Unique Features of Peer Relationships in Specific Developmental Periods Predict Borderline Personality Disorder vs. Major Depressive Disorder in Late Adolescence

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Unique Features of Peer Relationships in Specific Developmental Periods Predict Borderline Personality Disorder vs. Major Depressive Disorder in Late Adolescence

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Abstract

It is well established that peer relationships and psychopathology reciprocally influence each other across development, but it is less clear how different trajectories of peer functioning are associated with specific psychiatric disorders. To better understand how such trajectories might differentially predict risk for two debilitating diagnoses – borderline personality disorder (BPD) and major depressive disorder (MDD) - the current study explored how bullying victimization, peer acceptance, and

relational aggression, measured repeatedly across two distinct developmental periods, namely ages 3-8 (early childhood) and ages 9+ (middle childhood-adolescence), might individually and in combination predict BPD and MDD symptoms in adolescence. Elevated relational aggression in early childhood uniquely predicted greater adolescent BPD symptoms, whereas sustained peer acceptance from middle childhood through adolescence protected males against adolescent MDD, highlighting the need for timing- and sex-specific screening and prevention.

Introduction

Development of the capacity to establish and maintain meaningful interpersonal relationships is a core task of childhood and adolescence; failure to do so is consistently associated with increased risk for

psychopathology (Deater-Deckard, 2001; Hay et al., 2004). However, psychopathology and negative experiences with peers can transact to worsen both mental health and peer functioning over time (Parker et al., 2006). For example, social problems amplify negative affect and beliefs, which then erode future peer success, creating self-reinforcing cycles. While such interactions may occur across a variety of psychiatric disorders, the specific profile of maladaptive peer interactions likely differs across psychiatric disorders even from a young age (Parker et al., 2006), such that the specific nature of dysfunctional peer relationships a child experiences may both reflect and contribute to the unique psychiatric symptoms and disorder(s) they are experiencing. For example, prior research indicates that peer relationships, encompassing peer acceptance or rejection, bullying, and relational aggression, could play a crucial role in the development and persistence of both borderline personality disorder (BPD) and major depressive disorder (MDD) in childhood and adolescence (Crick et al., 2005; Modin et al., 2011; Runions et al., 2021). We therefore focus on BPD and MDD, two conditions in which childhood-adolescent peer functioning is closely tied to both risk and course, yet there is a notable gap in research examining the longitudinal developmental pathways linking specific aspects of peer relationships to both disorders. Understanding these trajectories is important, as both commonly emerge during adolescence, impair affected individuals, are costly to society, and are strongly influenced by peers and other social relationships (Bodden et al.,

2018; Bozzatello et al., 2019). By utilizing a unique longitudinal dataset, the present study assessed whether specific aspects of peer relationships experienced during two developmental periods (early childhood vs. middle childhood adolescence) are associated with later BPD and MDD.

Associations of Peer Acceptance with BPD and MDD

Peer acceptance is defined as the degree to which a child is socially accepted or rejected by their peer group (Miller-Johnson et al., 2002). Peer acceptance and social integration are essential developmental tasks from childhood through adolescence, with large cohort and longitudinal studies confirming that low peer acceptance and related problems (e.g., social withdrawal, aggression) are consistently linked to increased risk for internalizing and externalizing disorders, including anxiety and depression (Morneau-Vaillancourt et al., 2025; Martínez et al., 2024; Dryburgh et al., 2025). Meta-analyses and genetically informed studies have shown that peer problems in youth predict anxiety and depression in emerging adulthood, independent of familial and genetic factors (Morneau-Vaillancourt et al., 2025; Faur et al., 2024; Christina et al., 2021). Not only is peer acceptance likely to differentially impact symptoms, but a developmental psychopathology perspective suggests that there may be period-specific effects. In early childhood, the influence of peer acceptance may be less pronounced, as peer groups are more fluid and adult guided but remain foundational for future social and emotional development (Huber et al., 2019; Blandon et al., 2010; Hay et al., 2004). By later childhood and into

adolescence, social reorientation and pubertal onset heighten both neural and motivational sensitivity to peer evaluations and status, making changes in peer acceptance/rejection especially consequential for psychopathology symptoms (Capella et al., 2023; Venticinque et al., 2024).

