseline for regulating emotions and managing stress (Hughes et al., 2012). Early attachment relationships serve as the initial source of co-regulation, and consequently, the neural structures involved in self-control will begin to form and strengthen. If there is an inability of early attachment figures to provide consistent co-regulation, the developing frontolimbic circuits may

be overwhelmed. It is hypothesized that this overwhelm could lead to the development of BPD by disabling the ability to learn self-regulation. As children age, those with poor self-control are less likely to be accepted by their peers, further precluding opportunities for coregulation throughout development (Winsper, 2018).

Borderline Personality Traits

Adult criteria are used for a diagnosis of BPD in adolescents; however, there are some differences between the two. Compared to adults, adolescents are more likely to present with the more acute symptoms of BPD, such as recurrent self-harm and suicidal behaviour (Guile et al., 2018). In addition, other impulsive and self-damaging behaviours and inappropriate anger are more prevalent in youth. Specific behaviors and traits suggestive of adolescent BPD include repetitive non-suicidal self-injury (NSSI) or suicide attempts, impulsive risk-taking behaviors such as binge drinking, substance abuse, and risky sexual activities, as well as a combination of high levels of both internalizing (e.g., depressive symptoms, anxiety) and externalizing problems (e.g., conduct issues, attention deficit hyperactivity disorder symptoms). Other indicators include frequent anger outbursts, disruptive behavior, interpersonal conflicts, unstable relationships, very low self-esteem, an insecure identity, and a lack of life goals (Kaess et al., 2014).

Despite their prevalence and severity, little is known about the impact borderline personality traits (BPTs) have on the daily lives of adolescents, especially in regard to psychosocial functioning. In fact, only a few studies have examined this (Kramer et al., 2017; Wright et al., 2016). One study in particular showed adolescents with BPTs showed functional impairments in self-care and in relationships with peers and parents (Kramer et al., 2017). A five year follow up study by Zelkowitz et al. (2007) showed that adolescents with BPTs were more likely to have changed schools due to behaviour problems, live in foster homes, and have

difficulties with peers compared to an adolescent group of general psychiatric patients without BPTs.

BPTs Impact on Psychosocial Functioning

As previously mentioned, there is limited data that speak to the functional impact of BPD symptoms in adolescence. BPD disturbs one's sense of identity and disrupts interpersonal functioning, and the process of identity formation and understanding self in relation to peer and romantic partners are key developmental tasks of adolescence (Wright et al., 2016). There is research showing that adolescents at risk of internalizing problem behaviors (the majority of BPD symptoms) have difficulty developing their identity (Crocetti et al., 2013). Thus, difficulties in completing core developmental processes and emerging BPD symptoms during adolescence can trigger both ongoing psychological distress and impairments in functioning.

Studies conducted by Wright et al. (2016) and Kramer et al. (2017) examined how BPD symptoms and psychosocial functioning co-developed across adolescence in large samples of young girls. Their findings showed that every psychosocial domain was impacted by BPTs and increasing BPD symptoms were linked with worsening social, academic, and mental health outcomes throughout the adolescent period. These findings highlight the pervasive nature of borderline traits and the high level of psychosocial impairment they cause. An examination of social, school and health functioning deficits follows.

Social Domain. Compared to psychiatrically healthy teens, girls with BPTs have difficult relationships with both parents, more problems with friends, are more likely to date, and spend much of their free time alone (Kramer et al., 2017). Chanen et al. (2020) report impairment in developing fulfilling friendships and romantic connections as long-term outcomes for young people with BPD traits. Girls with BPT have more conflict in friendships, and the symptoms of

BPD themselves may directly contribute to relationship strain. High levels of impulsivity, difficulty controlling anger, affective instability, and frantic efforts to avoid abandonment may all set the stage for conflictual and high-emotion interactions (Lazarus et al., 2019). Additionally, rejection sensitivity causes girls to perceive small daily forms of rejection as signs of personal disapproval or devaluation (Koster et al., 2018). High rejection sensitivity leads to a self-fulfilling prophecy in which girls' expectations of rejection lead them to engage in defensive actions against or withdrawal from others, increasing the likelihood of actual rejection, and an increase in social conflict (Koster et al., 2018). Not surprisingly, girls with borderline traits report low levels of life satisfaction citing rejection, depression, and loneliness as key problems (Chanen et al., 2020). This leads to the conclusion that the impact of borderline characteristics on life satisfaction may be partially explained by difficulties in forming and maintaining social relationships. Koster et al. (2018) report that girls with BPT receive less social support than healthy individuals, report less positive relations overall, and experience more conflict in the relationships they do have. Due to the difficulties these girls have in establishing long-lasting and stable friendships, relationships with friends could be less influential than relationships with parents (Koster et al., 2018; Stepp et al., 2014).

Girls with borderline personality traits may attach greater value to supportive relationships with their parents and are more negatively affected by conflict in these relationships (Stepp et al., 2014). Studies have found that low levels of closeness between girls with BPTs and their parents account for higher levels of impairments in personality functioning (Skabeikyte-Norkiene et al., 2022). Parents may perceive raising a child who exhibits BPD symptoms as particularly challenging, which can negatively influence their parenting responses. These strained interactions may, in turn, contribute to the escalation of the child’s maladaptive

behaviours (Stepp et al., 2014). Stepp and colleagues (2014) have found supportive parenting behaviours declined over time when teens behaved consistently negative and inflexible. In addition, adolescents may engage in risky and problematic behaviours that parents deem worthy of discipline. If girls are engaging in risky and dangerous behaviours, they are not likely to evoke parental warmth. These interactions serve to highlight the bidirectional and transactional nature of BPD symptoms and parenting behaviours (Stepp et al., 2014). Caregiver/parental affection and discipline are critical factors for adolescent adjustment and mental health. If girls with BPTs are consistently met with warm, nurturing parenting, symptoms may actually abate or remain at their current levels rather than increasing. However, if parents react to symptoms with increasingly negative or decreasingly positive parenting practices, disorder may become unavoidable (2019; Lazarus et al; Stepp et al., 2014). Skabeikyte-Norkiene et al. (2022) report that low levels of closeness in teen-parent relationships account for higher impairments in personality functioning, and high maternal support was associated with lower BPD symptoms; therefore seen as a protective factor. Girls with BPTs typically struggle to establish and maintain stable friendships, making their relationship with parents more influential.

Adolescence is a critical window for the initiation and development of important interpersonal relationships, specifically the expansion of one's attachment system to include romantic relationships. Girls with borderline personality traits are at risk for the disruption of meaningful peer and romantic relationships (Chanen et al., 2020). High levels of attachment anxiety may increase the likelihood of romantic relationship dysfunction and the likelihood of becoming involved in a high-intensity romantic relationship (Lazarus et al., 2019). Romantic partners often serve as key attachment figures, fulfilling developmentally significant needs related to caregiving, emotional intimacy, affiliation, and sexuality. Kramer et al. (2017) found

teen girls with BPTs both dated more often, and for briefer periods than their healthy peers. For adolescents with elevated borderline traits, early romantic relationship intimacy may heighten the vulnerability for interpersonal intensity, which sets the stage for worsening symptoms (Lazarus et al., 2019). Engaging in sexual and romantic relations during early adolescence predicts greater depression, and in one study, sexual activity and worsening mental health symptoms were bidirectionally related in teen girls with BPD traits (Wright et al., 2016). As BPD symptoms increase, so does sexual activity. High levels of early intimacy, affection, and commitment represent what Lazarus and colleagues (2019) call a "too much too soon" situation for adolescents at risk for BPD. In addition, BPD symptoms predict elevated relationship stress, lower partner satisfaction, and teen dating violence (Lazarus et al., 2019). Girls with BPD features are more likely to experience poor interpersonal outcomes in relationships such as higher levels of aggression and dating violence and may be more vulnerable to their negative impact. Teen girls were also found to be more insecure in their romantic relationships and worried about partners cheating or being interested in others and had greater willingness to do anything to keep the relationship (Wright et al., 2016). All in all, symptoms of BPD may increase the likelihood of having romantic relationships characterized by high levels of intensity, aggression and conflict, and for girls already vulnerable, having intense romantic relationships may be a risk factor for even more severe psychopathology (Lazarus et al., 2019).

