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Recommendations of Treatment Priorities and Long-Term Interventions for BPD Patients in Different Age Groups

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Abstract:

Borderline Personality Disorder (BPD) is a common personality disorder with staple symptoms instability and impulsiveness. It is a progressive disorder that could even last for several decades, and the patients in different ages usually manifest distinct symptoms. However, at present, only a limited number of papers offer guidance on individualized and prolonged treatment for BPD patients. Instead, many of them tend to only regard BPD patients as a single entity and ignore differences among individuals, which is not conducive to the advancement of BPD treatment. Thus, this paper, from the perspective of clinical diagnosis and treatment for BPD patients, divides the patients into three age groups (adolescent, young adult, and older adult). By employing literature review and analyzing based on existing research, this paper provides more targeted suggestions for the treatment of BPD patients in different age groups and puts forward recommendations for implementing multi-modal and long-term interventions for BPD.

Keywords: Borderline Personality Disorder; Treatment; Psychotherapy.

1. Introduction

In recent years, with the increasing social pressure, people's mental stress has gradually intensified. A study illustrating the changing trends in the global burden of mental disorders predicts that the incidence of mental disorders among humans will continue to rise in the next 30 years, particularly among women and adolescents [1]. Notably, women and adolescents are also the high-risk groups for Borderline Personality Disorder (BPD).

The incidence of BPD in the general population ranges from 0.7% to 3.5% [2]. Meanwhile, BPD patients usually suffer from multiple mental and physical diseases simultaneously [2]. Due to the complexity of BPD, no universally recognized and effective treatment has been found to date. Also, there has long been a controversy in the academic community regarding the high diagnosis rate of BPD. Some psychologists argue that the diagnostic criteria are too broad. In clinical practice, patients with other mental disorders or even normal individuals are often misdi-

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agnosed as having BPD. Moreover, BPD patients are often regarded as a more difficult-to-manage group because of the high instability of their behavior patterns.

2. Key Concept

According to the DSM-5, the primary symptoms of Borderline Personality Disorder (BPD) include fear of abandonment, unstable interpersonal relationships, unstable self-identity, impulsive self-harm behaviors, self-injury, suicide attempts and suicide threats, unstable emotions, chronic feelings of emptiness, excessive and uncontrollable anger, as well as short-term delusions or severe dissociative symptoms [3]. To be diagnosed with BPD, patients must meet at least five of the above criteria [3]. It is known that for most mental disorders, pharmacological treatment can usually rapidly alleviate patients' suffering in the short term, while psychotherapy focuses more on long-term cognitive and behavioral interventions (such as Dialectical Behavior Therapy (DBT) and Mentalization-Based Therapy (MBT)). However, research indicates that currently, no pharmacological therapy can effectively treat BPD patients [4]. Nevertheless, almost all BPD patients still receive multiple psychotropic medications [4]. This not only demonstrates the limitations of pharmacological treatment but also reflects the fact that the effectiveness of psychotherapy still needs further improvement. Although there are currently some validated psychotherapies (like DBT and MBT), most of these methods evaluate the intervention effects by treating BPD patients as a homogeneous group, rarely considering the patients' individual differences [4]. This kind of "one-size-fits-all" approach significantly weakens the treatment efficacy. Therefore, it is particularly necessary to conduct research on more targeted, individualized treatment for BPD patients.

Thus, this paper will divide BPD patients into three age groups: adolescents (15 - 20), young adults (21 - 50), and older adults (50+). Then, on the basis of existing research on BPD symptoms and psychotherapy, this paper will propose differential treatment suggestions for BPD patients of different age groups, aiming to provide more effective and individualized treatment ideas and directions for BPD clinical practice.

3. Literature Review

3.1 Adolescent BPD Patients

A cross-sectional study involved 2029 randomly sampled and screened-out BPD outpatients aged 15-50 from the Shanghai Mental Health Center [5]. The study evaluated BPD traits using the Personality Diagnostic Questionnaire-4+ (PDQ-4+) and assessed childhood abuse experiences using the Childhood Trauma Questionnaire – Short Form (CTQ-SF) [5]. The results showed that adolescent BPD patients exhibited significantly more symptoms in multiple aspects compared to the other two age groups, particularly symptoms such as desperate struggles to avoid abandonment, unstable self-perception, self-harm impulses, unstable emotions, short-term delusions, or severe dissociative symptoms [5]. At the same time, adolescents reported experiencing childhood abuse with greater frequency and severity (especially physical abuse and emotional abuse) [5].