Consistent with this, across adolescence, higher perceived social acceptance predicts better concurrent and long-term psychosocial adjustment, whereas lower acceptance is linked to greater depressive symptoms and risk for MDD. (Shah et al 2024; Adedeji et al., 2022, Schwartz-Mette et al., 2020). Importantly, peer acceptance is not only correlated with depression but also shows longitudinal bidirectional coupling with depressive symptoms (Yu et al., 2024). Adolescents with lower perceived acceptance are more likely to develop depressive symptoms over time, and those with depressive symptoms are at increased risk for subsequent peer difficulties, as demonstrated in both prospective cohort and cross-lagged analyses (Zhao et al., 2023; Beeson et al., 2020). These findings underscore the central role of peer acceptance as both a predictor and a consequence of adolescent depression.

Peer acceptance is also salient to BPD because early peer acceptance may decrease rejection sensitivity over time (Feldman & Downey, 1994), a core feature of BPD (Foxhall et al., 2019). The findings suggest that these patterns start early, in accordance with Linehan’s (1993) biosocial theory of BPD: children and adolescents who experience less peer acceptance show more borderline personality features (Crick et al., 2005; Ostrov & Houston,

2008), whereas adolescents with BPD appear more sensitive to experimental manipulations of peer acceptance (Lawrence et al., 2011; Stead et al., 2023). A recent review revealed pervasive peer-relationship difficulties, including problems maintaining peer acceptance within the broader peer context, as characteristic of youth with BPD features (Runions et al., 2021). Given prior evidence, the current study considers peer acceptance a potential predictor of both BPD and MDD, although we anticipate stronger associations with MDD in middle childhood-adolescence.

Associations of bullying victimization with BPD and MDD

Bullying consists of repeated, harmful actions between peers (Olweus, 1993) and has been associated with psychopathology from childhood into adulthood (Arseneault et al., 2010; Evans-Lacko et al., 2017; Gibb et al., 2011; Moore et al., 2017). Longitudinal work implicates bullying victimization in the emergence of both BPD and MDD. In the Adolescent Brain Cognitive Development (ABCD) cohort of 11,844 children (mean baseline age ≈ 9.9 years), approximately 20% reported victimization, and greater exposure predicted increases in MDD symptoms across two years (Martinez et al., 2024). In addition, a 2025 longitudinal study of over 26,000 adolescents by Cheng et al. demonstrated that bullying victimization consistently led to increased internalizing symptoms (including depression) for both genders and reduced friendship and social support for girls. A 2024 meta-analysis of adolescent studies (27 samples) revealed that peer victimization was associated with 2.8x greater odds of depression (Song et

al., 2024). While peer victimization can be consequential in both early and middle childhood, it appears that effects often stabilize and compound during the later window and into adolescence when exposure becomes more chronic and sensitivity to peer evaluation increases.

Similarly, prospective cohorts have shown that childhood victimization forecasts early adolescent BPD symptoms and self-injury, particularly under adverse family circumstances (Wolke et al., 2012; Lereya et al., 2013). Additional research highlights the relationship between childhood dysregulated behaviors, including bullying victimization, and the presence of BPD symptoms by early adolescence (Winsper et al., 2017; Jopling et al., 2018; Wlodarczyk & Lawn, 2017; Wertz et al., 2020). A recent multilevel meta-analysis synthesizing 106 studies (N = 86,871) confirmed that problematic peer relationships—such as bullying and relational aggression—represent moderate and temporally stable risk factors for BPD features, comparable in magnitude to established predictors such as emotion dysregulation and early psychopathology, thereby reinforcing a transactional developmental model for BPD (Cavicchioli et al., 2024). Given prior evidence, the current study considers peer victimization as a potential predictor of both BPD and MDD.