School Domain. Although limited, research examining the impact of borderline personality traits on school functioning suggests concerning trends. Studies report that girls with borderline symptoms are more likely to be suspended or expelled and significantly less likely to participate in school or community organizations (Kramer et al., 2017). Challenging behaviours, including anger, impulsivity, mood reactivity, difficulties in relationships with peers and adults,

and risky behaviours such as self-harm, suicidal ideation, sexual activity, violence, and criminal behaviour, often contribute to these disciplinary actions (Townsend et al., 2018).

While girls with BPD do not differ from their peers in terms of IQ, they experience significant academic difficulties (Kaess et al., 2012; Kramer et al., 2017; Wright et al., 2016, Kaess et al., 2024). Poor academic performance in high school can significantly undermine long-term educational outcomes, ultimately limiting future employment opportunities and economic stability (Wright et al., 2016). Struggles in school may also lower self-esteem, which can exacerbate psychological vulnerability and identity issues (Kramer et al., 2017). Additionally, girls with BPTs often have a history of school difficulties and higher rates of absenteeism (Kramer et al., 2017; Townsend et al., 2018). According to Townsend and colleagues (2018), negative school experiences significantly influence the development and severity of personality disorder symptoms. As schools are the setting where young people spend much of their childhood and adolescence, they are essential sites for responding to mental health concerns.

Health Domain. Adolescents' tendency towards highly impulsive and self-destructive behaviours increases their vulnerability to adverse health outcomes (Kaess et al., 2014). Health risk behaviours of girls with BPTs include non-suicidal self-injury (NSSI), suicidal ideation, substance abuse, risky sexual activity, cigarette smoking, disordered eating, aggressive and risk-taking behaviours (Kaess et al., 2014; Klein et al., 2022; Mendez et al., 2022; Wright et al., 2016).

NSSI and suicidal behaviours are central characteristics of borderline personality disorder, with the majority of diagnosed adults reporting a longstanding pattern of recurrent self-harming behaviours beginning in childhood or adolescence (Kaess et al., 2014). Among teens with identified BPD, self-harm and suicidal behaviour are the most frequently met BPD criteria,

which differs from adulthood, where rates of suicidal behaviour and self-harm decline (Kaess et al., 2014). Mendez et al. (2022) found that approximately 61% of adolescents with BPD symptoms have engaged in NSSI at least once. In addition, the occurrence of NSSI often precedes a diagnosis of BPD and is therefore considered a precursor to the disorder. Symptoms such as emotion dysregulation and identity disturbance have been found to increase the risk of engaging in some form of NSSI in adolescence (Mendez et al., 2022). Both NSSI and suicidal behaviour are considered observable symptoms for the underlying problems of emotion regulation, impulse control, and interpersonal relations, and individuals with borderline traits have an elevated risk of engaging in NSSI and premature death (Reichl & Kaess, 2021). Self-harming behaviour has been identified as a risk factor for future suicide, and adolescents with BPTs who engage in NSSI for over a year have been found to repeat suicide attempts 6 months after hospitalization (Kaess et al., 2014). Interpersonal conflicts or feelings of rejection by peers are frequent triggers of NSSI, and adolescents who engage in NSSI often report feelings of loneliness, low social competence, poorer relationships with parents, and invalidating life environments (Mendez et al., 2022). A study by Koenig et al. (2021) found that among teen girls, heightened negative affective states have been found to predict incidents of NSSI within the subsequent hour. Paradoxically, engagement in NSSI is associated with an increase in negative affect and a reduction in perceived attachment within one hour following the self-injurious act (Koenig et al., 2021). Adolescents with low perceived social supports are especially vulnerable to NSSI, and the association between NSSI and emotion dysregulation becomes stronger in non-supportive environments, further emphasizing the protective role of social support (Mendez et al., 2022). Low social support from family and peers plays a crucial role in

the onset and maintenance of NSSI, and adolescents who engage in self-harming behaviours may feel rejected or stigmatized by family and friends due to their behaviour.

Overall evidence suggests the function of self-harming behaviour in BPD is largely affect regulation; however, there are other reasons. Self-reports from teens offer a range of reasons such as attempting to control, escape from, or avoid difficult and overwhelming feelings of emotional pain, expressing anger, feeling “something” (e.g., if feeling numb or disassociated), self-punishment, or communicating a need for help (Townsend et al., 2018). The presence of self-harming behaviours and impulsivity, combined with persistent feelings of emptiness or emotional distress, is associated with a poorer prognosis over 12 months (Townsend et al., 2018). BPD features, such as affective and interpersonal instability, may contribute to and interact with self-harming behaviours. In this way, core symptoms of BPD can be seen as playing a role in sustaining self-harm (Reichl & Kaess, 2021).

Given the high likelihood of teens with BPTs engaging in self-harm behaviours, they are frequent consumers of health care services. Klein and colleagues (2022) write that the high rates of ongoing suicidality and crisis visits to hospitals by people with BPD have made the disorder one of the most stigmatized and marginalized in mental health and healthcare settings. The recurrent visits to health care services place increased demand on the health system, and studies in Australia have found hospitalization rates for females aged 11-16 years outpace their male counterparts at a rate of 5:1 (Townsend et al., 2018). Teens with BPD features are stigmatized when accessing health services and report receiving suboptimal levels of care from health providers, including not being believed or dismissed in reaction to the nature and severity of their presentation (Klein et al., 2022). The stigma young people with BPTs face when accessing services and supports can lead to inequities and poor health outcomes for individuals and their

family/carers. The interactions between adolescents with borderline traits who self-harm and the health care system is an area that deserves further investigation.

Adolescents with BPD traits may engage in risky sexual behaviours, including unprotected sex, multiple partners, and early sexual activity. Results of a study by Thompson et al. (2019) found BPD pathology in youth is associated with poor sexual health and safety and uncertainty in sexual identity formation. Early initiation of sexual activity may increase lifetime prevalence of sexual partners, the likelihood of contracting sexually transmitted diseases, or early and unplanned pregnancies (Wright et al., 2016). In addition, several traits of BPD are likely associated with problematic sexual health including impulsivity (impulsive sexual behaviour), identity disturbance (unstable sexual identity), and unstable and intense interpersonal relationships that might involve costly relationship tactics in an attempt to retain a partner (impulsive and risky sexual behaviour that might expose girls to coercion and abuse) (Thompson et al., 2019). Often, the sexual behaviours of adolescents with BPTs are driven by impulsivity, emotional instability, and desire for validation (Lazarus et al., 2019).

There is a significant association between BPD traits and increased substance use, including alcohol and illicit drugs (Kaess et al., 2014). Studies by Scalzo et al. (2017) found prevalence rates of youth with alcohol dependence is approximately 5 times higher than that found in the general population, and daily tobacco use and monthly or more frequent use of illicit substances use is approximately four to seventeen times higher in teens with BPTs than matched controls. Despite these findings, there is limited research into substance use in youth with BPD.

Borderline personality disorder in adolescence interrupts the healthy development of the person, leading to high distress and poor social, academic, and health functioning. Even the

presence of borderline traits predicts long-term deficits in psychosocial functioning, especially for adolescent girls (Kaess et al., 2024).

