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Personality Disorder in Childhood and Adolescence comes of Age: a Review of the Current Evidence and Prospects for Future Research

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Abstract

In this article, the authors provide a narrative review of the mounting evidence base on personality disorder in childhood and adolescence. Topics covered include diagnostic validity, prevalence, developmental issues, comorbidity, risk and protective factors, and treatment. Novel indicated prevention and early intervention programs for borderline personality disorder in adolescence are given special priority. To conclude, directions for future research are provided.

Keywords: personality disorder; adolescence; diagnosis; early intervention; developmental psychopathology; psychotherapy; prevention

Introduction

Until recently, personality disorder (PD) was considered separately from other mental state disorders as a special and intractable form of adult mental disorder with a primarily environmental aetiology and a treatment refractory course (1,2). To paraphrase the Danish philosopher Søren Kierkegaard (3), it was as if PD was a sickness unto death. Fortunately, such beliefs—together with the associated therapeutic nihilism—have now been dispelled by empirical research. In adult mental health, PD is now widely recognized as a major mental disorder that is associated with severe psychosocial dysfunction and poor quality of life. Moreover, PD has come to be considered treatable and, in some cases, even to remit (4,5). This heightened recognition of PD is also reflected in the international proliferation of official treatment guidelines (6-9).

For decades, there has been general agreement, as reflected in the official diagnostic manuals, that PD has its onset at least by adolescence or early adulthood (10,11). By implication, this developmental perspective on PD opens up the possibility of identifying PD among children and young people. Historically, however, PD during childhood and adolescence has been a neglected area of empirical research and surrounded by controversy (12-17). Fortunately, research on PD in childhood and adolescence has flourished over the past two decades and shed light on many of the persistent clinical controversies and myths that surround these syndromes.

Despite the remarkable scientific progress of the past two decades, skepticism, unease, and misunderstanding with regard to PD diagnoses in adolescence seem to continue among some clinicians (18-21). Hence, a major goal of this special issue of the Scandinavian Journal of Child and Adolescent Psychiatry and Psychology is to increase researchers' and clinicians' awareness of the validity and importance of PD during adolescence so that it might be more readily identified and treated. We hope that this article, which reviews the current evidence base and offer suggestions for

future research, will help to ease some of these concerns by highlighting key research findings.

Synopsis Research Findings

Diagnosing personality disorder in children and adolescents

A source of controversy and misunderstanding has been whether PD diagnoses *can* be made or are *permitted* for children and adolescents. A common misperception among mental health professionals is that the official diagnostic systems—the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) (10) and the *ICD-10 Classification of Mental and Behavioural Disorders* (11)—do not permit PD diagnoses for individuals who are younger than 18 years (21). One possible reason for this misunderstanding is the ambivalent and contradictory phrasing employed in the DSM-5 (Section II) and the ICD-10 with regard to the diagnosis of PD in this age group. Despite the conceptualization of PD as a developmental disorder that usually has its onset by adolescence or early adulthood, the DSM-5 notes that PD diagnosis for individuals who are less than 18 years old should only be considered in "relatively unusual" circumstances (10) and ICD-10 considers the applicability of PD diagnoses in adolescence to be "highly unlikely" (11). The only exception to the allowance of diagnosing PD below age 18, is for antisocial PD, in the DSM-5, Section II, which explicitly requires individuals to be 18 years or older. Hence, despite allowing for PD diagnoses among individuals who are less than 18 years old, the use of such wording by the official diagnostic systems effectively discourages the use of this diagnosis. The DSM-5 confuses matters further by stating that the features of a PD only need to be present for one year when applying PD diagnoses to individuals who are less than 18 years old. This seems too short a period to accurately distinguish a mental state disorder from a PD (22). The division of the diagnostic manuals into separate sections on child and adolescent disorders versus adult disorders further contributes to the confusion. PD is not mentioned in the former but appears in the latter, with little account of its developmental origins and manifestations. The ICD-10 labeling of PDs as "Disorders of adult personality" is a case in point. As we demonstrate later in this review, such ideas enshrined in the current diagnostic manuals can no longer be supported. Section III of the DSM-5 and the forthcoming ICD-11 both reflect the progress made in understanding the reliability and validity of PD diagnoses (22) in childhood and adolescence, supporting the feasibility of their use and recognizing that they are as reliable and valid in young people as they are for adults (23-33).

Prevalence

Few studies have investigated the prevalence of PD in adolescence, and virtually none have looked at its prevalence in childhood. Extant studies have also used different sampling and assessment procedures. Accordingly, the prevalence data reviewed in this paragraph are at best tentative. The prevalence of PD in adolescent community samples and primary care settings generally ranges from 6% to 17% across studies (34). An exception to these estimates was a study by Lewinsohn and colleagues (35), which found a low prevalence of PD in the community (1.7% among participants without and 3.8% among participants with a history of other mental disorders). The relatively low prevalence estimates in this study are probably a result of the researchers using the International Personality Disorder Examination (IPDE) (36) for assessments, which required PD features to be present for 5 years, even in young people.

Prevalence estimates in clinical samples range from 41% to 64% (27,37), and from 36% to 88% in juvenile justice samples (38-40). These prevalence estimates are similar to or slightly higher than those reported for adults (41-43). The peak prevalence for PD is reported to occur during early and middle adolescence (23,44), whereas studies that have focused on late adolescence have obtained lower prevalence estimates comparable to those reported for adults (34,45). Consistent with these findings a community-based longitudinal study of PD trait levels found that PD peaks in early adolescence and subsequently declines in a linear fashion until the late 20s (46).

Additionally, studies have shown that, as in adult populations, the co-occurrence among specific PDs is frequent in adolescence (37,39,47,48). In terms of the DSM-5, Section II, grouping of PDs into three clusters on the basis of descriptive similarities, Cluster B PDs appear to be the most prevalent during adolescence (27,46), a finding that again converges with data for adult populations (49).

Continuity and change in personality disorder

Concerns about the temporal course of personality development are one possible source for the reticence of some clinicians to make PD diagnoses in adolescence. However, contemporary research has shown that personality development is a lifelong process, with no sudden changes occurring at age 18, and that personality stability and change coexist across the life course (22). From a research perspective, there are multiple ways to concept-

ualize the temporal course, continuity, and change of personality and its disorders throughout the life span (50-52). Here, we focus on the three most common methods used to do this: 1) rank-order continuity, 2) mean-level change, and 3) diagnostic stability.

Rank-order continuity or *differential continuity* refers to the consistency of the relative order of individuals on a given PD dimension or symptom over time, typically expressed as a test-retest correlation. The rank-order stability of PD symptoms in adolescence and early adulthood has typically ranged from .42 to .65 in longitudinal studies, thus indicating moderate to high stability (53,54). A longitudinal study that focused specifically on borderline PD features in childhood (in fourth through sixth graders) also reported moderate stability (55). A recent meta-analysis broadened these findings by showing that the rank-order stability of maladaptive personality traits and PD symptoms is moderately stable across childhood, increases in stability during early adolescence, and peaks in stability at around the age of 30 years (56).

Mean-level change addresses the increase or decrease in the average trait level of the population as a whole. Studies of mean-level change indicate that mean levels of PD symptoms peaks during early adolescence and then decline throughout middle adolescence, reaching levels comparable with those of adults in late adolescence or early adulthood (34,46,54). Prospective studies also show that the deviation of maladaptive personality traits increases from late adolescence to early adulthood (53,57,58). This could indicate that the significance of PD symptoms changes over time in relation to salient life tasks and environmental demands (53,58-60). Data from large community samples suggest that specifically for borderline PD, mean levels of severity scores remain relatively stable for the ages of 14 through 17 (61,62).

Diagnostic stability concerns the continuity of categorical PD diagnoses over time. Studies estimating the diagnostic stability of specific PDs in childhood and adolescence have generally reported low to moderate stability over time (23,24,34, 61,63,64); this could be conservatively interpreted as indicating modest diagnostic stability during adolescence (65).

How can we reconcile these research findings? To be sure, the issues surrounding the continuity and stability of PD are complex and unlikely to be easily resolved, for a number of reasons (66). First, we contextualize the results. Although diagnostic stability is low to moderate in adolescent populations, this is also the case in adulthood. A major finding from prospective follow-up studies of adult patients diagnosed with PDs is that diagnostic continuity is low to moderate, and that some patients even "remit" (22,51,67,68). However, diagnostic remission does not necessarily imply functional recovery (69). Indeed, most adult patients with PD who have been followed up for years remain significantly functionally impaired (5,67,70-73). Persons displaying PD symptoms below the threshold for a categorical diagnosis are considered to have remitted diagnostically, but they might continue to have clinically significant levels of subthreshold personality pathology. Accordingly studies show that individuals diagnosed with PD in adolescence often still have elevated PD traits in adulthood (46,74). Also, individuals with persistent impairments might change from one diagnostic category to another over time (74), perhaps indicating "heterotypic continuity" – that the underlying developmental and pathological processes remains the same despite changes in phenotypic presentation (16,75-77). Overall, the bulk of current research converges on demonstrating that persons diagnosed with PD in adolescence continue to have serious functional impairments well into adulthood (23,53,78,79).

Second, the framework of developmental psychopathology (80,81) implies the findings can be interpreted in light of results from normal personality development. Research has convincingly demonstrated that normal and abnormal personality are part of the same spectrum, and display a similar higher-order factor structure across age groups (22,82-87). However, Western folk psychology generally views children and adolescents as having personalities that are unstable or "under construction" whereas adult personalities are perceived as relatively unchanging (51,88). Research into normal personality development has challenged these assumptions by demonstrating that normal personality traits in childhood and adolescence, despite fluctuations within certain lower-order domains, are more stable than would commonly be expected, and also more stable than PD symptoms (87,89-92). Furthermore, contrary to common expectations, research reveals that normal personality undergoes normative changes throughout the entire lifespan (93). Hence, some degree of development and change in personality is to be expected throughout the life course, as a result of the complex interactions between heritable dispositions and the environment (94-99).

Third, it should be recognized that most longitudinal data on PD from childhood through adulthood stem from only one large prospective follow-up study, the Children in the Community (CIC) Study (53), and needs to be replicated (98). However, the findings of the CIC are consistent with cross-sectional prevalence studies of PDs

during early adolescence; results from studies of normal personality reporting age-related decreases in negative traits (51,100,101); and with findings from large-scale epidemiological studies which indicate that the onset for many common mental health disorders peaks during adolescence (102-104). Given the continuity between PD criteria and normal personality traits, the research findings also beg the question of whether developmental changes in PD symptoms are part and parcel of the same process as the one that drives normal personality changes. Finally, it should be noted that other methodological issues relevant to understanding the PD continuity and change across the lifespan include the use of different assessment instruments and measurement error (56,98,105-109).