The factors contributing to this severity may be multifaceted. First, from a developmental perspective, during adolescence, teenagers are in a transitional stage from dependence to independence, so they may encounter more obstacles in developing self-identity and establishing social relationships. From a physiological perspective, the impulsivity of adolescent BPD patients may be related to the immature development of the brain regions responsible for self-regulation and decision-making. The continuous development of the prefrontal cortex, which is involved in impulse inhibition and emotion regulation, may make adolescent BPD patients more prone to unstable behaviors. From a social perspective, due to factors such as the increasing reliance on educational qualifications in today's society, rising social expectations, and an oversaturated job market, contemporary teenagers face greater academic pressure than those in the past. In summary, the reasons from the developmental, physiological, and social perspectives cause adolescent BPD patients to exhibit more intense and unstable reactions to external stimuli and stress.

In a longitudinal study on the relationship between the recovery of BPD patients and age, patients participating in the study were systematically followed up at 3 months, 6 months, and every six months thereafter [6]. The researchers excluded the influence of severe mental disorders (such as schizophrenia) on the research results and adopted a multi-dimensional approach to evaluate the potential risk factors for BPD suicidal behavior [6]. Through the Final Model Predicting Total Recovery, the study showed that young patients ($p = .006$) with low impulsivity ($p = .003$) were more likely to achieve complete recovery [6]. Thus, the focus of treatment for adolescent BPD patients should initially be on early intervention, reducing impulsivity, and cultivating emotion-regulation skills.

For early intervention, regarding the emergence of prodromal BPD symptoms, usually at an early age, the goal of early intervention is to minimize the severity of adolescent BPD traits before the symptoms are fully established

and deteriorate into long-term negative personality traits, thereby preventing the development of severe self-harm, suicide, and completely impaired social functioning in adulthood (the most obvious characteristics of young adult BPD patients, as described below) [7]. First, identify adolescents with BPD temperament. The PDQ -4+ is a modified version of the test based on the DSM-IV criteria for personality disorders, aiming to evaluate 12 types of personality disorders. In schools, communities, and mental health centers, this test can be used to screen for BPD adolescents. However, it should be noted that the PDQ -4+ is a questionnaire designed for adults. If it is to be used for screening adolescent BPD patients, some questions need to be modified. For example, questions related to sex, marriage, driving, drinking, and the workplace are not applicable to adolescents. Take the question „I often wonder if my husband/wife has been unfaithful" as an example. The original intention of this question is to evaluate the characteristic of „fear of being abandoned," but most adolescents have no dating or marriage experience. Thus, this question can be changed to „I often worry that someone I trust or like will abandon me one day."

Regarding psychotherapy, the most widely used ones currently are Dialectical Behavior Therapy for Adolescents (DBT-A) and Mentalization-Based Treatment for Adolescents (MBT-A). DBT-A is an adolescent version of adult DBT, and its treatment includes individual therapy, family therapy, and skills training groups. Among them, the skills training is mainly divided into four modules: mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. These four modules are highly suitable for the main symptoms—emotional instability, impulsive behavior, and self-harm behavior—of adolescent BPD patients. Through repeated training of these skills, DBT-A can help adolescent patients find alternative coping methods towards crisis, thereby reducing self-harm behavior.

In contrast, the core of MBT-A is not to teach specific skills but to cultivate the mentalization ability of adolescent patients through individual and family conversations. Consider the prominent characteristics of adolescent BPD patients, such as unstable self-cognition, fear of being abandoned, and delusions and separation symptoms, which are manifested in significant misunderstandings and negative and over-interpreting attributions in interpersonal interactions. Therefore, MBT-A can effectively reduce interpersonal problems among adolescent BPD patients by helping them rationally recognize and interpret their own emotions and others' behaviors.

Compared with other common psychotherapies, such as Cognitive Behavioral Therapy (CBT), the advantages of DBT-A and MBT-A when applied to the adolescent population are mainly reflected in two aspects. First, they both emphasize the family involvement, which is in line with the situation of the adolescent development stage, as adolescents' emotion regulation and self-identity still highly depend on the support of the family environment. Second, the focuses of these two psychotherapies complement each other, so they correspond wholly to the core symptoms of adolescent BPD: self-harm, instability, fear of being abandoned, delusions and separation, and unstable self-perception. These complementary strengths make it feasible to combine the two therapies in clinical practice, thereby providing more comprehensive intervention for adolescent BPD patients.

However, it must be pointed out that there are limitations to DBT-A and MBT-A. Although multiple randomized controlled trials and systematic reviews have shown that DBT-A is significantly effective in reducing self-harm behavior, the existing evidence is inconsistent regarding whether it can significantly reduce suicidal ideation. Some studies have reported positive results, but others have pointed out that the impact of DBT-A on suicidal ideation is not significant [8]. In addition, both have limited ability to deal with complex childhood trauma. DBT-A and MBT-A do not provide direct and systematic methods to address early abuse and traumatic memories. Therefore, for most adolescent patients with a recent history of trauma, trauma-focused cognitive behavioral therapy (TF-CBT) should be combined in the treatment.