Interventions

As we have seen, BPD is highly impairing, and even the presence of a few traits of this disorder can seriously disrupt the lives of adolescents. On a positive note, symptoms tend to peak around mid-to-late adolescence and largely diminish over the adult years, although relapses are possible (Chanen & McCutcheon, 2013; Kaess et al., 2024). Even so, early onset of BPD pathology (before 19 years of age) predicts long-term deficits in interpersonal, occupational and general functioning (Winsper et al., 2015). Adolescence is a critical time for early detection and intervention (Chanen et al., 2020; Kaess et al., 2024), and BPD traits in youth are particularly malleable (Chanen & McCutcheon, 2013). Kaess et al. (2024) state that several structured psychotherapies have been developed for use with young people with BPD traits, and these have proven to elicit clinically significant improvements in affected individuals. Trained community professionals must deliver these therapies at either inpatient or outpatient programs. There are, however, programs designed to be delivered in schools and Townsend et al. (2018) claim school environments are ideal for early identification and intervention for youth. A brief examination of effective psychotherapies for youth follows, along with supportive interventions developed for school use.

Clinician-Delivered Therapies

Individual psychotherapy is a key component of early intervention programs for BPD (Kaess et al., 2014). The common principle is to prioritize early intervention, targeting the amelioration of BPTs (Bourvis et al., 2023). There are several treatment modalities developed for adolescent BPD, and the most commonly used ones are briefly described here.

Cognitive Analytic Therapy (CAT). Cognitive analytic therapy was the first individual therapy to be tested in a randomized controlled trial in adolescent BPD (Kaess et al., 2014). It is used within the Helping Young People Early (HYPE) program in Australia, which is a specific service model designed to care for adolescents at risk for BPD (Bourvis et al., 2023). CAT is a time-limited integrative psychotherapy (Chanen et al., 2009). It is practical and collaborative, with a particular focus on identifying, understanding, and revising the individual's problematic self-management and interpersonal relationship patterns. The thoughts, feelings and behavioural responses that result from these patterns is also addressed. A central feature of CAT is the patient-therapist collaboration in creating a shared understanding of the patient's difficulties and their developmental origins (Chanen et al., 2009). CAT is a talk-based therapy, with 24 sessions offered to each patient, and four follow-up post-therapy sessions at monthly intervals to monitor progress and risk (Kaess et al., 2014). In the HYPE model, CAT is integrated with assertive case management, active engagement of families or caregivers, general psychiatric care, and crisis care (Chanen et al., 2009).

Emotional Regulation Training (ERT). Emotion Regulation Training (ERT) was developed in the Netherlands by Schuppert and colleagues (2009) for adolescents exhibiting two or more borderline personality disorder criteria along with emotion dysregulation (Kaess et al., 2014). ERT integrates components from Systems Training for Emotional Predictability and Problem Solving (STEPPS), a U.S.-developed intervention shown to be effective for adults with BPD, along with skills training from dialectical behaviour therapy (DBT; Linehan, 1993) and elements of cognitive behavioural therapy. The program is a 17 week, manual-based outpatient group treatment, followed by two booster sessions held at six and 12 weeks post-treatment

(Schuppert et al., 2009). Treatment outcomes indicate a reduction in BPD symptoms and a significant increase in internal locus of control.

Mentalization-Based Therapy (MBT). Mentalization-based therapy was specifically designed for people with BPD and was created and manualized by Fonagy and Bateman (2009). It is inspired by attachment theory, particularly the internal working model of attachment (Bourvis et al., 2023). MBT shares many common features with CAT and has been adapted for use with adolescents. It is a psychodynamic approach that aims to improve the ability to mentalize (Kaess et al., 2014). Poor mentalizing is regarded as a core feature of BPD, and treatment aims to increase mental capacity, which would then result in improved affect regulation, attention, self-control, interpersonal competencies and reduced self-harm (Bourvis et al., 2023). The adapted adolescent version involves a five-month structured treatment of alternating individual and group therapy sessions (Bourvis et al., 2023).

Dialectical Behaviour Therapy (DBT). DBT is a cognitive-behavioural treatment originally developed for individuals with chronic suicidal behaviour and BPD and is based on Linehan's (1993) biosocial theory, where biological predisposition combined with an invalidating environment is thought to give rise to emotion dysregulation and problem behaviours (Shernoff et al., 2022). DBT places specific attention on the validation of a client's emotional experience and the acceptance of negative emotions (Bourvis et al., 2013). Facets of DBT include cognitive behaviour training, mindfulness meditation, behaviourism and dialectics approaches (Bourvis et al., 2013). The program is divided into four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The set of skills taught were developed based on behavioural research and other evidence-based treatments (Linehan, 1993). Skills for distress tolerance and mindfulness focus on the acceptance aspect, while the emotional regulation and

interpersonal relationship skills mainly focus on the aspect of change (Bourvis et al., 2013). Comprehensive DBT includes individual therapy, phone coaching, group skills training, and intensive team peer consultation for providers (Shernoff et al., 2022). DBT was initially designed for use with adults but has been adapted for use with adolescents (DBT-A) to treat a variety of mental health struggles (MacPherson et al., 2013). DBT-A consists of 20 weekly individual psychotherapy sessions, weekly participation in a skills group, and integration of families. It is used in the German specialized outpatient program AtR!sk, which provides evidence-based early intervention for adolescents with BPD features (Cavelti et al., 2024) Kaess et al. (2014) report there is some promising follow up data from this program, and a randomized control study is underway.

Pharmacotherapy. Current evidence does not support the use of medication to treat BPD (Bourvis et al., 2023; Kaess et al., 2014). Evidence regarding the effectiveness of medication for self-harm, suicide-related outcomes, and psychosocial functioning remains inconclusive (Bourvis et al., 2023). Treatment of co-occurring depression and anxiety should follow established clinical guidelines, which may include medication (Kaess et al., 2014). However, prescribing medication to adults with BPD remains controversial due to its limited effectiveness and should not be generalized to adolescents with BPD (Kaess et al., 2014).

Despite the lack of evidence supporting its efficacy, up to 96% of patients with BPD who seek treatment receive at least one psychotropic medication (Gartlehner et al., 2021). Both the National Institute for Health and Care Excellence (NICE) in the United Kingdom and the Australian National Health and Medical Research Council advise against using pharmacotherapy as a first-line treatment, except in cases of acute crisis (Gartlehner et al., 2021).

Clinical trials have shown that second-generation antipsychotics, anticonvulsants, and antidepressants do not significantly reduce the severity of BPD symptoms (Gartlehner et al., 2021).

School-Delivered Interventions

Schools are considered favourable and ideal environments for early identification and intervention for youth with mental health issues (Justo et al., 2018; Townsend et al., 2018). As the setting where young people spend a significant proportion of their childhoods and adolescence, schools are at the forefront of responding to student self-harm and mental health struggles. Mazza et al. (2016) state schools are the most likely places for students to receive psychological services, and 98% of students (in the United States), referred for mental health treatment in their schools received services, compared to less than 20% of students referred to outside services who actually received services. In addition, Townsend et al. (2018) state that early recognition of BPD features in at-risk teens, along with evidence-based interventions, has the potential to alter the course of the disorder. Early intervention may also require less intensity and be more effective than waiting until later adolescence.

Educating children involves attending to the social, emotional, and cognitive aspects of development, and the social-emotional well-being of young people is an area of increased focus of policy and practice (Hastings et al, 2022). Martinez et al. (2021) state that schools are increasingly being called to provide universal supports (e.g. classroom curricula provided to the general student population) that can help children and adolescents develop, build, and maintain their social-emotional skills. Multiple studies exploring universal social emotional learning (SEL) programs have demonstrated measurable improvements in many areas of the lives of students, such as emotional, behavioural and academic outcomes; however, most interventions

are designed for elementary school settings (Martinez et al., 2021; Mazza et al, 2016). In fact, in the United States there are 19 programs for elementary, six for middle school and five designed for use in high schools (Mazza et al., 2016). For adolescents, SEL is particularly important because of the many social and developmental stressors typical for this age group such as peer rejection, alcohol and drug abuse, dating and intimacy issues, bullying, social relationships, concerns about physical attractiveness, academic transitions from middle to high school, and becoming more independent of parents (Mazza et al., 2016). There is limited research on the efficacy of SEL programs for older adolescents, however the available data does show that these programs have been found to help teens successfully manage stressors and increase prosocial behaviour as well as decrease school failure, problem behaviours, physical aggression and disciplinary referrals (Martinez et al., 2021; Mazza et al., 2016).