To summarize, the current evidence shows a predictable pattern of stability and change in PD across the life course. PD seems to change from childhood through adulthood in similar ways to normal-range personality (22). In adolescence, as in adulthood, the rank order stability of PD is moderate to high, whereas diagnostic stability is low. The stability of functional impairments associated with PD is high across the lifespan. There is no sudden increase in trait stability in the transition from the second to third decade of life.

Co-occurrence

Research on PD in adults has consistently demonstrated that these conditions frequently co-occur concurrently and prospectively with a wide range of other mental state disorders (110-112). This co-occurrence accounts for increases in impairment and treatment needs, higher rates of treatment seeking, poorer prognosis, and greater chronicity (113-117).

Studies examining patterns of co-occurence in adolescent samples reveal that PD co-occur frequently with other mental disorders, such as affective and disruptive behavior disorders, post-traumatic stress disorder (PTSD), eating disorders, substance abuse, anxiety disorders, and psychosis spectrum disorders (37,53,114,118-122). Research also suggests that adolescent in- and outpatients with co-occurring PD and mental state disorders are substantially more impaired than those with only mental state disorders (28,118), and tend to display the most complex patterns of comorbidity (120). Moreover, PD co-occuring with other mental disorders in adolescence has been prospectively linked with elevated mental health service use, and elevated use of prescribed psychotropic drugs during early adulthood (123). The presence of PD together with other mental disorders is also a significant predictor of poor quality of life (124).

Data from the CIC Study have revealed that adolescents with co-occurring PD and other mental disorders have worse long-term prognoses for academic, occupational, and interpersonal functioning when followed for a period of more than 20 years (53,65,74). With regard to mental health outcomes, the CIC Study found that adolescents with co-occurring PD and mental state disorders had more severe current psychopathology and an almost nine-fold increase in the risk for future development of psychiatric disorders as compared with individuals with no disorders or those with only PDs or other mental disorders respectively (114). Additionally, reviews of major longitudinal studies suggest that PD co-occurring with other mental/behavioral disorders in adolescence increases the likelihood of PD continuing or worsening during young adulthood by up to 19 times and that it is more likely that improvement in PD leads to improvement in other co-occurring disorders than vice versa (51,53,57,65).

Adverse outcomes and adaptive functioning

Consistent with the literature on PD in adults (125-127), the presence of PD in adolescents is concurrently and prospectively associated with an elevated risk for suicidal ideation and suicide attempts in early adulthood (128-130). Psychological autopsy studies of completed suicides among adolescents support these findings. One study found that PDs—especially those belonging to Cluster B and Cluster C—were more common among suicide victims than community controls (131). This is consistent with another psychological autopsy study, which also reported a large proportion of PDs among suicide completers; notably the investigators found that borderline PD was present in 33% of the cases (132). PD during adolescence is also associated with non-suicidal self-injurious behavior such as cutting and burning (133-135).

PD in adolescence predicts conflictual romantic relationships (136), problems in friendships, poor educational achievements, problems at work (23,74,114,137,138), and problems with family members in early adulthood (34). PD in adolescence is also associated with high-risk sexual behaviors and a high number of sexual partners (139). Cluster A and Cluster B PDs in particular have been prospectively linked with an increased risk of violent and criminal behaviors in the community, during both adolescence and early adulthood (140,141). Cluster A PDs—most notably schizotypal PD—in childhood have been found to increase the risk for more severe schizophrenia spectrum disorders in adulthood (64), thereby reinforcing the view that Cluster A PDs, at least in

some cases, may represent developmental precursors or prodromes to psychosis and schizophrenia spectrum disorders (53).

Studies find that adolescents with borderline PD report significantly more mental health service use as compared with healthy controls (142). Borderline PD in early adolescence also prospectively predicts low social functioning and life satisfaction, fewer attained adult developmental milestones, and lower academic and occupational attainment, independent of other psychiatric disorders and despite age-related borderline PD symptom decline over time (74). Finally, PD in adolescence significantly reduces concurrent and future quality of life (124,143), and increases the risk of unnatural and violent death amongst offenders (144).

Risk and protective factors

Until the last 15 years, most developmental studies of PD focused on early childhood experiences and how they affect later adult psychopathology. Although early childhood experiences are important, their effects on future development and outcomes are likely to be mediated or even reversed by later experiences (22,145), and there are currently only limited data to inform us about these processes. With regard to "distal" risk factors, most data come from the CIC Study. Low socioeconomic status in the family of origin, being raised by a single parent, receiving family welfare support, frequent parental conflicts, and parental illness or death have been identified as prospective risk factors for future development of PD (53,65). Maladaptive family functioning and parenting, including low emotional closeness between parent and child, use of harsh punishment during childhood, maternal over-control, and parental psychopathology, have also been found to precede the later development of PD (53,65,146-148). Childhood sexual, physical, and verbal abuse and childhood neglect increase the risk for development of PD in adolescence and adulthood (65,147,149-152).

Early disruptive behavior disorders—especially conduct disorder but also attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder—are strong long-term predictors for most types of PDs (35,65,153-158). The available research evidence indicates a link between ADHD in childhood and heightened risk of borderline PD in adolescence and early adulthood (158-160). Such findings might suggest that similar or identical phenomena (e.g., impulsivity and aggression) may be misleadingly characterized as mental state pathology in children and then later relabeled as personality pathology in adolescence and adulthood (161).

With regard to antisocial PD, the DSM-5, Section II, requires evidence of conduct disorder with onset before age of 15 years, in order for this diagnosis to be considered applicable to persons aged 18 years or older. The available research evidence supports to some extend this notion of conduct disorder in childhood and adolescence as a developmental precursor to antisocial PD (162-164). Yet, it should be noted that conduct disorder is also prospectively associated with a wide range of other mental disorders, including other specific PDs. Hence, the predictive value of conduct disorder does not appear to be limited to antisocial PD, but rather to a broad range of psychopathology including other specific PDs, primarily from Cluster B PDs (153,154,156,162). Within the externalizing spectrum of disorders, substance use disorders (particularly alcohol abuse) have also been identified as predictors of early adult borderline PD (165). With regard to internalizing disorders, major depression and anxiety disorder in childhood has been prospectively linked with a heightened risk of developing PD during young adulthood (155,156). Symptoms of social anxiety have also been directly linked with avoidant PD (53,155), and some investigators argue that generalized social phobia and avoidant PD are not separate disorders but rather part of a single spectrum (53).

Few studies have investigated PD in childhood and adolescence as a predictor of adult PD using prospective longitudinal designs. However, the available studies indicate that PD symptoms in childhood and adolescence are the strongest long-term predictors of PD diagnoses in adulthood, over and above other predictors such as disruptive behavior disorders and depression (23,25,53,55, 74,78,155).

Few studies have examined the perinatal factors associated with PD. However, for schizotypal PD, and to some extend also schizoid PD, studies suggest links with prenatal malnutrition, exposure to prenatal stress, and influenza (166).

There is little empirical knowledge about resilience and protective factors for PD (167,168). One study has investigated the association between retrospective accounts of positive childhood experiences related to resiliency among adult patients with PD and prospective remission from avoidant, schizotypal, borderline, and obsessive-compulsive PD over the course of 4 years (167). This study found that positive achievement experiences were significantly associated with remission from avoidant and schizotypal PD. In addition, various types of positive interpersonal relationships were associated with remission from avoidant, borderline, and schizotypal PD. For obsessive-compulsive PD, they found no significant

predictors of remission, which the authors speculate could be due to the generally higher functioning of this group. Although competent parenting is considered important for the fostering of resiliency, perceived caretaker competence variables in this study were not found to be broadly associated with remission. The more general finding from the study was that the greater the number of positive experiences and the broader the developmental periods they spanned, the better the prognosis of the individuals with PDs (167).

Treatment: Prevention and early intervention

Whilst diagnosing PD during adolescence is evidence based and feasible, there would be little point in doing so unless corresponding treatments were available. The empirical evaluation of treatments has been slow to develop, but this is now changing.

Prevention and early intervention: The available data on PD in adolescence makes a compelling case for the development and implementation of empirically based prevention and early intervention programs (161,169,170). Like other forms of psychopathology, PD interferes with normative development and adaptation. PD can have severe repercussions, and its developmental disruptions have cascading effects (171-173) that potentially alter or divert the entire course of development (174). Prevention and early intervention programs hold the promise of not only alleviating present difficulties but also potentially averting future negative outcomes through targeting PD pathology before it become more ingrained and chronic (175).

Chanen and colleagues (161,169,176) have argued for applying preventive and early intervention strategies to PD during childhood and adolescence following the general framework for prevention of mental disorders outlined by the Institute of Medicine (177). An advantage of this framework is that it is not specifically concerned with aetiology, onset, and incidence—matters of which we only have limited knowledge—but rather focuses on risk factors associated with the persistence and maintenance of these disorders. Such a framework suits our current knowledge and understanding of PD. Chanen and colleagues argue that the available data do not yet support universal population based or selective risk-factor based prevention programs. Instead, they argue that indicated prevention and early intervention are currently the most feasible strategies (161,170,176). In contrast with conventional treatment programs that target individuals with established PD (i.e., those who meet the full criteria), indicated prevention programs target children and adolescents who display precursor signs and symptoms associated with PD (i.e., those who display some but not necessarily all of the required PD criteria). Early intervention programs aim for the early detection and treatment of the full-syndrome disorder. Consistent with knowledge on the course and development of PD, indicated prevention and early intervention programs should not just target the diagnostic features of PDs, which might naturally attenuate over time; rather, they should aim to improve adaptive functioning and alter the developmental trajectory of PD. Furthermore, it should be noted, that not all treatment that occurs for individuals who are less than 18 years old by definition is prevention or early intervention (161,169,178). For example, it is possible to see a 15-year-old child with many years of enduring personality pathology who is in need of standard treatment, and it is also possible to see a never-treated 24-year-old adult with subsyndromal personality pathology who is in need of indicated prevention.

Treatment programs: In adult populations, psychotherapy remains the treatment of choice for PDs (179,180), although most of the evidence is limited to borderline PD and antisocial PD. Similarly, treatment research on PD in adolescence primarily focuses on borderline PD, with most of the studies combining indicated prevention (subsyndromal cases) and early intervention (full-syndrome disorder). Of note, only two studies (181,182) explicitly included participants who had never before been treated for borderline PD (early intervention).