Associations of RA with BPD and MDD

A third variable of interest when investigating peer problems and psychopathology is relational aggression. Unlike physical aggression, which relies on causing physical harm or the threat of it, relational aggression

operates on a psychological level by damaging relationships or threatening them (Crick & Grotpeter, 1995). This can include exclusion, rumor spread, or the withdrawal of friendships. Relational aggression is linked to broad adjustment difficulties, including peer rejection, poor-quality friendships, and increases in both internalizing and externalizing problems (Crick et al., 1997; Prinstein et al., 2001; Werner & Crick, 1999). Longitudinal studies consistently affirm a strong positive correlation between relational aggression and internalizing problems across various developmental stages (Blain-Arcaro & Vaillancourt, 2017; Fite et al., 2011; Garber & Flynn, 2001), which can be linked to the development of MDD later in life. For example, Crick and colleagues (2006) demonstrated that perpetrating relational aggression foretells a gradual amplification in internalizing symptoms among school-age children, and other studies have reported that this pattern holds across demographic variables and accounts for rates of physical aggression (Crick et al., 1997; Murray-Close et al., 2007). More recent longitudinal work further supports a transactional model: Ji et al. (2025) identified bidirectional associations between aggression—including relational aggression—and depressive symptoms from late childhood through mid-adolescence, with academic difficulties mediating the pathway from depression to subsequent aggression.

A substantial body of literature also connects relational aggression to borderline features—childhood relational aggression predicts adolescent borderline symptoms over and above physical aggression—with evidence

from both community and clinical samples (Crick et al. 2005; Ostrov & Houston, 2008; Stepp et al., 2012; Tackett & Ostrov, 2010; Underwood et al., 2011). Several possible mechanisms may explain why RA is particularly linked to BPD risk. The core features of BPD— identity disturbance, affective instability, and unstable interpersonal relationships—closely mirror the consequences and dynamics of RA. Children who engage in relational aggression often exhibit preoccupation with relational concerns and form intense, enmeshed relationships (Geiger & Crick, 2001). They also display heightened sensitivity to relational events, including hypervigilance and distress, in response to interpersonal stressors (Crick et al., 2002; Mathieson et al., 2011). These relational vulnerabilities may foster the use of sensitive information acquired during close interactions as a tool in conflicts, further perpetuating aggressive behaviors (Grotpeter & Crick, 1996).

The meaning and impact of RA likely changes across development. In early childhood, relational aggression is less normative and may occur as isolated incidents that provide scaffolding for its later use as a persistent interpersonal style; higher levels at this stage are consistently associated with increased risk for BPD features. By later childhood and adolescence, relational aggression becomes more integrated into ongoing peer interactions, as sensitivity to peer evaluations and social status increase. Given prior evidence, the current study considers RA a potential predictor of both BPD and MDD.

Associations between sex, peer dynamics and the risk of BPD and MDD

Sex can shape how peers experience BPD and MDD, but effects are mixed across constructs and samples. For peer victimization and MDD, multiple longitudinal studies and meta-analyses have demonstrated that the association and transactional coupling are generally stronger for girls than boys (Israel & Gibb, 2023; Fredrick et al., 2022). Likewise, large cohorts show that victimization predicts internalization (including depression) in both sexes, with reduced friendship and social support, specifically for girls (Cheng et al., 2025).

The patterns of peer victimization and BPD features vary. For example, Vaillancourt et al. (2014) demonstrated that childhood relational aggression and depression predict BPD features in boys, whereas physical and relational aggression, depression, and ADHD predict BPD features in girls. For girls, physical aggression was the strongest predictor of BPD features, whereas for boys, all risk indicators had similar predictive impacts. Antila et al. (2017) reported that female victims of bullying had an almost fourfold increased risk of developing a personality disorder (mostly BPD) in early adulthood, whereas no such association was found for males.

With respect to peer acceptance/rejection and relational aggression, sex often moderates associations for both BPD and MDD. Girls tend to be more affected by relational victimization and peer rejection, which are linked to higher internalizing symptoms and BPD features, yet boys also

exhibit meaningful risk (Israel et al., 2023; Fredrick et al., 2022; Cheng et al., 2025; Vaillancourt et al., 2014; Antila et al., 2017). These findings highlight the importance of considering sex-specific pathways in understanding the risk for BPD and MDD.