DBT STEPS-A. The Dialectical Behavior Therapy Skills for Emotional Problem Solving for Adolescents (DBT STEPS-A; Mazza et al., 2016) is an adaptation of DBT more developmentally appropriate for youth. DBT skills teach individuals how to change unwanted behaviour, emotions, thoughts and events in one's life that cause misery and distress, as well as how to live in the moment to accept "what is" (Martinez et al., 2021). DBT is particularly helpful for individuals who struggle to regulate emotions, a core feature of BPD. DBT skills target many of the social, developmental, and academic pressures faced by adolescents, such as peer rejection, low self-confidence, impulsive behaviours, drug and alcohol use and issues rated to intimacy and sexual relationships (Martinez et al., 2021).

DBT STEPS-A is a SEL program that teaches emotion management strategies, decision making skills, and interpersonal skills (Hastings et al., 2022; Martinez et al., 2021; Mazza et al., 2016; Zapolski et al., 2021). It can be implemented at a universal level (tier 1) or in small groups

(tier 2). Targeted interventions (tier 2) are particularly useful for adolescents who are experiencing social, emotional or behavioural problems and may be at risk for negative health outcomes (Zapolski et al., 2021). The comprehensive manual is text-book style, consisting of 400 pages containing research on the effectiveness of DBT, instructor information, lesson plans, worksheets and handouts, tests and answer keys. The skill modules in DBT STEPS-A are specifically designed to address deficits in four areas: emotion regulation, mindfulness, distress tolerance, and interpersonal effectiveness (Mazza et al., 2016).

The emotion regulation module teaches skills for first recognizing and naming emotions, then decreasing unpleasant, distressing emotions, and lastly increasing positive emotions. According to the authors of the program (Mazza et al., 2016), teens often experience intense quickly changing emotions which can lead to impulsive emotion-based behaviours. In addition, they sometimes fail to recognize their emotions or physical sensations that accompany them.

The mindfulness module emphasizes self-awareness and control of attention. These skills are necessary for making balanced and well-considered decisions as well as focusing the mind. Adolescents are developing their identity and peer pressure, social media, and other environmental pressures can make it difficult for teens to understand themselves. These issues can also contribute to loss of focus and distraction, and the skills taught in this module can help improve confusion about the self and improve attention (Mazza et al., 2016).

The skills taught in the distress tolerance module help make emotional suffering more bearable, so teens do not engage in problematic impulsive behaviours such as skipping class, using drugs, risky sexual encounters, self-injurious and suicidal behaviours. Teens learn that sometimes impulsive behaviours function as an escape from painful emotions (Mazza et al., 2016).

In the interpersonal effectiveness module, students learn strategies for asking for what they want, saying no to what they don't want, building and maintaining long-term relationships, and maintaining self-respect during interpersonal interactions (Mazza et al., 2016).

Most SEL curricula do not teach adolescents how to cope with stress and decision making, making the DBT STEPS-A program unique in that it was developed to meet this need (Mazza et al., 2016). The four modules are designed to be delivered over 30 weeks (one 50-minute class per week); however, it can be adjusted and modified to allow for different delivery methods, and is applicable to racially, ethnically, and socio-economically diverse populations (Martinez et al, 2021). Each session begins with a mindfulness exercise, then a skill related to emotion regulation, distress tolerance, interpersonal effectiveness, or mindfulness. At-home practice is also assigned at the end of each session (Mazza et al., 2016; Zapolski et al., 2021). The curriculum was designed to be taught by educators or other school personnel with some understanding of adolescent mental health issues (e.g. school counsellors), to the universal student population. It can be enhanced with support from school counsellors and child and youth mental health clinicians as required for tier 2 (small group) and tier 3 (individual) interventions (Hastings et al., 2022). DBT STEPS-A is not a therapy program. The goal of the program, as stated by the authors, is to "...help youth develop their own toolboxes of effective strategies to regulate emotions, solve problems, improve relationships and enhance their lives." (Mazza et al., 2016, p.4).

AIR Therapy. The Project Air Strategy for Personality Disorders (2015) is an Australian initiative designed to enhance treatment options for individuals with personality disorders and their families and caregivers (Grenyer, 2014). The high prevalence of BPD, challenges in providing sufficient resources to meet the need, the cost-benefit of intervening effectively, and

the stigma and burden for those involved have led the Australian government to rethink treatment approaches (Grenyer, 2014). Out of this need to expand treatment options, AIR therapy was conceptualized. This manualized program was developed in collaboration between NSW Health and the Illawarra Health and Medical Research Institute, at the University of Wollongong. It has been adapted and expanded for use with clinicians, adolescents, schools, parents and caregivers, and pre-adolescents. Clinician and participant manuals are available free of charge on the university website.

Project AIR is based on a relational model that interprets personality disorders as disorders of relationship, with 3 key areas of focus: the relationship between the client and themself, the relationship between the client and professionals, and the relationship between the client and the broader environment including families, education, health, and community services (Grenyer, 2014; Stevenson et al., 2024). AIR stands for affect, identity and relationships, which are all areas of life adolescents with BPTs may struggle with.

There are two AIR therapy approaches which are relevant to schools: the “Brief Structured Approach to Working with Young People”, and “Project Air Strategy for Schools”.

AIR Therapy for Young People

The aim of this intervention program is to assist mental health clinicians (or school counsellors) to work together with adolescents aged 12-18 years to address emerging personality disorders. It is designed to build skills, enhance agency, and generate opportunities for reflection (Stevenson et al., 2024). This approach can be utilized in an online format, as a Tier 2 intervention (small group), or as a Tier 1 intervention (targeted individual). This brief manualized approach consists of 6 modules, each focusing on developing skills that have been shown to be effective in reducing core symptoms of BPD (Grenyer et al., 2025). The 74-page

facilitator manual provides research and background information on AIR therapy, as well as information on cultural considerations, boundaries, consent, trauma-informed approaches, and facilitator well-being. The accompanying 119-page adolescent workbook contains lessons featuring psychoeducation and exercises and activities that take approximately 30 minutes to complete (Grenyer et al., 2025; Stevenson et al., 2024). Topics include an introduction to AIR therapy, mindfulness and managing distress, emotions, self and identity, relationships and interpersonal skills, and self-care. Because interventions for BPD tend to be lengthy and resource-intensive, this brief intervention may be more appropriate for adolescents struggling with BPTs, who may be more responsive to less intensive treatments (Grenyer et al., 2025).

A study by Grenyer et al. (2025) found that adolescents who participated in the brief approach to AIR therapy reported that the treatment improved their mental health, self-regulation and coping skills. Their findings also support the efficacy of brief interventions for BPD, particularly for mild or emerging cases, or for younger teens (Grenyer et al., 2025).

Project AIR Strategy for Schools

Project AIR for schools is a 46-page guide written to support secondary schools to enhance their understanding and responses when working with young people with complex mental health issues, including personality disorders, trauma, self-harm, suicidal behaviour, difficulties with identity, emotions, and relationships (Townsend et al., 2018). Professionals working with adolescents, such as teachers, school counsellors, child and youth mental health clinicians, youth care workers and administrators, can use the guidelines to inform their actions when working with young people with mental health issues. The guide provides information and tools supported by evidence-based approaches and early intervention approaches (Grenyer et al., 2016). It can be aligned with existing school policies and resources. By engaging in Project Air

Schools, it is hoped staff can help their schools become a “protective factor” in a teen's environment. The program is divided into 6 sections: key principles for working with young people, understanding complex mental health problems, identifying and assessing risk, responding to crisis and self-harm situations, responding effectively to challenging behaviours, and working to improve the school and social environment (Townsend et al., 2018). Each section provides evidence-based strategies, information, and resources for promoting well-being. Included are helpful tips such as “talking to young people with emerging personality disorder – 5 steps”, “risk factors for self-harm and suicide in adolescents”, “key principles for responding to a crisis”, “working with parents with a personality disorder” (Grenyer et al., 2016).