Three randomized controlled trials (RCTs) have been conducted to assess the effectiveness of cognitive analytic therapy (CAT) for adolescents with borderline PD. CAT is an integrative and time-limited form of psychotherapy that combines object relations theory with cognitive psychology. The initial study (181) compared the effectiveness of adding up to 24 sessions of CAT to the Helping Young People Early (HYPE) program (183) versus manualized good clinical care (GCC). Seventy-eight participants between the ages of 15 and 18 years who fulfilled two to nine DSM-IV borderline PD criteria completed the trial. No significant differences between the two treatment groups with regard to predetermined outcomes were found at 24 months. However, participants in the CAT group improved more rapidly. No adverse effects were observed for either treatment. Using a quasi-experimental design, this research group later compared the effectiveness of CAT and good clinical care (GCC) as determined by their RCT with historical data on treatment-as-usual (TAU) in

their clinic (182). Results from this study revealed that both HYPE with CAT and HYPE with GCC were more effective than TAU and that HYPE with CAT was the most effective. Recently, a pilot RCT (184) have also been conducted to investigate the feasibility of treating co-occurring first-episode psychosis and borderline PD in adolescents with a hybrid treatment model that mixed elements from the HYPE with CAT program with a specialized first episode psychosis treatment program. The preliminary results were promising, suggesting that the brief hybrid intervention program was safe and acceptable to this complex subgroup of adolescent patients.

Mentalization-based treatment (MBT) has also been adapted for adolescents (MBT-A) (185-187). An RCT (188) included 80 adolescents (73% of whom met full diagnostic criteria for borderline PD) who consecutively presented to mental health services with self-harm and co-occurring depression. Participants were randomly assigned to MBT-A or TAU (not manualized). MBT-A is an attachment and psychodynamically oriented treatment program comprised of weekly individual therapy sessions and monthly MBT family groups. Results indicated that MBT-A was more effective than TAU for reducing self-harm and depression and that the superior effectiveness of MBT-A was explained by improvements in mentalizing and borderline PD features as well as reduced attachment avoidance. Further studies of MBT-A are underway to investigate the efficacy and effectiveness of this treatment for adolescents with borderline PD (187,189,190).

Dialectical behavior therapy (DBT) is another treatment that has been implemented for the treatment of suicidal and self-harming adolescents (DBT-A) displaying features of borderline PD (191,192). DBT is a modified form of cognitive-behavioral therapy that combines cognitive-behavioral therapy techniques for emotion regulation and reality testing with Zen Buddhist and mindfulness concepts and techniques (193). The only RCT of DBT-A for adolescents with borderline PD compared the effectiveness of DBT with non-manualized enhanced usual care (EUC) for the reduction of self-harm (194). The study included 77 self-harming adolescents (of which 21% met full criteria for borderline PD) recruited from psychiatric outpatient clinics. The results revealed that DBT-A was superior to enhanced EUC for reducing self-harm, depressive symptoms, and suicidal ideation.

Two RCTs have investigated the effectiveness of emotion regulation training (ERT). ERT is a 17-session adjunctive program, based on the Systems Training for Emotional Predictability and Problem Solving (STEPPS) program for adults with borderline PD (195) that combines group-based skills training with family psychoeducation. In both studies, the effectiveness of ERT was compared with TAU. In the first study (196), 43 adolescents were randomized to ERT plus TAU or TAU alone. The results revealed a significant decrease in borderline PD symptoms in both groups, and there was no significant difference between the two groups in terms of improvements. In the second study (197), 109 participants with features of borderline PD (73% met the full criteria for this condition) were randomized to ERT plus TAU or TAU alone. This study also found no significant differences between the two treatment groups. Both groups improved equally on measures of borderline PD severity, general psychopathology, and quality of life.

Psychopharmacological treatment: To our knowledge, the only pharmacotherapeutic RCT for adolescents with borderline PD was a small (N = 15) post hoc subgroup analysis of a larger RCT that investigated the effects of long-chain omega-3 (n-3) polyunsaturated fatty acids (PUFAs) on functioning and psychiatric symptoms among young people with borderline PD who also met ultra-high-risk criteria for psychosis (198). Results indicated that fatty acid (n-3 PUFA) levels at baseline correlated positively with psychosocial functioning and negatively with psychopathology. At the end of the intervention, these fatty acids were associated with improved functioning and reduced psychiatric symptoms as compared with placebo.

Taking the Dodo Bird serious: effective ingredients and common factors: The RCTs just discussed suggest that indicated prevention, early intervention, and standard treatment programs for borderline PD in adolescents are acceptable and effective. It is noteworthy that all interventions, including manualized TAU and other control treatments, were effective. Hence it remains unclear to what extent the reported effects can be attributed to specific psychotherapeutic interventions (161). Of course, control treatments such as TAU or GCC should not be equated across studies, and research suggests that the choice of comparison treatment can considerably influence effect sizes in psychotherapy research (199,200), which has also been demonstrated in recent RCTs for treatments of borderline PD in adult patients (201-205). However, a general finding from RCTs for treatment of borderline PD in both adolescent and adult samples (206) and in reviews and meta-analyses of psychotherapy outcome research is that there is often little or no difference in efficacy

among various *bona fide* psychotherapeutic treatments (207-210); a finding commonly referred to as the *Dodo bird verdict* (211). Taken together this points toward the importance of common factors, extra-therapeutic factors, and placebo effects (206,212-216). It may thus be proposed that some of the most important factors related to effecting change have less to do with the specific techniques promoted by the various schools of psychotherapy and more to do with the core and common elements shared across these various therapies (113,161,170,206,217-219).

On the basis of studies of adults, Fonagy (218) and other investigators (179,206,217) have identified a number of common features of effective treatments for borderline PD in adults, such as: 1) considerable efforts to enhance treatment compliance; 2) consistent focus on problem behaviors (e.g., self harm) and interpersonal problems; 3) a coherent conceptual theory, framework, and language for the patient and the therapist/staff to share; 4) encouragement of a supportive attachment relationship between the therapist and the patient that is of relatively long duration; and 5) that the treatment is highly structured and well integrated with other services that the patient uses.

Recently, Chanen and colleagues (161,170) extended this line of reasoning to adolescents by identifying potential (common) key ingredients in effective prevention and early intervention programs for borderline PD – including factors beyond individual psychotherapy related to models of service delivery. Among other things, they highlighted the importance of the following features: 1) assertive and psychologically informed case management integrated with the delivery of psychotherapy; 2) the capacity for outreach care into the community; 3) the active engagement and inclusion of family members and carers in the treatment process, including psychoeducation and brief family interventions delivered in accordance with the overall treatment model; 4) the consistent use of a plain and common language based on a shared model of the self and the psychopathology across all aspects of care; 5) the integration of general psychiatric care within the specialist treatment team, including assessment and treatment of co-occurring disorders; 6) the presence of a crisis team and availability of inpatient care programs with clear and time-limited goals; 7) access to a psychosocial recovery program; and 8) regular supervision of staff and quality assurance. Elements such as those highlighted by Chanen and colleagues must be implicated in our future understanding of why structured treatments, including those in the control conditions of the RCTs, for adolescents with borderline PD appear to be equally effective. In passing it should be noted, that many of the key elements highlighted by Chanen and colleagues (161) are also identified and used in the adolescent mentalization-based integrative therapy (AMBIT) approach to hard-to-reach adolescents with multiple mental health problems and vulnerabilities (220,221). This could indicate that they have wider applicability beyond borderline PD, for management and treatment of youth with complex psychopathology.

First, do no harm: dropout and iatrogenic harm: A more disheartening finding from the previously described RCTs for borderline PD in adolescence is that the dropout rates appear to be relatively high across the studies and in both the treatment and control groups (181,188,194,196,197). As a result of differences in defining and reporting dropout in the trials, it is not possible to compute and compare exact estimates of dropout rates across the trials and treatment conditions. But based on the published data from these RCTs, there are indications that approximately 20% to 54% of the participants appear to dropout of treatment prematurely. More generally, it is estimated that 20% to 70% of persons, across all age groups and diagnoses, who begin psychosocial mental health treatment discontinue such treatment against their clinicians' recommendations (222). For adolescents specifically, a study suggests that about a third of patients in mental health psychosocial treatments dropout prematurely (223). A systematic review that included 25 studies of non-completion among PD treatments found a median non-completion rate of 37% (224). Taken together, such data suggest that dropout or premature termination from psychotherapy is a major challenge that should be addressed explicitly in future treatment research.

Another important issue to consider is the iatrogenic or harmful effects of therapies. Both quantitative and qualitative reviews find that around 75% to 80% of those individuals treated with psychotherapy benefit from it (225,226). However, a somewhat neglected but crucial finding of such reviews is that 5% to 10% of those who participate in treatment trials get worse. For child psychotherapy, these numbers may be even higher, with up to 24% of children between the ages of 4 and 17 years who are treated in community mental health settings deteriorating (227). A recent uncontrolled treatment study of adolescent inpatients with PD found that 26% of the participants showed reliable change and moved into a normative range of symptom severity; the rest of the participants did not change or only displayed modest symptom reduction, and 9% deteriorated (228). Data from an RCT study of CAT for PD in adults have also

demonstrated that TAU can act as a "nocebo" condition in which harmful effects arise from a placebo treatment (161,229,230). Furthermore, studies have demonstrated that therapists are not good at predicting patients' outcomes or at determining patients' perceptions of the quality of the therapeutic relationship or of group relationships; the therapists tend to underestimate the number of patients who are deteriorating during therapy (231-233). Research has also consistently demonstrated that the therapeutic alliance is one of the most consistent and robust predictors of therapeutic outcome (234,235) and that it is therapist variability—rather than patient variability—that brings about most of this alliance–outcome association (234,236). Moreover, intervention research suggests that focusing on the therapeutic relationship or transference seems to have the strongest effect for patients with personality problems within the context of a weak alliance (237-239), whereas it can have negative effects for patients without personality problems and in the context of a strong alliance (240). Taken together, these data make a compelling case for implementing routine outcome monitoring systems in the treatment of PD so that clinicians can respond adequately and flexible if progress is lacking or when signs of deterioration become apparent (113,233,241,242).

Conclusions and clinical implications

On the basis of the preceding selected review of the available research evidence, the following conclusions and clinical implications can be drawn with regard to PD in adolescence:

- PD can be diagnosed as reliable and valid in adolescents as in adults.
- The point prevalence of PD diagnoses peaks in early adolescence and then declines reaching estimates comparable to those for adults by late adolescence.
- Studies suggest that 41% to 64% of adolescents in clinical settings meets diagnostic criteria for PDs, indicating they are highly prevalent
- Co-occurrence between PDs is frequent.
- PD changes from childhood through adulthood in similar ways to normal-range personality. In adolescence, as in adulthood, the rank order stability of PD is moderate to high, whereas diagnostic stability is low.
- The functional impairments associated with PD are stable across the lifespan.
- PD co-occurring with other mental disorders is frequent, and associated with a poorer prognosis.
- PD is associated with considerable treatment needs and mental health service use.
- RCTs show that indicated prevention and early intervention programs are promising and effective for adolescents with borderline PD.
- There is currently no evidence to support the superiority of one treatment over another for adolescents with borderline PD.
- Considering the very limited evidence for the psychopharmacological treatment of PD in adolescence (and even during adulthood), this type of treatment cannot be recommended at present.