The Current Study

Although prior research has established associations between peer relationships and BPD and MDD, no longitudinal study to date has simultaneously examined these disorders using repeated assessments of peer functioning across early development to inform the developmental specificity and course of this risk trajectory. The current study leverages data from a 17-year prospective longitudinal cohort that began in the preschool period (ages 3–5) and oversampled children with elevated depressive and disruptive symptoms. Peer functioning was assessed repeatedly across childhood and adolescence (up to 8 times per child), providing a rare opportunity to examine the developmental trajectories of three core domains of peer relations—peer acceptance, bullying victimization, and relational aggression—and their unique and interactive contributions to later psychopathology. Specifically, the present analyses test whether distinct trajectories of these peer experiences during unique developmental periods differentially predict BPD versus MDD symptom severity in late adolescence. We hypothesize that BPD symptoms are most strongly associated with trajectories of RA, whereas MDD symptoms are more closely linked to low peer acceptance. We hypothesize that both BPD

symptoms and MDD symptoms are associated with increased reports of bullying/peer victimization. As there is growing evidence that these peer variables may interact to influence the development of both BPD and MDD, additional analyses further examine potential interactive effects between peer variables in predicting adolescent BPD and MDD outcomes.

Methods

Participants

The participants were 306 (148 females) children enrolled in the longitudinal Preschool Depression Study at the Washington University School of Medicine in the St. Louis Early Emotional Development Program, which prospectively investigated associations between childhood factors and later adolescent outcomes (Luby et al., 2009; Figure 1). Participants were initially recruited during the preschool period (ages 3.0--5.11) from daycare and primary care centers in the St. Louis region, and the final sample of 306 children was selected after oversampling for higher depressive and disruptive symptoms on the basis of scores from the Preschool Feelings Checklist but also included children with no psychopathology (Luby et al., 2004). Children and their caregivers completed the baseline (T1) assessment and up to 9 follow-up assessments (T2--T10). Waves T1--T3 occurred at 1-year intervals; then, after an approximately 2.5-year period, waves T4--T8 also occurred approximately one year apart. Finally, T9 occurred approximately 3 years after T8, with T10 occurring approximately 2 years after T9. The participants were

between the ages of 13 and 21 at waves T9--T10. In addition to the 306 patients who began the study at T1, 42 healthy subjects (20 F) were included in the study at T6 to increase the size of the healthy comparison group. The 189 children included in the present study (see Table 1 for descriptive statistics) were assessed with the MacArthur Health and Behavior Questionnaire–Parent (HBQ-P) during at least one of the first eight assessment waves (T1--T8) and had BPD/MDD data from one or both final adolescent waves (T9--T10).

Preschool-to-School-Age Peer Relationships

The MacArthur Health and Behavior Questionnaire–Parent (HBQ-P) (Essex et al., 2002) is a parent-report questionnaire that includes scales of children's social functioning. It is a validated, psychometrically robust parent-report tool for assessing internalizing, externalizing, and attention problems in children under 9 years of age, demonstrating strong reliability, cross-informant agreement, and discriminant validity, and it performs well against structured diagnostic interviews—especially for detecting underrecognized internalizing disorders (Lemery-Chalfan et al., 2007; Luby, J. L et al., 2002). The HBQ-P for middle childhood was administered when the subjects were aged 3--8 years and younger, and the HBQ-P for late childhood and adolescence was administered when the participants were aged 9 years and older through the T8 assessment. These were completed up to 8 times from early childhood into adolescence. Table S1 details the items from the two HBQ-P versions that were included in the Bullied by

Peers, Peer Acceptance, and Relational Aggression subscales. The values for the Bullied by Peers and Peer Acceptance items were 1=not at all, 2=very little, 3=somewhat, and 4=very much, whereas the values for the Relational Aggression items were 0=never or not true, 1=sometimes or somewhat true, and 2=often or very true. Subscale scores are the means of the items, and higher scores indicate more bullying by peers, greater peer acceptance, and greater relational aggression. The Cronbach's alphas of the HBQ-P for middle childhood and the HBQ-P for late childhood and adolescence were 0.73--0.81 and 0.82--0.91, respectively, for bullied by peers; 0.81--0.89 and 0.85--0.91, respectively, for peer acceptance; and 0.81--0.87 and 0.73--0.83, respectively, for relational aggression.