Townsend and colleagues (2018) conducted a study on using the Project Air Strategy for Schools, providing school counsellor -led structured approaches to help classroom teachers identify and respond to youth in distress. Results of this whole school model of intervention showed improvement in teachers’ knowledge, attitudes and skills in working with adolescents with complex mental health issues. Findings also suggest early intervention in the school setting fostered collaborative practice between school staff and school counsellors (Towsend et al., 2018).

Unlike the DBT STEPS-A program, Project AIR for schools is not a social-emotional curriculum; however, it is a whole school approach to supporting young people experiencing mental health difficulties. Alternatively, school counsellors can partake in professional development regarding the AIR therapy program and provide training to their respective schools, to “up-skill” teachers to identify, understand, and respond to students with complex mental health disorders (Townsend et al., 2018).

Effective early interventions for adolescent BPD include specialized psychotherapies delivered by trained clinicians, with growing support for school-based programs like DBT STEPS-A and Project AIR. These approaches prioritize early detection, skill development, and whole-system support to improve long-term outcomes for at-risk youth.

Chapter Summary

Research shows that BPD is a complex and highly impairing condition, with particularly severe effects on adolescent girls. Chapter 2 draws on multiple scholarly sources to explore the diagnosis, development, psychosocial impacts, and interventions associated with borderline personality traits. Leading theories suggest that BPD emerges through interactions between a young person's innate temperament, their relationships with parents or caregivers, and broader environmental influences.

Borderline traits often emerge during adolescence, yet research on how these traits impact adolescents' daily lives remains limited. Existing data indicate that BPTs impair functioning across nearly all psychosocial domains. Teen girls with BPTs often experience heightened conflict with parents, turbulent friendships, and challenges in romantic relationships. Academically, they face greater difficulties and receive more disciplinary actions than their peers. Health-risk behaviours such as non-suicidal self-injury, suicidal behaviours, substance use, and risky sexual activity are also more prevalent.

Early detection and intervention are critical and can help mitigate the most severe symptoms. Treatment options include both clinician-delivered therapies and school-based interventions. As schools and society in general increasingly recognize the importance of addressing students' emotional and mental well-being, support for school-based programs continues to grow.

Universal social-emotional learning programs like DBT STEPS-A have shown promise as both whole-school and targeted interventions. Additionally, specialized programs such as Project AIR Therapy are designed specifically for youth with emerging personality disorders and can be implemented by school counsellors as Tier 2 (small group) or Tier 3 (individualized) interventions.

The presence of BPTs in teen girls can delay key developmental milestones, such as identity formation and independence. These adolescents may struggle with separating from parents and forming healthy relationships and may find it difficult to function independently in academic and social settings. They are also more prone to maladaptive coping strategies, emotional volatility, and impulsive behaviours.

Although the severity of BPTs typically peaks in adolescence, research shows that these traits are also highly malleable during this period, making adolescence an ideal window for intervention and support.

Chapter 3: Summary, Recommendations and Conclusions

This paper's aim is to uncover and examine the psychosocial effects of borderline personality traits on adolescent girls. Findings indicate every domain - social, academic, and health, is adversely impacted by borderline traits and behaviours, with teen girls being particularly affected. Data suggests there is flexibility and malleability of BPD traits in youth, making it a key developmental period for intervention.

Summary

The literature discussed in Chapter 2 described the complicated nature of BPD by defining the disorder, how it develops, and the effects of BPTs on the psychosocial functioning of adolescent girls. As many authors and researchers in Chapter 2 have found, adolescents with BPTs benefit from early detection and intervention, the merits of which can alter the life-course trajectory of the disorder, reducing long term adverse consequences such as poor psychosocial functioning (Chanen et al., 2020; Chanen & McCutcheon 2013; Kaess et al., 2014; Townsend et al, 2018). More research needs to be done on the effects of BPTs on the daily functioning of adolescent girls, and accessible, effective interventions, especially in schools, must be developed and promoted.

Chapter 3 will further explore ways school counsellors can provide intervention and support to adolescents with borderline personality traits.

Recommendations

The presence of just a few borderline traits can have damaging effects on the psychosocial functioning of teen girls. If left untreated, the progression to diagnosable borderline personality disorder is almost assured. While school counsellors do not diagnose mental health disorders or provide therapy at school, they are trained to provide supportive interventions to

students and psychoeducation to staff (Martinez et al. 2021). For students with BPTs, counsellors can recommend whole school approaches, such as a DBT SEL program, and/or group and individual interventions.

Whole School Approach

Schools are optimally positioned to identify and respond to students struggling with mental health concerns, and there is growing awareness of the need to promote health and well-being of students (Townsend et al., 2018). While a few social emotional learning programs exist for teens, Mazza et al. (2016) note they often fail to address stress management, decision making, or specific emotional coping skills. The DBT Skills in Schools: Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A) curriculum offers a comprehensive approach that teaches practical skills in emotional regulation, impulse control, problem solving, and relationship building. Ideally, Canadian middle and high schools would adopt this as a universal SEL program; however, costs related to manuals and teacher training may pose barriers.

A study conducted by Hastings et al. (2021) on the universal school delivery of a DBT STEPS-A program, included teacher feedback that it took time to become confident with the material, principles, and skills. When delivering the class lessons, teachers felt hindered by scheduling conflicts, interruptions, and student absences. However, they also reported that the skills taught to students were relevant to the challenges teens typically faced. Teachers also reported that learning the DBT skills improved their own emotional regulation and mental health. Similarly, Justo et al (2018), observed that Brazilian teachers who participated in DBT based continuing education reported enhanced mental health and improved social emotional competencies. Teachers who consistently provide emotional support for their students also foster

improved emotional regulation in students and reduced negative behaviours. Given the central role teachers play in student development, their emotional competence is crucial, and learning DBT skills can enhance well-being.

Although DBT STEPS-A benefits both students and teachers, financial constraints may limit its implementation. As an alternative, schools can use resources like Project AIR Schools (2016), which provides guidance for working with adolescents facing complex mental health challenges.

Chanen and McCutcheon (2013) state that early temperamental and behavioural patterns akin to BPD symptoms may indicate risk for the disorder, yet do not invariably lead to its full manifestation. These include ADHD, ODD, conduct disorder, substance use, depression, and self-harm, along with the actual features of BPD. These "precursor signs and symptoms" or early signs of emerging disorder could be directly targeted for intervention. This is what the Project Air Schools (2016) guide was designed to assist with.

School counsellors are ideally positioned to educate school personnel on emerging signs of mental health disorders and can assist in identifying adolescents who may need intervention and targeted support. In staff meetings, care team meetings, IEP meetings, and other venues, school counsellors may disseminate information such as the following:

A) What to look for when a teen is struggling with mental health problems

Middle School

- Difficulty interacting with peers such as shyness or awkwardness
- Being anxious, sad, withdrawn most of the time
- Avoiding new situations or missing school
- Being overly compliant and obedient, or seeming fearful

- Acting aggressive
- Excessive risk taking
- Difficulty anticipating consequences

High School

- Decline in academic performance
- Poor personal hygiene/appearance
- Neglecting responsibilities
- Changes in attendance
- Frequently lethargic or irritable
- Drug or alcohol abuse
- Displaying signs of paranoia, delusions, hallucinations
- Aggression and risk-taking
- Thinking about death, suicide or engaging in self-harm or suicidal (Adapted from Project Air Schools, 2016, p. 21)

For a more comprehensive explanation of personality disorder and early signs consider sharing a fact sheet (See Appendix A).

5) Steps for talking to an adolescent with an emerging personality disorder:

- In a private and safe environment, invite the teen to share
- Using a strength-based approach, identify skills and abilities
- Be supportive and work together
- Emphasize school attendance and the importance of school work
- Support the development of a safe and trusting relationship

An example of this type of conversation could be “I’ve noticed you seem sad and uninterested in school lately. How’re things going?” and “It sounds like things have been tough at home, and I know it can be hard to concentrate at school when this happens. I would like to support you and help you be successful in class. What do you think you can accomplish when it comes to homework?” Finally, in being collaborative and supportive, the teacher might say, “If you become upset or distressed during class, let me know and perhaps you can take a short walk. Does that sound ok?” (Adapted from Project Air Schools, 2016, p. 15).