Hume's Guillotine: Barriers and Potential Risks

Although diagnosing PD during adolescence is feasible, this does not necessarily imply that one ought to diagnose it during this period. As the moral philosopher David Hume (243) pointed out long ago, one cannot automatically make a normative claim solely based on facts: in moral matters, claims of *what is* must be severed from claims about *what ought to be*. Indeed, mental health professionals who work with children and adolescents often report concerns about stigma as a reason for not using PD diagnoses (20). Researchers and clinicians should always be wary of the potential harmful effects of diagnostic labeling. PD generally—and borderline and antisocial (including psychopathy) PD more specifically—are stigmatized among some mental health professionals, patients, the judicial system, and society at large (244-247). However, well-intentioned clinicians who purposefully refrain from using PD diagnoses with adolescent patients in order to avoid stigma or discrimination may thereby unwittingly be reinforcing and perpetuating the very stigma that they wish to avoid (170). This in turn may increase the risk of inappropriate diagnosis and iatrogenic harm (e.g., from polypharmacy), which may hinder young people from receiving targeted evidence-based treatment (170). We propose that, on balance, the potential harmful effects of labeling young people via the diagnosis of PD are outweighed by the risk of them not receiving appropriate treatment. In our clinical experience, most patients and families welcome the diagnosis and the implicit acknowledgement of their difficulties and needs. Arguably, evidence-based prevention and early intervention programs for these conditions may also prove to be cost-effective for society at large (124). This favorable disposition toward early detection and intervention through a diagnosis of PD during

adolescence is also reflected in national guidelines (6,7), alternative classification models (60,98,248), and is likely to be included in the forthcoming ICD-11 (249).

Although we are enthusiastic about these developments within the field, it should also be recognized that the removal of age-related caveats from the diagnostic criteria for PD will in all likelihood lead to more young people being diagnosed and treated, and some of these individuals may not meet the full criteria for PD (i.e., they may exhibit subthreshold PD) (22). In this context, we need to recognize that the potential benefits arising from such changes will need to be weighed against the potential risks, such as the "medicalizing" of common or normative problems, as well as the problems associated with over-treatment, side effects, stigma, and iatrogenic harm (169,250).

Future Research

Although the current evidence converges to support the clinical utility and feasibility of diagnosing PD in adolescence, it also reveals the limitations inherent to our current diagnostic systems. Despite the similarities between the adolescent and adult PD phenotypes, it is important to note that these diagnostic categories were originally derived from descriptions of adult patients. Hence, the downward extension of these diagnoses runs the risk of "adultomorphizing" (251) PD during childhood and adolescence, potentially not encompassing the whole domain of preadult personality pathology during childhood and adolescence (60,98,252,253). Both the DSM-5 (Section III, alternative PD classification system) and the ICD-11 proposal for PD classification are promising because they incorporate developmental evidence regarding PD in adolescence, remove age criteria, and take a dimensional approach to classification (10,249,254). These alternative classification schemes combine a dimensional approach with ratings of impairment in personality functioning and/or severity. Improvement in the classification of PD is likely to lead to improvements in the design and delivery of effective prevention and early intervention programs (4,22).

In an effort to extend contemporary approaches to the classification of PD, we propose a transdiagnostic clinical staging approach (255), eschewing diagnostic syndrome categories and arbitrary age criteria in favor of focusing on defining the stage of progression of PD at a particular point in time, and assessing symptom severity and persistence, need for care, and the proportionality of treatment interventions (256). The clinical staging approach to PD (257,258) attends to where an individual is currently placed on the continuum of the course of PD. The individual's treatment needs and the severity of PD will differ as a function of the stage or progression of the disorder, with treatment in theory being more benign (i.e., less intensive and invasive) and effective during the early stages (170). In accordance with this approach and its inherently transdiagnostic nature, the task for future research is to identify and describe a range of risk syndromes for the later development of psychopathology. Such risk syndromes can act as indicators for preventive and early intervention programs (259).

Prospective studies are required to advance our understanding of the course of the full range of personality pathology throughout the life span and to counter our current overreliance on data from the CIC Study. The meta-theoretical framework of developmental psychopathology could be used in the design of such studies (80,81). Moreover, we need greater knowledge on continuity and change dynamics, different developmental trajectories, and risk and protective factors associated with both adaptive and maladaptive development, including pathogenesis and salutogenesis. Future studies must include infants or children, and should ideally incorporate genetic/biological, individual, and environmental/societal factors into their designs. This would further our understanding of the factors, dynamics, and risk syndromes that are prospectively associated with onset, development, and maintenance of PD, as well as of the factors and processes associated with resilience and remission.

Although results from the available RCTs are promising, we still need follow-up data from these to evaluate whether they effectively alter the life course trajectory of PD and lead to stable improvements in functioning over time. Prospectively improving quality of life and adaptive functioning should indeed be the main aims of future prevention and early intervention programs targeting PD in adolescence. Improving patient retention in the treatment programs and reducing iatrogenic harm are also high priorities for future research to address. The use of client feedback and outcome tracking systems has been shown to be effective in psychotherapy research (260) for the reduction of the harmful effects of treatments. We therefore hypothesize that this could also be the case for the treatment of PD in childhood and adolescence. Moreover, the future development of novel prevention and early interventions programs targeting PD in adolescence should focus more on common factors and effective ingredients rather than specific "brand name" psychotherapies (161,179,261). This would include targeting both the

young person as well as that person's environment, including his or her family members and other relevant systems. Research is also needed to identify those subgroups that do not benefit from treatment or deteriorates, so that we can prevent adverse effects and develop new interventions for the non-responders. Finally, we recommend that future research focus on relatively simple treatment programs to enhance the external validity of those programs, thereby enabling their implementation in routine clinical practice so that they might ultimately lessen the burden of PDs on individuals, families, and society.

References

1. Oldham JM. Borderline personality disorder comes of age. Am J Psychiatry 2009;166(5):509-11.

2. Silk KR. Augmenting psychotherapy for borderline personality disorder: The STEPPS program. Am J Psychiatry 2008;165(4):413-15.

3. Kierkegaard S. The sickness unto death: A Christian psychological exposition for edification and awakening. London, England: Penguin Books; 1989.

4. Ronningstam E, Simonsen E, Oldham JM, et al. Studies of personality disorders: Past, present, and future in recognition of ISSPD's 25th anniversary. J Pers Disord 2014;28(5):611-28.

5. Skodol AE, Gunderson JG, McGlashan TH, et al. Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. Am J Psychiatry 2002;159:276-83.

6. National Collaborating Centre for Mental Health. Borderline personality disorder: Treatment and management. [NICE guideline number 78]. London, UK; 2009.

7. National Health and Medical Research Council. Clinical Practice Guideline for the Management of Borderline Personality Disorder. Melbourne; 2012.

8. National Institute for Mental Health England. Personality disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder. Leeds, UK; 2003.

9. National Institute for Health and Clinical Excellence (NHS). Antisocial personality disorder: Treatment, management and prevention. [NICE clinical guideline 77]. London; 2009.

10. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5. 5th ed. Washington, DC: American Psychiatric Association; 2013.

11. World Health Organization. The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. Geneva: World Health Organization; 1992.

12. Chanen AM, McCutcheon LK. Personality disorder in adolescence: The diagnosis that dare not speak its name. Personal Ment Health 2008;2(1):35-41.

13. Cicchetti D, Crick NR. Precursors and diverse pathways to personality disorder in children and adolescents. Dev Psychopathol 2009;21(3):683-5.

14. Freeman A, Rigby A. Personality disorders among children and adolescents: Is it an unlikely diagnosis? In: Reinecke MA, Dattilio FM, Freeman A (eds). Cognitive therapy with children and adolescents. New York: Guilford Press; 2003. p. 434-64
.

15. Kernberg PF, Weiner AS, Bardenstein KK. Personality disorders in children and adolescents. New York, NY: Basic Books; 2000.

16. Paris J. Personality disorders over time: Precursors, course, and outcome. Washington, D.C.: American Psychiatric Publishing; 2003.

17. Westen D, Chang C. Personality pathology in adolescence: A review. Adolesc Psychiatry 2000;25:61-100.

18. Elliott T, Tyrer P, Horwood J, Fergusson D. Assessment of abnormal personality in childhood: A Delphi survey of questionnaire data. J Pers Disord 2011;25(1):89-100.

19. Freeman A, Reinecke MA. Personality disorders in childhood and adolescence. Freeman A, Reinecke MA (eds). Hoboken, NJ: John Wiley & Sons; 2007.

20. Griffiths M. Validity, utility and acceptability of borderline personality disorder diagnosis in childhood and adolescence: Survey of psychiatrists. The Psychiatrist 2011;35(1):19-22.

21. Laurenssen EM, Hutsebaut J, Feenstra DJ, Van Busschbach JJ, Luyten P. Diagnosis of personality disorders in adolescents: A study among psychologists. Child Adolesc Psychiatry Ment Health 2013;7(1):3.

22. Newton-Howes G, Clark LA, Chanen AM. Personality disorder across the life course. Lancet 2015;385(9969):727-34.

23. Bernstein DP, Cohen P, Velez CN, Schwab-Stone M, Siever LJ, Shinsato L. Prevalence and stability of the DSM-III-R personality disorders in a community-based survey of adolescents. Am J Psychiatry 1993;150(8):1237-43.

24. Chanen AM, Jackson HJ, McGorry PD, Allot KA, Clarkson V, Yuen HP. Two-year stability of personality disorder in older adolescent outpatients. J Pers Disord 2004;18(6):526-41.

25. Fossati A. Diagnosing borderline personality disorder during adolescence: A review of the published litterature. Scand J Child Adolesc Psychiatr Psychol 2015;3(1):5-21.

26. Glenn CR, Klonsky ED. Reliability and validity of borderline personality disorder in hospitalized adolescents. J Can Acad Child Adolesc Psychiatry 2013;22(3):206-11.

27. Grilo CM, McGlashan TH, Quinlan DM, Walker ML, Greenfeld D, Edell WS. Frequency of personality disorders in two age cohorts of psychiatric inpatients. Am J Psychiatry 1998;155(1):140-2.

28. Levy KN, Becker DF, Grilo CM, et al. Concurrent and predictive validity of the personality disorder diagnosis in adolescent inpatients. Am J Psychiatry 1999;156(10):1522-8.

29. Michonski JD, Sharp C, Steinberg L, Zanarini MC. An item response theory analysis of the DSM-IV borderline personality disorder criteria in a population-based sample of 11- to 12-year-old children. Personal Disord 2013;4(1):15-22.

30. Sharp C, Ha C, Michonski J, Venta A, Carbone C. Borderline personality disorder in adolescents: Evidence in support of the childhood interview for DSM-IV borderline personality disorder in a sample of adolescent inpatients. Compr Psychiatry 2012; 53(6):765-74.

31. Sharp C, Kalpakci A. If it looks like a duck and quacks like a duck: Evaluating the validity of borderline personality disorder in adolescents. Scand J Child Adolesc Psychiatr Psychol 2015;3(1):49-62.

