Borderline personality disorder is not a variant of normal adolescent development.

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It now seems extraordinary to recall the time when clinicians believed that young people could not become depressed. Yet, it was only in the 1980s that the contemporary concept of depression entered mainstream child and adolescent psychiatry. Three decades later and this special issue of the Journal asks a variant of this question about borderline personality disorder. Perhaps this might help lay to rest the question of whether borderline personality disorder represents a variant of normal adolescent development? It does say something about the crisis of legitimacy for BPD in mainstream psychiatry that we are still asking if BPD is non-normative in young people, when a wealth of evidence now suggests that BPD can take its rightful place as a severe mental disorder across the life course ¹.

This series of papers systematically asks whether young people with BPD differ from their healthy peers on a range of parameters. It should not be surprising to learn that the answer is an emphatic yes. These data add to what is now a coherent literature demonstrating that young people with BPD differ from their healthy peers, not only on the parameters presented in this special issue, but on many others, such as substance use ².

Zanarini and colleagues (this issue) note that psychiatrically healthy adolescents are not devoid of BPD features. They conceive of these features as “manifestations of adolescent angst”. However, the normative adolescent development literature has tended to move away from such ideas. It might be that these are “subthreshold” features, which point to the dimensional nature of the BPD construct. This does raise the issue of whether the arbitrary categorical threshold set by DSM-5 (5 of 9 criteria) is the appropriate cut point for treatment initiation, which brings us to the paper by Stepp and colleagues (this issue). This begins to address this question in new analyses from the informative high-risk community sample in the Pittsburgh Girls Study. This study identifies

dimensions of childhood temperament and psychopathology symptom severity that predict “conversion” to a positive screen for BPD over a 14-year follow-up. This study highlights the need for a broad-based, integrated model of disorder “onset”, rather than one for each diagnostic ‘silo’. A key premise of Stepp and Lazarus’ study seems to be that childhood temperament and psychopathology are qualitatively different to BPD. Yet, existing research highlights substantial overlap in the content covered across the domains of temperament, normal-range child personality, and child personality pathology³. This suggests that the same phenomena (in this case, emotion dysregulation and impulsivity) might be being measured but given different labels during different developmental periods. Nonetheless, this study supports and extends work on continuities and discontinuities of psychopathology and adds to an important literature identifying pathways toward BPD.

Goodman and colleagues (this issue) point to the alarmingly high lifetime rates of self-mutilation and suicide attempts in both adolescents and adults with BPD. What is striking in this paper is the observation that extreme levels of lifetime self-mutilation were even higher among the adolescent group, compared with the adult group. In part, this might reflect the natural history of self-harm in young people or secular trends that reflect the different eras in which these cohorts were collected. However, it does accord with recent data in 107 outpatient youth (15-25 years old) with BPD reporting a 76% 12-month prevalence for self-mutilation and a 66% 12-month prevalence for suicide attempts⁴. This does give one pause for thought regarding where such young patients with extreme levels of self-mutilation might end up later in life? If the comparison between the cohorts is assumed to be valid, clearly, they don’t end up in inpatient services for BPD and this points to the need for long-term follow-up studies of clinical cohorts of young people with BPD.

The interpersonal and vocational dysfunction among adolescents with BPD, identified by Kramer and colleagues (this issue), points to an aspect of BPD that is repeatedly under-emphasised but arguably which has the most profound consequences for young people with BPD. This study also points to the need for further research regarding peer relationships and strengths among young people with BPD, with important clinical implications for prevention. Wall and colleagues (this issue) remind us that a key feature of treatment programs for young people with BPD is the high level of family involvement. Although preliminary, the findings from this study suggest a high level of diagnostic concordance between young people and their parents and an important role for interview-based measures of BPD. In common with Stepp and Lazarus (this issue), this study reminds us of the importance of the multiple informant sources.

What is more difficult to interpret from this series of papers is how the McLean/Mount Sinai sample of young people compares with adults with BPD. This is particularly evident in the paper led by Temes (this issue) on adverse childhood experiences, along with Borkum and colleagues' (this issue) novel focus on protective factors. The latter paper makes the point that the two adolescent groups had more similarities than differences, yet both differed from the adult BPD group. The use of a non-contemporaneous sample of adults with BPD makes comparisons challenging. It is salient to remember that the data were collected from the adult sample before the adolescent sample were even born, in an era before the Internet, social media, the global financial crisis and many other social and political changes. The transition to adulthood has changed dramatically over the latter half of the 20th and the early 21st centuries ⁵ and it seems unlikely that we are comparing like with like. It might be that secular trends have led to increases in certain forms of abuse (physical, emotional, and sexual), such that now they are represented equally among

BPD and healthy adolescents. Moreover, there are likely to have been significant changes in the healthcare systems from which the patient groups were recruited and our knowledge of the longitudinal course of BPD suggests that there might be significant selection biases among people who enter services as adults. The limited data on mortality among people with BPD suggests that some might not make it to adult services. Moreover, selection biases in treatment services often systematically lock out the most severe and needy from care.

BPD is neither a variant of normal adolescent development, nor a “passing phase” of trivial consequence. It is to be hoped that the papers in this special issue of the Journal will help to put this issue to rest. This will allow the field to focus on the unique aspects of BPD and those shared with other disorders, and most importantly, what we might do to help change the lives of young people with borderline personality pathology. Finally, a challenge for the field is to move away from a narrow focus on *adolescent* BPD, in recognition of studies from sociology, developmental psychology, and developmental neuroscience⁵⁻⁸ that all point to an extended but coherent period of development from puberty through to around mid-20s in economically developed societies. Recently, we have recommended that, for personality disorder research and treatment, more natural developmental periods would be childhood, youth (adolescents and emerging adulthood), adulthood, and old age⁹.

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