While it may seem counterintuitive to emphasize completing classwork and school attendance when a teen is emotionally struggling, studies have shown that schools with a high focus on learning were associated with declines in personality disorder traits (Townsend et al., 2018).

C) Highlight the key principles in working with a teen with complex mental health issues, such as being compassionate and listening to and validating their current experience. An example conversation could be, “It sounds like you are really struggling right now...” and “I can understand you’d feel upset about that because...”. In addition, staff should be non-judgmental and remain calm, respectful and caring. Lastly, be clear, consistent, reliable and convey encouragement and hope. For example, “Thank-you for telling me about this, we can figure it out together” or “I’ll do my best to help you or connect you with the right supports”. (See Appendix B for a fact sheet on these key principles).

D) How to respond to challenging behaviour:

- Establish safety of the teen, their peers, and staff
- Approach with a desire to understand and be curious about what is going on for that person

- Validate their experience “I can see why you’d be upset about that”
- Focus on relationship “How would you like me to help?”
- Consult with peers and appropriate staff regularly

(Adapted from Project Air Schools, 2016, p.30-31)

E) How schools can provide a safe and supportive environment:

- Normalize asking for help
- Foster open communication about mental health
- Be empathetic and non-judgmental
- Create a “culture of caring”
- Emphasize staff support and consultation
- Encourage autonomy of students
- Be firm but kind
- Be inclusive and accepting of cultures, gender identities, religions etc.

(Adapted from Project Air Schools, 2016, p. 36)

Schools are optimally situated to respond to student mental health concerns. Early recognition by teachers and education staff of emerging mental health issues can facilitate stronger links to school counsellors. Education staff may need additional education, knowledge, and skills to promote the mental health of students, and using an SEL curriculum such as DBT STEPS-A can support this, with teachers as well as students receiving the benefits of learning and using the skills taught. Additionally, school counsellors may wish to educate staff on complex mental health issues, using information gleaned from the Project Air Schools (2016) guide.

Small Group Intervention

Hastings et al. (2021) note a growing number of initiatives encouraging schools to prioritize student emotional and mental health through whole-school approaches. However, they also highlight several limitations of universal programs, including implementation challenges, difficulty in measuring outcomes, and insufficient intensity or duration for at-risk students. As a result, they propose that targeted interventions may be more effective.

Given the strengths of both the DBT STEPS-A (2016) program and AIR Therapy for Young People (2024), combining elements from each may offer the most comprehensive approach to addressing the specific challenges faced by adolescent girls with borderline personality traits, particularly in the areas of relationships, identity, behavior, and emotional regulation.

A proposed integrated program titled *RISE,* is outlined in Appendix C. RISE is an acronym for relationships, identity, self-behaviour, and emotions. It is designed to teach skills, emphasize strengths, and bolster hope. RISE includes 10 sessions, with each lesson focusing on different aspects of psychosocial functioning where girls may have difficulties. Lesson 1 is designed as an introduction and is focused on building rapport and establishing goals and boundaries. Lessons 2 and 3 focus on distress tolerance and crisis survival skills. Lessons 4 and 5 include developing an awareness of emotions and learning strategies to cope with uncomfortable emotions. Lessons 6 and 7 address identity and goal setting, and lessons 8 and 9 focus on healthy relationships and effective communication skills. In Lesson 10 all skills are reviewed and completion of the group is celebrated.

Girls experiencing complex mental health challenges are often misidentified as simply exhibiting behavioural problems, leading to responses focused on discipline and behaviour

management. However, given the nature of personality disorders and borderline personality traits (BPTs), such strategies can inadvertently escalate the situation (Townsend et al., 2018). In these cases, the school counsellor plays a crucial role in guiding educators and caregivers to consider the underlying function of the behaviour and what the student may be attempting to communicate. As Grenyer et al. (2024) explain, these behaviours often reflect a need for connection, attachment, or a desire for emotional pain to be acknowledged, heard, and validated.

Effective intervention involves a structured approach where teens are encouraged to take responsibility for their actions. In addition, clinicians should play an active, responsive, and validating role, helping teens connect their feelings with the situations and behaviours they experience (Grenyer et al, 2024). The RISE curriculum does this and incorporates elements from DBT STEPS-A and AIR Therapy (both evidence-based interventions), to provide a holistic approach to group intervention for girls struggling with BPTs in schools.

Steps for further consideration would be to implement a DBT SEL curriculum in elementary schools, so specific emotional problem-solving skills can be taught before problems begin, and the skills can then be reinforced and expanded upon in middle and high school. In addition, schools may want to host parenting information sessions, where strategies for parenting teens with concerning behaviours can be discussed and regulation and attachment techniques can be explored.

Limitations to this Capstone

Further research is needed to understand better the unique psychosocial experiences of adolescent girls exhibiting BPTs. Studies on the evolution of BPTs from adolescence to adulthood, and an examination of factors such as attachment style, parenting, and family dynamics that predict persistence versus remission would be valuable. Clarifying risk and

resilience patterns of adolescent girls would also contribute to a better understanding of how girls develop mental health disorders. Another idea for future research is to explore how social media and peer influence shape and affect identity development of teen girls exhibiting BPTs.

Gaps in research include the limited exploration of how subclinical borderline traits impact daily psychosocial functioning in girls. Few studies examine the broader consequences of BPTs, especially those affecting education, peer dynamics, and identity formation. In addition, there is a lack of knowledge about how BPTs develop over time, and which traits are transient versus predictive of long-term dysfunction. Lastly, there are very few studies examining how girls with BPTs function in school settings, and few resources developed to be used in school settings to address borderline traits

Conclusion

Borderline personality traits (BPTs) significantly disrupt the psychosocial development of adolescent girls, impacting their emotional well-being, identity formation, interpersonal relationships, academic performance, and overall functioning. These traits often emerge during a critical developmental period, compounding the challenges adolescents already face. The interplay between emotional dysregulation, insecure attachments, and environmental stressors creates a cycle that can lead to long-term impairments if left unaddressed. Early identification and targeted, developmentally appropriate interventions, particularly those delivered in accessible settings such as schools, are essential in mitigating the effects of BPTs. A comprehensive, trauma-informed approach that fosters emotional regulation, strengthens relationships, and builds resilience offers the greatest promise for improving psychosocial outcomes in this vulnerable population. Continued research and innovation are needed to refine

effective strategies and ensure adolescent girls receive the support they need during this pivotal stage of development.

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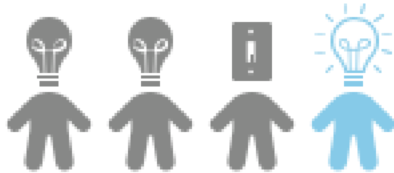
Appendices

Appendix A: Personality Disorder in Young People Fact Sheet



SCHOOLS, TEACHERS & STUDENTS

Personality disorder in young people – the facts

Everyone has a personality. However, this may become a personality disorder when personality traits become pervasive, inflexible, and deviate markedly from cultural norms, causing significant impairment or distress for the individual.