32. Taylor J, Elkins IJ, Legrand L, Peuschold D, Iacono WG. Construct validity of adolescent antisocial personality disorder. J Youth Adolesc 2007;36(8):1048-57.

33. Westen D, Shedler J, Durrett C, Glass S, Martens A. Personality diagnoses in adolescence: DSM-IV axis II diagnoses and an empirically derived alternative. Am J Psychiatry 2003;160(5):952-66.

34. Johnson JG, Bromley E, Bornstein RF, Sneed JR. Adolescent personality disorders. In: Wolfe DA, Mash EJ (eds). Behavioral and emotional disorders in children and adolescents: Nature, assessment, and treatment. New York: Guilford Press; 2006. p. 463-84.

35. Lewinsohn PM, Rohde P, Seeley JR, Klein DN. Axis II psychopathology as a function of axis I disorders in childhood and adolescence. J Am Acad Child Adolesc Psychiatry 1997;36(12): 1752-9.

36. Loranger AW, Sartorius N, Andreoli A, et al. The International Personality Disorder Examination. The World Health Organization/Alcohol, Drug Aabuse, and Mental Health administration international pilot study of personality disorders. Arch Gen Psychiatry 1994;51(3):215-24.

37. Feenstra DJ, Busschbach JJ, Verheul R, Hutsebaut J. Prevalence and comorbidity of axis I and axis II disorders among treatment refractory adolescents admitted for specialized psychotherapy. J Pers Disord 2011;25(6):842-50.

38. Gosden NP, Kramp P, Gabrielsen G, Sestoft D. Prevalence of mental disorders among 15-17-year-old male adolescent remand prisoners in Denmark. Acta Psychiatr Scand 2003;107(2):102-10.

39. Kongerslev M, Moran P, Bo S, Simonsen E. Screening for personality disorder in incarcerated adolescent boys: Preliminary validation of an adolescent version of the standardised assessment of personality - abbreviated scale (SAPAS-AV). BMC Psychiatry 2012;12(1):94.

40. Lader D, Singleton N, Meltzer H. Psychiatric morbidity among young offenders in England and Wales. London: Office for National Statistics; 2000.

41. Coid J. Correctional populations: Criminal careers and recidivism. In: Oldham JM, Skodol AE, Bender D (eds). The American psychiatric publishing textbook of personality disorders. Washington, DC: American Psychiatric Publishing, Inc.; 2005. p. 579-606.

42. Paris J. Estimating the prevalence of personality disorders in the community. J Pers Disord 2010;24(4):405-11.

43. Zimmerman M, Chelminski I, Young D. The frequency of personality disorders in psychiatric patients. Psychiatr Clin North Am 2008;31(3):405-20.

44. Johnson JG, Cohen P, Dohrenwend BP, Link BG, Brook JS. A longitudinal investigation of social causation and social selection processes involved in the association between socioeconomic status and psychiatric disorders. J Abnorm Psychol 1999;108(3): 490-9.

45. Daley SE, Hammen C, Burge D, et al. Depression and axis II symptomatology in an adolescent community sample: Concurrent and longitudinal associations. J Pers Disord 1999;13(1):47-59.

46. Johnson JG, Cohen P, Kasen S, Skodol AE, Hamagami F, Brook JS. Age-related change in personality disorder trait levels between early adolescence and adulthood: A community-based longitudinal investigation. Acta Psychiatr Scand 2000;102:265-75.

47. Coid J, Yang M, Tyrer P, Roberts A, Ullrich S. Prevalence and correlates of personality disorder in Great Britain. Br J Psychiatry 2006;188:423-31.

48. Loas G, Pham-Scottez A, Cailhol L, Perez-Diaz F, Corcos M, Speranza M. Axis II comorbidity of borderline personality disorder in adolescents. Psychopathology 2013;46(3):172-5.

49. Lenzenweger MF. Epidemiology of personality disorders. Psychiatr Clin North Am 2008;31(3):395-403.

50. Caspi A, Roberts BW. Personality continuity and change across the life course. In: Pervin LA, John OP (eds). Handbook of personality: Theory and research. New York: Guilford Press; 1999. p. 300-26.

51. Clark LA. Stability and change in personality disorder. Curr Dir Psychol Sci 2009;18(1):27-31.

52. Roberts BW, Wood D, Caspi A. The development of personality traits in adulthood. In: John OP, Robins RW, Pervin LA (eds). Handbook of personality: Theory and Research. New York: Guilford Press; 2008. p. 375-98.

53. Cohen P, Crawford TN, Johnson JG, Kasen S. The children in the community study of developmental course of personality disorder. J Pers Disord 2005;19(5):466-86.

54. Shiner RL. The development of personality disorders: Perspectives from normal personality development in childhood and adolescence. Dev Psychopathol 2009;21(3):715-34.

55. Crick NR, Murray-Close D, Woods K. Borderline personality features in childhood: A short-term longitudinal study. Dev Psychopathol 2005;17(4):1051-70.

56. Ferguson CJ. A meta-analysis of normal and disordered personality across the life span. J Pers Soc Psychol 2010;98(4):659-67.

57. Clark LA. Stability and change in personality pathology: Revelations of three longitudinal studies. J Pers Disord 2005;19(5):524-32; discussion 594-6.

58. Cohen P, Chen H, Kasen S, Johnson JG, Crawford T, Gordon K. Adolescent cluster A personality disorder symptoms, role assumption in the transition to adulthood, and resolution or persistence of symptoms. Dev Psychopathol 2005;17(02):549-68.

59. Blakemore SJ, Mills KL. Is adolescence a sensitive period for sociocultural processing? Annu Rev Psychol 2014;65:187-207.

60. Tackett JL, Balsis S, Oltmanns TF, Krueger RF. A unifying perspective on personality pathology across the life span: Developmental considerations for the fifth edition of the diagnostic and statistical manual of mental disorders. Dev Psychopathol 2009;21(3):687-713.

61. Bornovalova MA, Hicks BM, Iacono WG, McGue M. Stability, change, and heritability of borderline personality disorder traits from adolescence to adulthood: A longitudinal twin study. Dev Psychopathol 2009;21(4):1335-53.

62. Stepp SD, Whalen DJ, Scott LN, Zalewski M, Loeber R, Hipwell AE. Reciprocal effects of parenting and borderline personality disorder symptoms in adolescent girls. Dev Psychopathol 2014; 26(2):361-78.

63. Biskin RS, Paris J, Renaud J, Raz A, Zelkowitz P. Outcomes in women diagnosed with borderline personality disorder in adolescence. J Can Acad Child Adolesc Psychiatry 2011;20(3):168-74.

64. Esterberg ML, Goulding SM, Walker EF. Cluster A personality disorders: Schizotypal, schizoid and paranoid personality disorders in childhood and adolescence. J Psychopathol Behav Assess 2010;32(4):515-28.

65. Cohen P. Child development and personality disorder. Psychiatr Clin North Am 2008;31(3):477-493.

66. Morey LC, Hopwood CJ. Stability and change in personality disorders. Annu Rev Clin Psychol 2013;9:499-528.

67. Zanarini MC, Frankenburg FR, Reich DB, Fitzmaurice G. Time to attainment of recovery from borderline personality disorder and stability of recovery: A 10-year prospective follow-up study. Am J Psychiatry 2010;167(6):663-7.

68. Zanarini MC, Frankenburg FR, Reich DB, Fitzmaurice G. The 10-year course of psychosocial functioning among patients with

borderline personality disorder and axis II comparison subjects. Acta Psychiatr Scand 2010;122(2):103-9.

69. Chanen AM. Outcomes in women diagnosed with borderline personality disorder in adolescence: Early detection and timely intervention are fundamental. J Can Acad Child Adolesc Psychiatry 2011;20(3):175.

70. Skodol AE, Pagano ME, Bender DS, Tracie S. Stability of functional impairment in patients with schizotypal, borderline, avoidant, or obsessive--compulsive personality disorder over two years. Psychol Med 2005;35(03):443-51.

71. Skodol AE. Longitudinal course and outcome of personality disorders. Psychiatr Clin North Am 2008;31(3):495-503.

72. Gunderson JG, Stout RL, McGlashan TH, et al. Ten-Year course of borderline personality disorder: Psychopathology and function from the collaborative longitudinal personality disorders study. Arch Gen Psychiatry 2011;68(8):827-37.

73. Kvarstein EH, Karterud S. Large variations of global functioning over five years in treated patients with personality traits and disorders. J Pers Disord 2012;26(2):141-61.

74. Winograd G, Cohen P, Chen H. Adolescent borderline symptoms in the community: Prognosis for functioning over 20 years. J Child Psychol Psychiatry 2008;49(9):933-41.

75. Caspi A, Houts RM, Belsky DW, et al. The p factor: One general psychopathology factor in the structure of psychiatric disorders? Clin Psychol Sci 2014;2(2):119-37.

76. Krueger RF. Continuity of axes I and II: Toward a unified model of personality, personality disorders, and clinical disorders. J Pers Disord 2005;19(3):233-61.

77. Sanislow CA, Little TD, Ansell EB, et al. Ten-year stability and latent structure of the DSM-IV schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. J Abnorm Psychol 2009;118(3):507-19.

78. Cohen P. Childhood risks for young adult symptoms of personality disorder: Method and substance. Multivariate Behav Research 1996;31(1):121-48.

79. Skodol AE, Johnson JG, Cohen P, Sneed JR, Crawford TN. Personality disorder and impaired functioning from adolescence to adulthood. Br J Psychiatry 2007;190:415-20.

80. Cicchetti D. Illustrative developmental psychopathology perspectives on precursors and pathways to personality disorder: Commentary on the special issue. J Pers Disord 2014;28(1):172-9.

81. Rutter M, Sroufe LA. Developmental psychopathology: Concepts and challenges. Dev Psychopathol 2000;12(3):265-96.

82. de Clercq B, de Fruyt F, van Leeuwen K, Mervielde I. The structure of maladaptive personality traits in childhood: A step toward an integrative developmental perspective for DSM-V. J Abnorm Psychol 2006;115(4):639-57.

83. de Clercq B, de Fruyt F, de Bolle M, van Hiel A, Markon KE, Krueger RF. The hierarchical structure and construct validity of the PID-5 trait measure in adolescence. J Pers 2014;82(2):158-69.

84. Markon KE, Krueger RF, Watson D. Delineating the structure of normal and abnormal personality: An integrative hierarchical approach. J Pers Soc Psychol 2005;88(1):139-57.

85. Tromp NB, Koot HM. Psychometric qualities of the dimensional assessment of personality pathology - short form for adolescents. Scand J Child Adolesc Psychiatr Psychol 2015; 3(1):71-79.

86. Wright AG, Thomas KM, Hopwood CJ, Markon KE, Pincus AL, Krueger RF. The hierarchical structure of DSM-5 pathological personality traits. J Abnorm Psychol 2012;121(4):951-7.