Adolescent Outcomes

BPD symptoms

Adolescents (aged 13--21 years) self-reported BPD symptoms via the Borderline Personality Features Scale for Children (BPFS-C) (Crick et al., 2005), which has demonstrated high criterion validity (Chang et al., 2011; Sharp et al., 2011). The BPFS-C has 24 items rated on a scale ranging from 1=not at all true to 5=always true. The BPFS-C total score is the sum of the items, with values ranging from 24 to 120 and higher scores indicating greater BPD severity. For participants completing the BPFS-C at both adolescent assessments, the maximum BPFS-C total score was used for analysis.

MDD Symptoms

Adolescents (aged 13--21) and caregivers were interviewed via the Kiddie Schedule for Affective Disorders and Schizophrenia (KSADS; (Birmaher et al., 2009)). For subjects aged 18 or older at T10, only the subject was interviewed. An MDD core score was defined as the number of 9 core MDD symptoms endorsed at a threshold level by either the parent or the child so that higher scores indicate greater MDD severity. When participants completed the KSADS at both adolescent assessments, the maximum of their two scores was used for analysis.

Covariates

Age at the last assessment and parent-reported sex at preschool age were included as covariates in all analyses of BPD/MDD outcomes.

Income-to-needs ratio. Caregivers reported their family income at the baseline assessment. The income-to-needs ratio was computed as the total family income divided by the federal poverty level, which was based on family size, at the time of data collection (McLoyd, 1998).

Analytic Plan

Multilevel models of the HBQ-P Bullied by Peers, Peer Acceptance, and Relational Aggression subscales across waves T1--T8 were conducted in SAS v9.4. Separate models were conducted for the early childhood (ages 3--8) and late childhood/adolescence (ages 9 and older) versions of the HBQ-P. These models included random intercept and slope components and assumed an unstructured covariance structure. The time variable was age at assessment, centered at the median age of 6 years for the younger

version and 11 years for the older version. Individual subject intercepts and slopes were extracted and examined as potential predictors of BPD and MDD severity at waves T9/T10. Separate general linear models were used to assess the relationships between the 6 intercept and slope variables for each developmental period (independent variables) and BPD and MDD severity (dependent variables) covaried for age at the last assessment, the baseline income-to-needs ratio, and sex.

The effect of sex on the relationship between the peer measures and BPD and MDD severity was assessed by running the above models separately in males and females and by including the interaction between the intercepts/slopes and sex in the models to test for moderating effects.

Finally, interactions between the Peer Acceptance and Relational Aggression intercepts and slopes were assessed in separate general linear models for each outcome and developmental period, covarying for age at last assessment, baseline income-to-needs ratio, and sex.

To account for multiple comparisons, the false discovery rate (FDR) correction (Benjamini & Hochberg 1995) was applied to each set of 6 models for each developmental period in the primary analyses of BPD and MDD severity outcomes and the follow-up models separating the sample by sex and with sex as a moderator.

Results

The participant characteristics are presented in Table 1. The sample was 50.8% female, 54.0% white, 34.4% black, and 11.6% more than one

race and had a baseline income-to-needs ratio of 2.04 (SD=1.12). The means and standard deviations, along with the minimum and maximum values for all predictor and outcome variables, are presented in Table 1, and a comparison of the characteristics of the included and excluded subjects from the analyses is shown in Table S2.

BPD symptoms

As shown in Table 2, the Relational Aggression intercept during early childhood was significantly positively associated with the BPFS-C total score, indicating that greater aggression at age 6 was associated with greater BPD severity in adolescence. Several findings did not survive FDR correction: the Relational Aggression intercept during late childhood/adolescence was positively associated with the BPFS-C total score; the Peer Acceptance slope during late childhood/adolescence was negatively associated with the BPFS-C total score; and in males, the Relational Aggression slope during late childhood/adolescence was positively associated with BPD severity. Sex was not a significant moderator for any of the peer intercepts or slopes in either of the developmental periods.

MDD Symptoms

Both the peer acceptance intercept and slope in late childhood/adolescence were negatively associated with the MDD core score, indicating that greater peer acceptance at age 11 and a sharper increase in peer acceptance across late childhood/adolescence were associated with

fewer MDD symptoms in adolescence, but these results did not survive FDR correction (Table 3). However, in males, the relationship between the Peer Acceptance slope in late childhood/adolescence survived FDR correction. Sex did not moderate any of the MDD core score models.