Common experiences of young people with emerging personality disorder

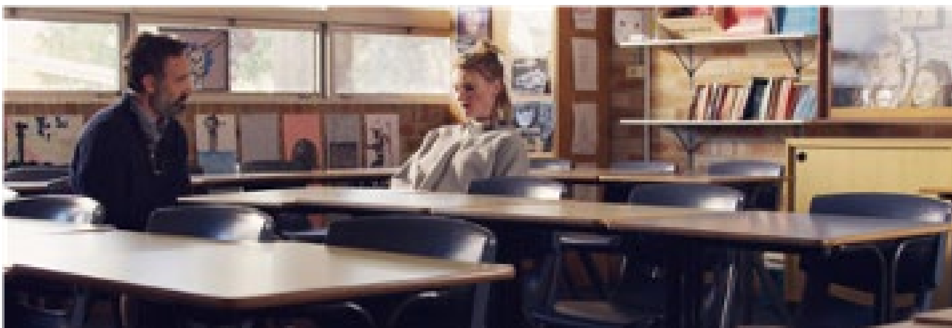
For a young person with emerging difficulties the ordinary challenges of adolescence and young adulthood are heightened. Emotions are felt more intensely and interpersonal relationships can be particularly challenging. It is common for young people experiencing emerging difficulties to feel misunderstood, face stigma, and confusion as to what is going on for them. If a young person is experiencing emerging symptoms, they may not understand what is happening or why their journey towards adulthood is more difficult than that of their peers. It is important to recognise that young people may be experiencing these unique challenges and to maintain a caring position that is centred on compassion and understanding.

Young people with emerging difficulties often resort to unhelpful behaviours to manage their emotions such as self-harm, drug and alcohol use, binge eating, social withdrawal, aggressive behaviour, and risky sexual behaviour. While these behaviours result in short-term relief by numbing overwhelming emotion, over the long-term they lead to increased distress and poorer functioning.

Problems with emerging difficulties may also be confused with conduct disorder in young people. A key difference between these disorders is that people with conduct disorder violate societal norms and the rights of others through aggression, destruction, and deceitfulness. On the other hand, people with personality disorders often do not realise the consequences of their behaviour. The message that they are trying to send through their behaviour is often misinterpreted as manipulative, attentionseeking or simply “bad” behaviour. In reality, what the young person is often communicating is a need for attachment and for their pain to be heard.

Early warning signs of emerging personality disorder

- Unstable self-image
- Frequent mood swings
- Self-harming behaviour
- Difficulty regulating emotions
- Preoccupation with real or imagined abandonment
- Excessive self-criticism
- Disturbances in attention
- Impulsivity or risk-taking
- Abuse of drugs or alcohol
- Thinking about death or suicide
- Social isolation and difficulty making friends
- Aggressive behaviour or high irritability



What causes personality disorder?

The disorder emerges from a complex interaction of risk factors including: genetic and hereditability factors, adverse childhood experiences, peer victimisation, and attachment disorganisation. A diagnosis is possible in young people. However, if diagnostic criteria are not met but the young person is experiencing serious difficulties the diagnosis may be termed ‘emerging personality disorder’.

More research is needed to fully understand the causes of personality disorder.

Support for students, teachers and parents

Teachers, parents and health professionals should work collaboratively to support students affected by emerging personality disorder.

- Respond with compassion

- Talk honestly with students and encourage them to seek help from a health professional and school counsellors
- The student should be aware of and contribute to all decision-making
- Effective communication among staff, student, and carer is vital
- Ensure plans for students are in place for when they are stressed or when they are getting unwell
- Build on students' strengths and keep good things that are helping the student
- Reflect on difficulties experienced in the school environment and make changes to keep routines simple and stress levels low
- Encourage positive coping strategies and use the support available at school
- Address negative attitudes in others and maintain a supportive approach
- Prioritise school attendance and make adjustments to prevent the student becoming overwhelmed
- Work to keep the young person engaged with their peers

Provide a calm, non-reactive environment as much as possible. When emotions flare up, do not fuel them but listen and respond in as calm a way as possible. The person may invite you to join them in reacting to their emotional feelings, however it can be helpful to model being calm. Try to be compassionate as this mental illness causes significant suffering. Try to provide a good enough relationship so that the person feels a connection with you that provides hope. Recognise the importance of social integration with peers and the community as much as possible and promote safety when feelings become overwhelming.

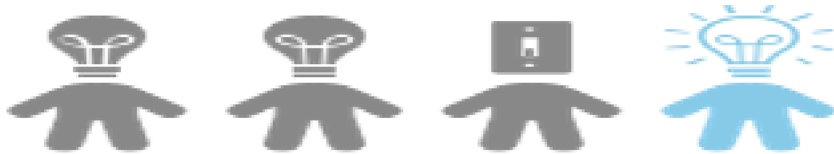
Can it be treated?

Yes, specific psychological treatments provided by mental health professionals have been shown to be effective in reducing symptoms and improve life functioning.

Credits: This factsheet complements a filmed resource 'Chloe's Story: Helping Schools Help with Mental Health'. The film was developed as a training tool as part of a broader initiative aimed at assisting school staff in identifying, supporting and managing young people with severe and complex mental health concerns. As part of this initiative, a guide has been developed which aims to help schools work effectively with young people that have complex mental health issues. It provides guidance to understand and respond to emerging personality disorder, trauma history, self-harm and suicidal behaviour, and other difficulties with identity, emotions and relationships. We would like to acknowledge and thank the consumers, families, and caregivers who have shared their lived experiences which have informed the development of this film. Film by the Project Air Strategy for Personality Disorders. Original film script developed by Brin Grenyer and film directed by Nick Pollack from Louder Than Words films. This project is supported by the NSW Ministry of Health in partnership with the NSW Department of Education.

Appendix B: Key Principles for Working with Young People with Complex Mental Health Issues

SCHOOLS, TEACHERS & STUDENTS



Key principles for working with young people with complex mental health issues

- Be compassionate
- Listen and validate the young person's current experience
- Take the young person's experience seriously
- Maintain a non-judgemental approach
- Remain calm, respectful and caring
- Engage in open communication
- Be clear, consistent and reliable
- Convey encouragement and hope
- Monitor your own internal reactions
- Do not misattribute extreme distress or impairment as "normal" adolescent difficulties
- Create a welcoming and understanding environment that encourages open discussion about mental health among young people and adults
- Work collaboratively with the young person, parents, guardians, schools and health professionals
- Be aware and supportive of diversity in identity and background, including the indigenous, culturally and linguistically diverse (CALD), and the LGBTQIA (lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual) community
- Prioritise the education of the young person, including school attendance and completion of school work
- Support and make reasonable adjustments to assist a young person's return to school after a mental health emergency
- Reinforce the young person's strengths and resilience while implementing trauma-informed care where appropriate

Appendix C: RISE Curriculum

RISE Curriculum

RISE is an acronym for relationships, identity, self-behaviour, and emotions. It is designed to teach skills, emphasize strengths, and bolster hope. RISE is still being refined; however, a framework for the lessons is provided here.

Lesson 1 – Introduction

Note: when screening girls for addition to the group, it will be important to choose individuals who are not significantly struggling, as these teens should be supported by mental health clinicians and would benefit more from one-on-one intervention.

As this is the first meeting, the goals of the group will be discussed and guidelines for behaviour addressed. It is important to emphasize being non-judgmental, supportive, kind, and confidential (i.e. "What is said here stays here"). The counsellor could have these on the board or typed up and participants add their name as a sign of agreement. Move onto reading "continuum of problems" (DBT STEPS-A p. 367). In this worksheet, students mark where on a continuum they fall in difficulty with emotions, confusion/distraction, impulsiveness, relationships. After they have had a chance to do this, the counsellor may facilitate a discussion on what this looks like for each of the girls and ask for examples of problematic behaviour.

As the girls in the group will have mental health struggles, an important step in this first module is to ensure they know who they can turn to for help. Initiate a brief discussion on who they consult when struggling and have them complete the "Circle of Closeness" page (Air Therapy Adolescent Workbook" p. 8.), and the "My support people" chart on pg. 10.

This lesson is focused on building rapport, establishing goals and group expectations. It is also the beginning of helping the girls build agency regarding their mental health and reinforcing support systems.