87. Tackett JL, Slobodskaya HR, Mar RA, et al. The hierarchical structure of childhood personality in five countries: Continuity from early childhood to early adolescence. J Pers 2012;80(4):847-79.

88. James W. Principles of psychology. New York: Dover; 1950.

89. McCrae RR, Costa PT, Terracciano A, et al. Personality trait development from age 12 to age 18: Longitudinal, cross-sectional, and cross-cultural analyses. J Pers Soc Psychol 2002;83(6):1456-68.

90. Moya J, Viruela A, Mezquita L, Villa H, Ibáñez MI, Ortet G. Stability and change of personality in adolescents: A 4-year longitudinal study. Pers Individ Dif 2014;60:S15.

91. Tackett JL, Krueger RF, Iacono WG, McGue M. Personality in middle childhood: A hierarchical structure and longitudinal connections with personality in late adolescence. J Res Pers 2008;42(6):1456-62.

92. Pullmann H, Raudsepp L, Allik J. Stability and change in adolescents' personality: A longitudinal study. Eur J Pers 2006; 20(6):447-59.

93. Wortman J, Lucas RE, Donnellan MB. Stability and change in the big five personality domains: Evidence from a longitudinal study of australians. Psychol Aging 2012;27(4):867-74.

94. Brunner R, Henze R, Richter J, Kaess M. Neurobiological findings in youth with borderline personality disorder. Scand J Child Adolesc Psychiatr Psychol 2015;3(1):22-30.

95. Caspi A, Roberts BW, Shiner RL. Personality development: Stability and change. Annu Rev Psychol 2005;56:453-84.

96. Kendler KS, Aggen SH, Czajkowski N, et al. The structure of genetic and environmental risk factors for DSM-IV personality disorders: A multivariate twin study. Arch Gen Psychiatry 2008;65(12):1438-46.

97. Kendler KS, Aggen SH, Knudsen GP, Røysamb E, Neale MC, Reichborn-Kjennerud T. The structure of genetic and environmental risk factors for syndromal and subsyndromal common DSM-IV axis I and all axis II disorders. Am J Psychiatry 2011;168(1):29-39.

98. de Fruyt F, de Clercq B. Antecedents of personality disorder in childhood and adolescence: Toward an integrative developmental model. Annu Rev Clin Psychol 2014;10:449-76.

99. Roberts BW, DelVecchio WF. The rank-order consistency of personality traits from childhood to old age: A quantitative review of longitudinal studies. Psychol Bull 2000;126(1):3-25.

100. de Clercq B, van Leeuwen K, van den Noortgate W, de Bolle M, de Fruyt F. Childhood personality pathology: Dimensional stability and change. Dev Psychopathol 2009;21(3):853-69.

101. Roberts BW, Mroczek D. Personality trait change in adulthood. Curr Dir Psychol Sci 2008;17(1):31-5.

102. Costello EJ, Copeland W, Angold A. Trends in psychopathology across the adolescent years: What changes when children become adolescents, and when adolescents become adults? J Child Psychol Psychiatry 2011;52(10):1015-25.

103. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Arch Gen Psychiatry 2005;62(6):593-602.

104. Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton R. Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. Arch Gen Psychiatry 2003;60(7):709-17.

105. Clark LA. Emergent issues in assessing personality pathology: Illustrations from two studies of adolescent personality and related pathology. J Psychopathol Behav Assess 2010:1-7.

106. Klonsky ED, Oltmanns TF. Informant-reports of personality disorder: Relation to self-reports and future research directions. Clin Psychol: Science and Practice 2002;9(3):300-11.

107. Morey LC. Personality disorders in childhood and adolescence: Conceptual challenges. J Psychopathol Behav Assess 2010:1-7.

108. Tackett JL. Measurement and assessment of child and adolescent personality pathology: Introduction to the special issue. J Psychopathol Behav Assess 2010;32:463-6.

109. Watson D. Stability versus change, dependability versus error: Issues in the assessment of personality over time. J Res Pers 2004;38(4):319-50.

110. Lenzenweger MF, Lane MC, Loranger AW, Kessler RC. DSM-IV personality disorders in the national comorbidity survey replication. Biol Psychiatry 2007;62(6):553-64.

111. Links PS, Eynan R. The relationship between personality disorders and axis I psychopathology: Deconstructing comorbidity. Annu Rev Clin Psychol 2013;9:529-54.

112. Links PS, Ansari JY, Fazalallasha F, Shah R. The relationship of personality disorders and axis I disorders. In: Widiger TA (eds). The Oxford Handbook of Personality Disorders. Oxford, UK: Oxford University Press; 2012. p. 237-59.

113. Bateman A, Fonagy P. Impact of clinical severity on outcomes of mentalisation-based treatment for borderline personality disorder. Br J Psychiatry 2013;203(3):221-7.

114. Crawford TN, Cohen P, First MB, Skodol AE, Johnson JG, Kasen S. Comorbid axis I and axis II disorders in early adolescence: Outcomes 20 years later. Arch Gen Psychiatry 2008;65(6):641-8.

115. Grilo CM, Sanislow CA, Shea MT, et al. Two-year prospective naturalistic study of remission from major depressive disorder as a function of personality disorder comorbidity. J Consult Clin Psychol 2005;73(1):78-85.

116. Jackson HJ, Burgess PM. Personality disorders in the community: Results from the Australian national survey of mental health and wellbeing part II. Relationships between personality disorder, axis I mental disorders and physical conditions with disability and health consultations. Soc Psychiatry Psychiatr Epidemiol 2002;37(6):251-60.

117. Zanarini MC, Frankenburg FR, Hennen J, Reich DB, Silk KR. Prediction of the 10-year course of borderline personality disorder. Am J Psychiatry 2006;163(5):827-32.

118. Chanen AM, Jovev M, Jackson HJ. Adaptive functioning and psychiatric symptoms in adolescents with borderline personality disorder. J Clin Psychiatry 2007;68(2):297-306.

119. Cohen P, Chen H, Crawford TN, Brook JS, Gordon K. Personality disorders in early adolescence and the development of later substance use disorders in the general population. Drug Alcohol Depend 2007;88 Suppl 1:S71-84.

120. Ha C, Balderas JC, Zanarini MC, Oldham J, Sharp C. Psychiatric comorbidity in hospitalized adolescents with borderline personality disorder. J Clin Psychiatry 2014;75(5):457-64.

121. Kaess M, von Ceumern-Lindenstjerna IA, Parzer P, et al. Axis I and II comorbidity and psychosocial functioning in female adolescents with borderline personality disorder. Psychopathology 2013;46(1):55-62.

122. Köhler D, Heinzen H, Hinrichs G, Huchzermeier C. The prevalence of mental disorders in a german sample of male incarcerated juvenile offenders. Int J Offender Ther Comp Criminol 2009;53(2):211-27.

123. Kasen S, Cohen P, Skodol AE, et al. Comorbid personality disorder and treatment use in a community sample of youths: A 20-year follow-up. Acta Psychiatr Scand 2007;115(1):56-65.

124. Feenstra DJ, Hutsebaut J, Laurenssen EM, Verheul R, Busschbach JJ, Soeteman DI. The burden of disease among adolescents with personality pathology: Quality of life and costs. J Pers Disord 2012;26(4):593-604.

125. Blasco-Fontecilla H, Baca-Garcia E, Dervic K, et al. Severity of personality disorders and suicide attempt. Acta Psychiatr Scand 2009;119(2):149-55.

126. Boisseau CL, Yen S, Markowitz JC, et al. Individuals with single versus multiple suicide attempts over 10 years of prospective follow-up. Compr Psychiatry 2013;54(3):238-42.

127. Oldham JM. Borderline personality disorder and suicidality. Am J Psychiatry 2006;163(1):20-6.

128. Alessi NE, McManus M, Brickman A, Grapentine L. Suicidal behavior among serious juvenile offenders. Am J Psychiatry 1984;141(2):286-7.

129. Johnson JG, Cohen P, Skodol AE, Oldham JM, Kasen S, Brook JS. Personality disorders in adolescence and risk of major mental disorders and suicidality during adulthood. Arch Gen Psychiatry 1999;56(9):805-11.

130. Yalch MM, Hopwood CJ, Fehon DC, Grilo CM. The influence of borderline personality features on inpatient adolescent suicide risk. Personal Disord 2014;5(1):26-31.

131. Brent DA, Johnson BA, Perper J, et al. Personality disorder, personality traits, impulsive violence, and completed suicide in adolescents. J Am Acad Child Adolesc Psychiatry 1994;33(8):1080-6.

132. Runeson B, Beskow J. Borderline personality disorder in young swedish suicides. J Nerv Ment Dis 1991;179(3):153-6.

133. Cawood CD, Huprich SK. Late adolescent nonsuicidal self-injury: The roles of coping style, self-esteem, and personality pathology. J Pers Disord 2011;25(6):765-81.

134. Jacobson CM, Muehlenkamp JJ, Miller AL, Turner JB. Psychiatric impairment among adolescents engaging in different types of deliberate self-harm. J Clin Child Adolesc Psychol 2008;37(2):363-75.

135. Nock MK, Joiner TE, Gordon KH, Lloyd-Richardson E, Prinstein MJ. Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. Psychiatry Res 2006, Sep 30;144(1):65-72.

136. Chen H, Cohen P, Johnson JG. Adolescent personality disorders and conflict with romantic partners during the transition to adulthood. J Pers Disord 2004;18(6):507-25.

137. Ehrensaft MK, Cohen P, Johnson JG. Development of personality disorder symptoms and the risk for partner violence. J Abnorm Psychol 2006;115(3):474-83.

138. Johnson JG, First MB, Cohen P, Skodol AE, Kasen S, Brook JS. Adverse outcomes associated with personality disorder not otherwise specified in a community sample. Am J Psychiatry 2005;162(10):1926-32.

139. Lavan H, Johnson JG. The association between axis I and II psychiatric symptoms and high-risk sexual behavior during adolescence. J Pers Disord 2002;16(1):73-94.

140. Johnson JG, Cohen P, Smailes E, et al. Adolescent personality disorders associated with violence and criminal behavior during adolescence and early adulthood. Am J Psychiatry 2000; 157(9): 1406-12.

141. Rey JM, Singh M, Morris-Yates A, Andrews G. Referred adolescents as young adults: The relationship between psychosocial functioning and personality disorder. Aust N Z J Psychiatry 1997;31(2):219-26.

142. Cailhol L, Jeannot M, Rodgers R, et al. Borderline personality disorder and mental healthcare service use among adolescents. J Pers Disord 2013;27(2):252-9.

143. Chen H, Cohen P, Crawford TN, Kasen S, Johnson JG, Berenson K. Relative impact of young adult personality disorders on subsequent quality of life: Findings of a community-based longitudinal study. J Pers Disord 2006;20(5):510-23.