Interaction between Peer Variables

No significant interactions were found between peer acceptance and relational aggression and MDD or BPD in adolescence.

Discussion

The purpose of this study was to investigate how childhood peer interactions, such as acceptance, bullying/peer victimization, and relational aggression, predict the emergence of BPD or MDD in adolescence and how these may differ by sex. We found that higher RA levels in early to middle childhood were linked to increased severity of BPD symptoms in adolescence. Additionally, in males, a steeper increase in peer acceptance over late childhood adolescence was linked to fewer symptoms of MDD in adolescence. In our analyses, bullying/victimization was not related to BPD or MDD symptoms, nor were interactions between peer variables.

These findings align with developmental cascade models, which posit that early social challenges can initiate a sequence of problematic interactions, ultimately leading to adverse psychosocial outcomes (Masten & Wright, 2009). In this context, both the initial level (intercept) and change over time (slope) of peer variables serve as leading indicators of later psychopathology, which is consistent with the notion that failure to

complete salient developmental tasks in peer relationships can set off a cascade of risk for BPD and MDD (Masten et al., 2005). The social information processing model further clarifies these pathways, suggesting that children who experience peer rejection or engage in relational aggression may develop biased interpretations of social cues, maladaptive attributions regarding peers' behaviors, and patterns of reinforcement or punishment that perpetuate these behaviors (Crick & Dodge, 1994). Over time, these processes can entrench relational aggression and peer rejection, amplifying risk for both BPD and MDD patients.

Our finding that for males, increases in peer acceptance from age 9 predicted fewer MDD symptoms in adolescence is intuitive in light of prior research. Peer rejection entails negative judgments about the target of the rejection, and these statements may be internalized over time, gradually taking the form of depression (Card, 2010; Duffy et al., 2020). Similarly, social isolation, especially in middle childhood and adolescence, when withdrawn is seen as nonnormative (Younger et al., 1993), can easily engender feelings of loneliness that contribute to depression (Hymel et al., 1990). By considering several aspects of peer functioning simultaneously, these analyses reinforce a previous finding that peer acceptance may be especially predictive of depressive symptoms relative to other peer-related constructs (Adedeji et al., 2022.

Our finding that early RA predicts subsequent BPD symptoms both accords with and advances the existing literature. Crick et al. (2005) were

the first to propose that relational aggression might be a potentially prominent factor in a developmental psychopathology approach to the underpinnings of BPD, and Underwood and colleagues (2011) demonstrated that the developmental paths of aggressive behavior were predictive of borderline personality features (BPFs) at age 14. The current results extend these findings by demonstrating associations over a longer and earlier developmental window than previous studies (Cramer et al., 2016); they also suggest directionality (i.e., that engaging in relational aggression early may predict BPD features later). Importantly, our results showed that the intercept of RA in early to middle childhood, but not the trajectory, predicted BPD symptoms in adolescence. These findings suggest that these associations are already present at an early age and that stable, elevated RA in childhood may serve as a reliable marker of BPD risk across development. Since rates of relational aggression seem fairly stable across childhood (Nelson et al., 2014), this behavior may serve as a relatively reliable early predictor of BPD risk across childhood and adolescence.

Strengths and Limitations

While our study provides valuable insights, it is important to acknowledge several limitations that should be considered when interpreting the findings. First, adolescents self-reported their borderline personality features in our study, which may introduce response and recall biases. While self-reports offer insights into the subjective experiences and self-perceptions of individuals, they may not always align with objective

assessments, and interviews are generally considered the gold standard assessment method for BPD (Hopwood et al., 2008).

Second, the absence of BPD feature measurement in preschool-aged and school-aged children introduces a limitation in inferring the directionality of our findings, as it is not possible to conduct bidirectional models. Without early childhood data on BPD features, we cannot definitively determine whether RA precedes or follows the emergence of BPD features in adolescence. Therefore, caution should be exercised when interpreting the implied directionality of our findings. Third, our study was based on secondary data analysis, as the original data collection was designed primarily to validate measures of preschool depression. As a result, there were limitations in the types and scopes of assessments that could be conducted. Finally, the HBQ-P was used to measure peer relationships; as a parent-report questionnaire, it is potentially subject to reporter bias, although prior research by Luby and colleagues (2002) has demonstrated encouraging levels of specificity and sensitivity of parental reports in predicting psychopathology in young children.