Lessons 2&3 – Managing Distress

Review confidentiality and what was covered in the last class. Initiate a discussion on how the girls cope with difficult thoughts and feelings, and how helpful or positive their strategies are. Discuss distress, how it feels, where it's felt in the body, and the thoughts that accompany it. Coping with painful feelings and urges is important so we don't act out impulsively. This is why we learn distress tolerance skills. Suggest strategies such as distraction (listen to music, draw a picture, sensory activities), seeking support (if possible, leave the situation and take a "time out," talk to someone they trust), and breathing exercises in the moment (e.g. take a deep breath in, hold, then take a long exhale, activating the parasympathetic nervous system). Discuss distress tolerance skill sheets pgs. 385-386 in the DBT STEPS-A curriculum. If needed, the counsellor may want to distinguish between crisis survival skills and reality acceptance skills.

Crisis survival skills help us carry on and stay functional, avoid making things worse, and stop impulsive behaviour (Mazza et al., 2016). They are to be used when emotion is high and problem solving is difficult (see pg. 398 in DBT STEPS-A for a student worksheet). Reality acceptance involves completely and totally accepting the facts of reality regardless of the painful emotions that may arise. Accepting painful feelings means turning suffering you can't cope with into pain you can cope with (suffering = pain + nonacceptance) (Mazza et al., 2016). See pages 402-405 for information and worksheets in the DBT STEPS-A curriculum.

Coping with distressful feelings and thoughts is hard and it's important we look after ourselves. Discuss with the girls ways in which they can practice self-care (e.g., get enough sleep, eat properly, spend time with friends). Make a list of things they can do to relax.

To conclude, encourage reflection on how the girls experience distress and how they can manage these feelings. Have them keep a "diary" of daily self-care activities.

Lessons 4&5– Emotions

Review previous weeks and go over self-care diaries. Allow time for follow-up and reflection. Did they use any of the skills they learned last time? Move onto discussing emotions and what they are (information to help us understand ourselves and the world around us). You may want to discuss different emotions or show pictures of different emotional faces and have the girls name them. For further information, distribute pg. 418 in DBT STEPS-A, "What Good are Emotions?". Sometimes we develop beliefs about emotions that aren't necessarily true, like thinking an emotion is "good" or "bad." Complete "Myths about Emotions" pg. 419-420 in DBT STEPS-A.

Discuss how sometimes during distressing or crisis situations we may feel like we are in an emotional storm, like a boat being tossed around by waves and wind. In these situations, we need to learn how to "drop anchor" when we get overwhelmed by emotions and thoughts. Discuss "Steps to 'drop anchor'..." p. 47 in AIR Therapy Adolescent Workbook.

Emotions are linked to our thoughts and behaviours, and may urge us to act in certain ways, however our thoughts and interpretations of events may not always be supported by facts. Refer to pg. 433-434 "Check the Facts" and "Examples of Emotions That Fit the Facts" in DBT STEPS-A.

When feeling strong emotions, we may try to escape the pain in harmful ways. When this happens, we can try to act opposite to the action urge. Ask the girls what examples of this could be e.g. "My friend made me mad and I wanted to yell, but instead I walked away." For more examples and worksheets refer to pgs. 435-439 in DBT STEPS-A.

By practicing skills to manage emotions, we improve many aspects of life. We can break down managing emotions into three steps: identifying and naming emotions, understanding the experience, and communicating our emotions. Reflecting on our emotional experiences helps us understand the reasons we feel certain ways. Review how to do this on pg. 49 of the AIR Therapy Adolescent Workbook, and assign pg. 50 to either complete in class or as homework.

The central focus of these lessons is to increase awareness of emotional experiences and to develop and practice effective strategies for managing them.

Lessons 6&7 – Identity

Who are you as a person? Some teens struggle with knowing who they are, and their identity is developing in this phase of life. Discuss influences on identity: family, culture, friends, media etc. Identity is both who we are and how we relate to others. Sexuality, gender identity, likes and dislikes, and our motivations all contribute to a sense of identity (Grenyer et al., 2024).

When we are distressed, it's hard to think of our strengths. Ask the girls what their strengths are and make a list. Remind them to challenge negative thoughts about this and judgements they have about themselves. Would they judge their friends as harshly?

Part of understanding identity is discovering our beliefs and values. Our beliefs can guide our decision making and behaviours. Values are ideas about what we consider to be meaningful and they help us navigate through life being the person we want to be (Grenyer et al., 2024).

Everyone has a different set of values. Refer to pg. 63 “Beliefs and Values” in the Air Therapy Adolescent Workbook and have girls complete pg. 64, “My Values”. Alternatively, the counsellor can have them fold a plain piece of paper into 16 squares and write one thing in each square (three favourite activities, five important people in their lives, three goals they have for the future, three favourite possessions, two things they would like to own someday). From this a discussion can take place about values and how they differ from person to person. When you have a clear understanding of what you value, it’s easier to be true to yourself.

This can lead to a discussion about goals and what goals we set for ourselves. Setting goals takes self-reflection and positive self-talk - we must believe we can achieve them (as long as they are realistic). We can set goals for doing more of what we’re good at (strengths) and getting better at things you want to improve (values). Encourage the girls to set personal goals, and provide support as needed.

These lessons are about the concept of identity. Exploring strengths, beliefs, and values helps teens think of and create a meaningful life. Goal setting is also important for personal growth.

Lessons 8&9- Relationships

Begin these lessons with a review of what has been learned to date and review the goals the girls set for themselves. Move into a discussion on relationships and how we have different relationships in our lives. Ask the girls to think about who they have relationships with and gather their ideas. Sometimes relationships are difficult, but they are important to work on and important for our wellbeing. Having healthy relationships is key. What do healthy relationships look like? There are a few principles to consider:

1) Respect – treat each other with kindness even when you disagree

2) Trust- believe each other and don't feel the need to constantly check-in

3) Communication – talk openly and honestly about how you feel

4) Boundaries – you can say “no” without guilt and your limits are respected

5) Support – you cheer each other on and show up when things are hard

6) Equality – both people make decisions and no one’s voice is more important

7) Solving Conflicts – you can disagree without yelling, blaming, or holding grudges

8) Quality Time – you show you care through words, hugs, texts, just being there

9) Shared Values – you agree on what matters

10) Safety – emotional (you feel safe being yourself without fear of judgment or criticism) and physical

Discuss which two qualities are most important to you in a relationship and why. Which ones are the hardest, and what can you do if a relationship you’re in is missing some of these qualities? Healthy relationships help you feel good about yourself, support your growth, and let you be you. Refer to pg. 470 in DBT STEPS-A “Building and Maintaining Positive Relationships”.

Conflicts in relationships such as ongoing arguments and disagreements can have a negative impact on connection and trust. Common sources of tension include external pressures or expectations from others, being asked to act in ways that don’t align with your true feelings, differing opinions, misunderstandings, or navigating major life changes. Ask the girls if they’ve experienced any of these situations or invite them to share additional examples.

What can help when conflict arises? Take some time out to process your emotions, acknowledge your feelings and why you feel this way, get some support, talk to the person you had the argument with. Refer to pg. 82 in the Air Therapy Adolescent Workbook “Tips for

Talking Through an Argument". Ideas include discussing the topic when you're feeling calmer, be honest, avoid sarcasm, listen to the other person and try to understand their point of view, work towards a solution you are both happy with, apologize if you need to. Discuss the basic formula for communicating in a difficult situation: I feel ____ when ____, because___ I need/want ____. Practice this statement with each teen and use the scenarios on pgs. 86-88 in the AIR Therapy Adolescent Workbook.

To keep good relationships and communicate effectively, try the DBT skill of GIVE: be gentle (consider tone of voice), be interested (eye contact and gestures), validate (e.g., "I hear what you're saying..."), use an easy manner (smile, use gentle body language). For more examples and practice, refer to pgs. 470-471 in DBT SKILLS-A.

These final lessons are focused on healthy relationships and effective communication skills. Ideas for managing conflicts, arguments, and relationships are also covered.

Lesson 10 – Wrap Up

In the final session, review all the skills the girls have learned and celebrate their accomplishments in completing the group. You may want to include an anonymous survey on what they have learned, to assess effectiveness. Providing snacks and a fun activity such as a craft or game would be a good idea too.