144. Sailas ES, Feodoroff B, Lindberg NC, Virkkunen ME, Sund R, Wahlbeck K. The mortality of young offenders sentenced to prison and its association with psychiatric disorders: A register study. Eur J Public Health 2006;16(2):193-7.

145. Schulenberg JE, Sameroff AJ, Cicchetti D. The transition to adulthood as a critical juncture in the course of psychopathology and mental health. Dev Psychopathol 2004;16(04):799-806.

146. Bezirganian S, Cohen P, Brook JS. The impact of mother-child interaction on the development of borderline personality disorder. Am J Psychiatry 1993;150(12):1836-42.

147. Widom CS, Czaja SJ, Paris J. A prospective investigation of borderline personality disorder in abused and neglected children followed up into adulthood. J Pers Disord 2009;23(5):433-46.

148. Johnson JG, Cohen P, Chen H, Kasen S, Brook JS. Parenting behaviors associated with risk for offspring personality disorder during adulthood. Arch Gen Psychiatry 2006;63(5):579-87.

149. Zelkowitz P, Paris J, Guzder J, Feldman R. Diatheses and stressors in borderline pathology of childhood: The role of neuro-psychological risk and trauma. J Am Acad Child Adolesc Psychiatry 2001;40(1):100-5.

150. Moran P, Coffey C, Chanen A, Mann A, Carlin JB, Patton GC. Childhood sexual abuse and abnormal personality: A population-based study. Psychol Med 2010;41:1-8.

151. Johnson JG, Cohen P, Smailes EM, Skodol AE, Brown J, Oldham JM. Childhood verbal abuse and risk for personality disorders during adolescence and early adulthood. Compr Psychiatry 2001;42(1):16-23.

152. Battle CL, Shea MT, Johnson DM, et al. Childhood maltreatment associated with adult personality disorders: Findings from the collaborative longitudinal personality disorders study. J Pers Disord 2004;18(2):193-211.

153. Bernstein DP, Cohen P, Skodol A, Bezirganian S, Brook JS. Childhood antecedents of adolescent personality disorders. Am J Psychiatry 1996;153(7):907-13.

154. Helgeland MI, Kjelsberg E, Torgersen S. Continuities between emotional and disruptive behavior disorders in adolescence and personality disorders in adulthood. Am J Psychiatry 2005;162(10):1941-7.

155. Kasen S, Cohen P, Skodol AE, Johnson JG, Brook JS. Influence of child and adolescent psychiatric disorders on young adult personality disorder. Am J Psychiatry 1999;156(10):1529-35.

156. Kasen S, Cohen P, Skodol AE, Johnson JG, Smailes E, Brook JS. Childhood depression and adult personality disorder: Alternative pathways of continuity. Arch Gen Psychiatry 2001;58(3):231-6.

157. Zoccolillo M, Pickles A, Quinton D, Rutter M. The outcome of childhood conduct disorder: Implications for defining adult personality disorder and conduct disorder. Psychol Med 1992; 22(04):971-86.

158. Stepp SD, Burke JD, Hipwell AE, Loeber R. Trajectories of attention deficit hyperactivity disorder and oppositional defiant disorder symptoms as precursors of borderline personality disorder symptoms in adolescent girls. J Abnorm Child Psychol 2012; 40(1):7-20.

159. Storebø OJ, Simonsen E. Is ADHD an early stage in the development of borderline personality disorder? Nord J Psychiatry 2014;68(5):289-95.

160. Burke JD, Stepp SD. Adolescent disruptive behavior and borderline personality disorder symptoms in young adult men. J Abnorm Child Psychol 2012;40(1):35-44.

161. Chanen AM, Thompson K. Preventive strategies for borderline personality disorder in adolescents. Curr Treat Options Psych 2014;1(4):358-68.

162. Burke JD, Waldman I, Lahey BB. Predictive validity of childhood oppositional defiant disorder and conduct disorder: Implications for the DSM-V. J Abnorm Psychol 2010;119(4):739-51.

163. Frick PJ, Viding E. Antisocial behavior from a developmental psychopathology perspective. Dev Psychopathol 2009;21(4):1111-31.

164. Pardini DA, Frick PJ, Moffitt TE. Building an evidence base for DSM-5 conceptualizations of oppositional defiant disorder and conduct disorder: Introduction to the special section. J Abnorm Psychol 2010;119(4):683-8.

165. Thatcher DL, Cornelius JR, Clark DB. Adolescent alcohol use disorders predict adult borderline personality. Addict Behav 2005;30(9):1709-24.

166. Raine A. Schizotypal personality: Neurodevelopmental and psychosocial trajectories. Annu Rev Clin Psychol 2006;2:291-326.

167. Skodol AE, Bender DS, Pagano ME, et al. Positive childhood experiences: Resilience and recovery from personality disorder in early adulthood. J Clin Psychiatry 2007;68(7):1102-8.

168. Paris J, Perlin J, Laporte L, Fitzpatrick M, DeStefano J. Exploring resilience and borderline personality disorder: A qualitative study of pairs of sisters. Personal Ment Health 2014;8(3):199-208.

169. Chanen AM, Jovev M, McCutcheon LK, Jackson HJ, McGorry PD. Borderline personality disorder in young people and the prospects for prevention and early intervention. Current Psychiatry Reviews 2008;4(1):48-57.

170. Chanen AM, McCutcheon L. Prevention and early intervention for borderline personality disorder: Current status and recent evidence. Br J Psychiatry Suppl 2013;54:s24-9.

171. Garber J. Classification of childhood psychopathology: A develop-mental perspective. Child Dev 1984;55(1):30-48.

172. Masten AS, Roisman GI, Long JD, et al. Developmental cascades: Linking academic achievement and externalizing and internalizing symptoms over 20 years. Dev Psychol 2005;41(5):733-46.

173. Shiner RL, Masten AS. Childhood personality as a harbinger of competence and resilience in adulthood. Dev Psychopathol 2012;24(2):507-28.

174. Masten AS, Cicchetti D. Developmental cascades. Dev Psychopathol 2010;22(03):491-5.

175. McGorry PD. Issues for DSM-V: Clinical staging: A heuristic pathway to valid nosology and safer, more effective treatment in psychiatry. Am J Psychiatry 2007;164(6):859-60.

176. Chanen AM, McCutcheon LK, Jovev M, Jackson HJ, McGorry PD. Prevention and early intervention for borderline personality disorder. Med J Aust 2007;187(7 Suppl):S18-21.

177. Mrazek PB, Haggerty RJ, Institute OOM, United U, Congress.. Reducing risks for mental disorders frontiers for preventive intervention research. Washington, D.C.: National Academy Press; 1994.

178. Chanen AM. Borderline personality disorder in young people: Are we there yet? J Clin Psychol[In press].

179. Bateman AW, Gunderson J, Mulder R. Treatment of personality disorder. Lancet 2015;385:735-43.

180. Kendall T, Pilling S, Tyrer P, et al. Borderline and antisocial personality disorders: Summary of NICE guidance. BMJ 2009; 338:b93.

181. Chanen AM, Jackson HJ, McCutcheon LK, et al. Early intervention for adolescents with borderline personality disorder using cognitive analytic therapy: Randomised controlled trial. Br J Psychiatry 2008;193(6):477-84.

182. Chanen AM, Jackson HJ, McCutcheon LK, et al. Early intervention for adolescents with borderline personality disorder: Quasi-experimental comparison with treatment as usual. Aust N Z J Psychiatry 2009;43(5):397-408.

183. Chanen AM, McCutcheon LK, Germano D, Nistico H, Jackson HJ, McGorry PD. The HYPE clinic: An early intervention service for borderline personality disorder. J Psychiatr Pract 2009; 15(3):163-72.

184. Gleeson JFM, Chanen A, Cotton SM, Pearce T, Newman B, McCutcheon L. Treating co-occurring first-episode psychosis and borderline personality: A pilot randomized controlled trial. Early Interv Psychiatry 2011;6(1):21-9.

185. Bateman A, Fonagy P. Psychotherapy for borderline personality disorder: Mentalization-based treatment. Oxford: Oxford University Press; 2004.

186. Bateman A, Fonagy P. Mentalization-based treatment for borderline personality disorder: A practical guide. Oxford: Oxford University Press; 2006.

187. Bleiberg E, Rossouw T, Fonagy P. Adolescent breakdown and emerging personality disorder. In: Bateman AW, Fonagy P (eds). Handbook of mentalizing in mental health practice. Washington, DC: American Psychiatric Publishing; 2012. p. 463-509.

188. Rossouw TI, Fonagy P. Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. J Am Acad Child Adolesc Psychiatry 2012;51(12):1304-13.

189. Laurenssen EM, Hutsebaut J, Feenstra DJ, et al. Feasibility of mentalization-based treatment for adolescents with borderline symptoms: A pilot study. Psychotherapy (Chic) 2014;51(1):159-66.

190. Laurenssen EM, Westra D, Kikkert MJ, et al. Day hospital mentalization-based treatment (MBT-DH) versus treatment as usual in the treatment of severe borderline personality disorder: Protocol of a randomized controlled trial. BMC Psychiatry 2014;14:149.

191. Klein DA, Miller AL. Dialectical behavior therapy for suicidal adolescents with borderline personality disorder. Child Adolesc Psychiatr Clin N Am 2011;20(2):205-16.

192. Miller A, Carnesale MT, Courtney EA. Dialectical behavior therapy. In: Sharp C, Tackett JL (eds). Borderline personality disorder in children and adolescents. New York: Springer; 2014. p. 385-401.

193. Linehan M. Cognitive-behavioral treatment of borderline personality disorder. New York: The Guilford Press; 1993.

194. Mehlum L, Tørmoen AJ, Ramberg M, et al. Dialectical behavior therapy for adolescents with repeated suicidal and self-harming behavior: A randomized trial. J Am Acad Child Adolesc Psychiatry 2014;53(10):1082-91.

195. Blum N, Pfohl B, John DS, Monahan P, Black DW. STEPPS: A cognitive-behavioral systems-based group treatment for outpatients with borderline personality disorder—a preliminary report. Compr Psychiatry 2002;43(4):301-10.

196. Schuppert HM, Giesen-Bloo J, van Gemert TG, et al. Effectiveness of an emotion regulation group training for adolescents--a randomized controlled pilot study. Clin Psychol Psychother 2009;16(6):467-78.

197. Schuppert HM, Timmerman ME, Bloo J, et al. Emotion regulation training for adolescents with borderline personality disorder traits: A randomized controlled trial. J Am Acad Child Adolesc Psychiatry 2012;51(12):1314-1323.

198. Amminger GP, Chanen AM, Ohmann S, et al. Omega-3 fatty acid supplementation in adolescents with borderline personality disorder and ultra-high risk criteria for psychosis: A post hoc subgroup analysis of a double-blind, randomized controlled trial. Can J Psychiatry 2013;58(7):402-8.