A strength of the study is its longitudinal and prospective design, tracking trajectories of peer functioning across 17 years. This fills a significant gap in research by focusing on early childhood precursors of BPD and MDD, an area that has been largely overlooked. Unlike previous studies limited to school-age or adolescent assessments, our research underscores the importance of examining risk patterns as early as preschool

age, highlighting the potential for early screening and intervention starting at three years of age. Furthermore, we employed a well-validated questionnaire for measuring BPD, the BPFS-C, which has been shown to be uniquely associated with theoretically identified indicators of borderline personality in childhood and controls for depressive symptoms. This is significant given the high degree of comorbidity between borderline pathology and depression observed in previous studies (Gunderson et al., 2014).

Clinical Implications

Peer relationships have the potential to both heal and harm (Prinstein & Giletta, 2016). Our findings highlight the importance of early identification and routine screening for problematic peer dynamics—including victimization, low peer acceptance, and relational aggression—as opportunities for targeted, disorder-specific interventions that foster corrective social experiences. Relational aggression at age 6 emerged as a reliable marker for later BPD risk, whereas trajectories of peer acceptance were a key predictor of MDD in males. Clinicians should incorporate regular screening protocols with direct questions about peer relationships, bullying, and social exclusion, as these social indicators often precede the onset of psychopathology. Universal, indicated, and selective prevention strategies are warranted, alongside tailored interventions: interpersonal effectiveness and emotion regulation training for BPD (Bourvis et al., 2023) and cognitive bias modification and interpersonal reframing for MDD (Platt et al., 2013),

particularly in youth with peer or family relational challenges. These approaches should be developmentally attuned and integrated into routine care. Future research should focus on scalable, culturally responsive models for screening and intervention and on elucidating the mechanisms linking peer dysfunction to disorder onset, including the development of brief, widely applicable tools for early detection.

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Figures

Figure 1. Preschool Depression Study Across 17 Years

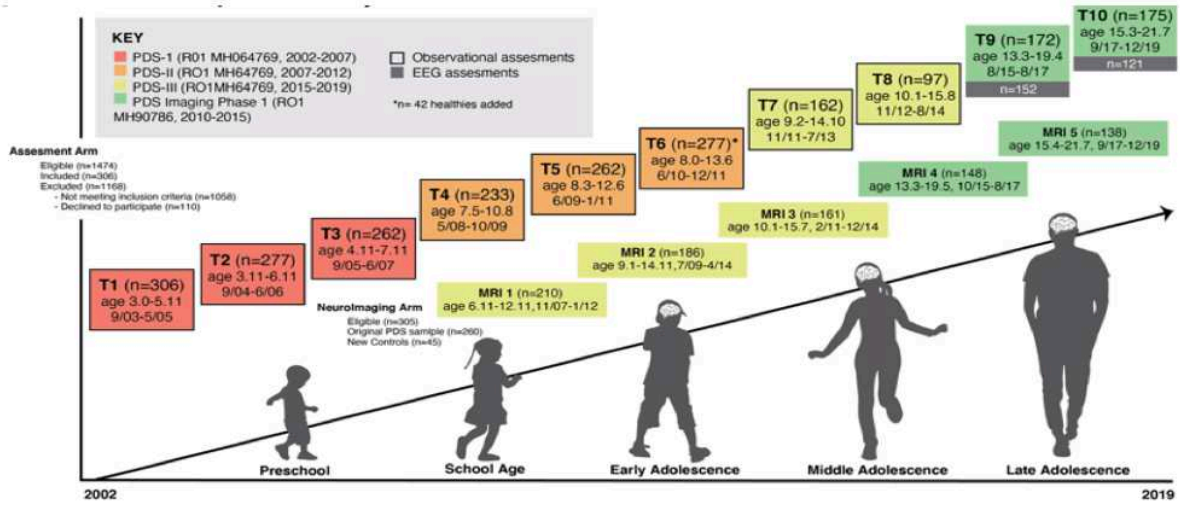

Figure 1

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