199. Freedland KE, Mohr DC, Davidson KW, Schwartz JE. Usual and unusual care: Existing practice control groups in randomized controlled trials of behavioral interventions. Psychosom Med 2011;73(4):323-35.

200. Furukawa TA, Noma H, Caldwell DM, et al. Waiting list may be a nocebo condition in psychotherapy trials: A contribution from network meta-analysis. Acta Psychiatr Scand 2014;130(3):181-92.

201. Bateman A, Fonagy P. Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. Am J Psychiatry 2009; 166(12):1355-64.

202. Jørgensen CR, Freund C, Bøye R, Jordet H, Andersen D, Kjølbye M. Outcome of mentalization-based and supportive psychotherapy in patients with borderline personality disorder: A randomized trial. Acta Psychiatr Scand 2013;127(4):305-17.

203. McMain SF, Links PS, Gnam WH, et al. A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. Am J Psychiatry 2009; 166(12):1365-74.

204. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. The personality disorders institute/borderline personality disorder research foundation randomized control trial for borderline personality disorder: Rationale, methods, and patient characteristics. J Pers Disord 2004;18(1):52-72.

205. Bamelis LL, Evers SM, Spinhoven P, Arntz A. Results of a multicenter randomized controlled trial of the clinical effectiveness of schema therapy for personality disorders. Am J Psychiatry 2014;171(3):305-22.

206. Bateman AW. Treating borderline personality disorder in clinical practice. Am J Psychiatry 2012;169(6):560-3.

207. Benish SG, Imel ZE, Wampold BE. The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. Clin Psychol Rev 2008;28(5):746-58.

208. Imel ZE, Wampold BE, Miller SD, Fleming RR. Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. Psychol Addict Behav 2008;22(4):533-43.

209. Miller S, Wampold B, Varhely K. Direct comparisons of treatment modalities for youth disorders: A meta-analysis. Psychother Res 2008;18(1):5-14.

210. Spielmans GI, Pasek LF, McFall JP. What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. Clin Psychol Rev 2007;27(5):642-54.

211. Rosenzweig S. Some implicit common factors in diverse methods of psychotherapy. Am J of Orthopsychiatry 1936;6(3):412-5.

212. Duncan BL, Miller SD, Wampold BE, Hubble MA. The heart and soul of change: Delivering what works in therapy. 2nd ed. American Psychological Association; 2009.

213. Lambert MJ. Early response in psychotherapy: Further evidence for the importance of common factors rather than "placebo effects". J Clin Psychol 2005;61(7):855-69.

214. Psychotherapy relationships that work: evidence-based responsiveness. New York: Oxford University Press; 2011.

215. Lambert MJ. The efficacy and effectiveness of psychotherapy. In: Lambert MJ (eds). Bergin and Garfield's handbook of psychotherapy and behavior change. 6th ed. New York: Wiley. 2013. p. 169-218.

216. Wampold BE, Minami T, Tierney SC, Baskin TW, Bhati KS. The placebo is powerful: Estimating placebo effects in medicine and psychotherapy from randomized clinical trials. J Clin Psychol 2005;61(7):835-54.

217. Allen JG, Fonagy P, Bateman A. Mentalizing in clinical practice. Washington, DC: American Psychiatric Pub; 2008.

218. Fonagy P, Allison E. The role of mentalizing and epistemic trust in the therapeutic relationship. Psychotherapy 2014;51(3):372-80.

219. Kongerslev M, Simonsen S, Bo S. The quest for tailored treatments: A meta-discussion of six social cognitive therapies. J Clin Psychol 2015;71(2):188-98.

220. Bevington D, Fuggle P, Fonagy P, Target M, Asen E. Innovations in practice: Adolescent mentalization-based integrative therapy (AMBIT)--a new integrated approach to working with the most hard to reach adolescents with severe complex mental health needs. Child Adolesc Ment Health 2013;18(1):46-51.

221. Bevington D, Fuggle P, Fonagy P. Applying attachment theory to effective practice with hard-to-reach youth: The AMBIT approach. Attach Hum Dev 2015;17(2):157-74.

222. Gearing RE, Townsend L, Elkins J, El-Bassel N, Osterberg L. Strategies to predict, measure, and improve psychosocial treatment adherence. Harv Rev Psychiatry 2014;22(1):31-45.

223. Gearing RE, Schwalbe CS, Short KD. Adolescent adherence to psychosocial treatment: Mental health clinicians' perspectives on barriers and promoters. Psychother Res 2012;22(3):317-26.

224. McMurran M, Huband N, Overton E. Non-completion of personality disorder treatments: A systematic review of correlates, consequences, and interventions. Clin Psychol Rev 2010;30(3):277-87.

225. Lambert MJ, Ogles BM. The efficacy and effectiveness of psychotherapy. In: Lambert MJ (eds). Bergin and Garfield's handbook of psychotherapy and behavior change. 5th ed. New York: Wiley; 2004. p. 139-93.

226. Wampold BE. The great psychotherapy debate models, methods, and findings. Mahwah, N.J.: L. Erlbaum; 2001.

227. Warren JS, Nelson PL, Mondragon SA, Baldwin SA, Burlingame GM. Youth psychotherapy change trajectories and outcomes in usual care: Community mental health versus managed care settings. J Consult Clin Psychol 2010;78(2):144-55.

228. Feenstra DJ, Laurenssen EMP, Hutsebaut J, Verheul R, Busschbach JJV. Predictors of treatment outcome of inpatient psychotherapy for adolescents with personality pathology. Personal Ment Health 2014;8(2):102-14.

229. Clarke S, Thomas P, James K. Cognitive analytic therapy for personality disorder: Randomised controlled trial. Br J Psychiatry 2013;202:129-34.

230. Mulder R, Chanen AM. Effectiveness of cognitive analytic therapy for personality disorders. Br J Psychiatry 2013;202:89-90.

231. Chapman CL, Burlingame GM, Gleave R, Rees F, Beecher M, Porter GS. Clinical prediction in group psychotherapy. Psychother Res 2012;22(6):673-81.

232. Walfish S, McAlister B, O'Donnell P, Lambert MJ. An investigation of self-assessment bias in mental health providers. Psychol Rep 2012;110(2):639-44.

233. Whipple JL, Lambert MJ. Outcome measures for practice. Annu Rev Clin Psychol 2011;7:87-111.

234. Del Re AC, Flückiger C, Horvath AO, Symonds D, Wampold BE. Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. Clin Psychol Rev 2012;32(7):642-9.

235. Shirk SR, Karver MS, Brown R. The alliance in child and adolescent psychotherapy. Psychotherapy (Chic) 2011;48(1):17-24.

236. Baldwin SA, Wampold BE, Imel ZE. Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. J Consult Clin Psychol 2007;75(6):842-52.

237. Falkenström F, Granström F, Holmqvist R. Therapeutic alliance predicts symptomatic improvement session by session. J Couns Psychol 2013;60(3):317-28.

238. Høglend P. Exploration of the patient-therapist relationship in psychotherapy. Am J Psychiatry 2014;171(10):1056-66.

239. Safran JD, Muran JC, Eubanks-Carter C. Repairing alliance ruptures. Psychotherapy (Chic) 2011;48(1):80-7.

240. Høglend P, Hersoug AG, Bøgwald KP, et al. Effects of transference work in the context of therapeutic alliance and quality of object relations. J Consult Clin Psychol 2011;79(5):697-706.

241. Lambert MJ. Helping clinicians to use and learn from research-based systems: The OQ-analyst. Psychotherapy 2012;49(2):109-14.

242. APA presidential task force on evidence-based practice. Evidence-based practice in psychology. Am Psychol 2006;61(4):271-85.

243. Hume D. A treatise of human nature. Harmondsworth: Penguin Books; 1984.

244. Forth AE, Bo S, Kongerslev M. Assessment of psychopathy: The hare psychopathy checklist measures. In: Kiehl KA, Sinnott-Armstrong WP (eds). Handbook on psychopathy and law. New York: Oxford University Press; 2013. p. 5-33.

245. Aviram RB, Brodsky BS, Stanley B. Borderline personality disorder, stigma, and treatment implications. Harv Rev Psychiatry 2006;14(5):249-56.

246. Rüsch N, Hölzer A, Hermann C, et al. Self-stigma in women with borderline personality disorder and women with social phobia. J Nerv Ment Dis 2006;194(10):766-73.

247. Bodner E, Cohen-Fridel S, Mashiah M, et al. The attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with borderline personality disorder. BMC Psychiatry 2015;15:2.

248. Skodol AE, Bender DS, Morey LC, et al. Personality disorder types proposed for DSM-5. J Pers Disord 2011;25(2):136-69.

249. Tyrer P, Reed GM, Crawford MJ. Classification, assessment, prevalence, and effect of personality disorder. The Lancet 2015; 385(9969):717-26.

250. Yudkin JS, Montori VM. The epidemic of pre-diabetes: The medicine and the politics. BMJ 2014;349:g4485.

251. Stern DN. The interpersonal world of the infant: A view from psychoanalysis and developmental psychology. New York: Basic Books; 2000.

252. Johnstone L, Cooke DJ. Psychopathic-like traits in childhood: Conceptual and measurement concerns. Behav Sci Law 2004; 22(1):103-25.

253. Egger HL, Emde RN. Developmentally sensitive diagnostic criteria for mental health disorders in early childhood: The diagnostic and statistical manual of mental disorders-IV, the research diagnostic criteria-preschool age, and the diagnostic classification of mental health and developmental disorders of infancy and early childhood-revised. Am Psychol 2011;66(2):95-106.

254. Tyrer P, Crawford M, Mulder R. Reclassifying personality disorders. Lancet 2011;377:1814-5.

255. McGorry PD, Hickie IB, Yung AR, Pantelis C, Jackson HJ. Clinical staging of psychiatric disorders: A heuristic framework for choosing earlier, safer and more effective interventions. Aust N Z J Psychiatry 2006;40(8):616-22.

256. McGorry P. Early clinical phenotypes and risk for serious mental disorders in young people: Need for care precedes traditional diagnoses in mood and psychotic disorders. Can J Psychiatry 2013;58(1):19-21.

257. McGorry PD. Risk syndromes, clinical staging and DSM V: New diagnostic infrastructure for early intervention in psychiatry. Schizophr Res 2010;120(1-3):49-53.

258. Chanen AM, Thompson K. Borderline personality and mood disorders: Risk factors, precursors and early signs in childhood and youth. In: Choi-Kain L, Gunderson J (eds). Borderline personality and mood disorders: Comorbidity and controversy. New York: Springer; 2015. p. 155-74.

259. McGorry P, van Os J. Redeeming diagnosis in psychiatry: Timing versus specificity. Lancet 2013;381(9863):343-5.

260. Lambert MJ. Outcome in psychotherapy: The past and important advances. Psychotherapy (Chic) 2013;50(1):42-51.

261. Livesley WJ. Practical management of personality disorder. New York: Guilford Press; 2003.