Regarding trauma, adolescents may have a higher awareness of recent abuse experiences and be able to recall them immediately. Due to their closer temporal proximity to these events, they may perceive abuse more acutely than adults [5]. Traumatic experiences in childhood can lead to chronic hypervigilance of the hypothalamic-pituitary-adrenal axis (HPA Axis), resulting in elevated cortisol levels [7]. Excessive stimulation of the hippocampus by cortisol can lead to a distorted interpretation of environmental signals as continuous threats and then send these danger signals to the amygdala that regulates fear and aggressive behavior [7]. This physiological process usually causes adolescent BPD patients to have strong emotional reactions to minor stress and take a longer time to return to a normal state [7]. Therefore, in order to avoid the continuous impact of traumatic experiences on the HPA axis, the focus of early intervention should also be on traumatic experiences in order to reduce the chronic hypervigilance state and promote the restorative regulation of the nervous system.

A longitudinal study on 20 adolescent BPD patients aged 15-25 was conducted at Headspace Sunshine in Melbourne, Australia [9]. The study evaluated the feasibility, safety, and potential clinical effects of TF-CBT. In the study, after an average of 15 treatments within 25 weeks

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for the 20 participants, only 1 out of the 16 individuals who met the PTSD diagnosis at baseline still met the diagnostic criteria at the end of the study [9]. Meanwhile, the symptoms of PTSD, anxiety, and depression all showed significant decreases (d = -.83, d = -.74, d = -.76) [9]. Since a large number of adolescent BPD patients have a history of childhood or adolescent trauma, TF-CBT may have unique advantages in stabilizing trauma-related symptoms and reducing hypervigilance. Although schema therapy can also deal with maladaptive schemas originating from early attachment and trauma, its main goal is to repair long-term personality problems, rather than directly targeting specific traumatic memories. In contrast, TF-CBT has more advantages in dealing with recent and prominent traumatic events. Therefore, in the comprehensive treatment of adolescent BPD, TF-CBT can be used as a supplementary therapy to DBT-A or MBT-A, providing more targeted intervention for the adolescent patients with a significant trauma background and also preventing the consolidation of hypervigilant states in adulthood.

There are still several limitations in these current studies. First, most of the current evidence regarding the efficiency of DBT-A and MBT-A is still based on small-sample controlled clinical studies with limited evaluation time. Therefore, it is difficult to assess the long-term outcomes of adolescent BPD patients after receiving treatments. Second, although TF-CBT has shown good efficacy in adolescent PTSD, there is a lack of direct empirical research on its efficacy for BPD patients. The current inferences are mainly based on the high overlap between the self-reported childhood abuse of adolescent BPD patients and their sensitivity to trauma. Third, the applicability of PDQ-4+ in the adolescent population needs further verification. Although there are suggestions for modification, their reliability and validity still lack systematic evaluation, and their applicability in different cultural backgrounds also needs to be verified.

3.2 Young Adult BPD Patients

According to a study mentioned formerly, the most prominent symptoms of young adult BPD patients include unstable interpersonal relationships, as well as suicide, suicide threats, and self-harm. These symptoms may be the internalization and solidification of the core symptoms of adolescent BPD patients, such as emotional instability, fear of being abandoned, and self-harm impulses, as they develop into adulthood. If these symptoms are not effectively intervened during adolescence, they may gradually intensify over time. In that way, BPD patients may repeatedly experience emotional crises in the context of interpersonal conflicts (with partners, friends, etc.) without emotion-regulation skills. These problems eventually manifest as a persistent and severe pattern of interpersonal instability in adulthood, accompanied by a high risk of suicide and self-harm.

Currently, existing therapies, like DBT, MBT, and schema therapy, are relatively widely used in alleviating the core symptoms of adult BPD patients [10]. DBT first helps the adult patients recognize their core negative emotions through individual therapy and then enhances their pain tolerance, interpersonal effectiveness, self-awareness, and emotion-regulation ability through skills training, thereby reducing patients' suicidal and self-harm tendencies and helping to stabilize their emotional and behavioral patterns. MBT tends to enhance the mentalization ability of BPD patients through individual therapy, that is, helping patients understand their own and others' emotions, recognize misunderstandings and conflicts in relationships, and thus improve the stability of interpersonal relationships. Schema Therapy employs techniques including the identification of schema modes and schema repair to help adult BPD patients identify and repair maladaptive schemas caused by early trauma (such as childhood abuse and neglect) or insecure attachment relationships (usually anxious attachment) and deeply explore the root causes of patients' emotional distress, thereby improving long-term emotional problems.

In addition to these therapies, other treatment methods such as Transference-Focused Psychotherapy (TFP) and Systems Training for Emotional Predictability and Problem Solving (STEPPS) also have some improvement effects on specific symptoms of BPD patients [10]. However, these treatment methods usually only focus on one or a few aspects of BPD and fail to comprehensively cover the various symptoms. Rather than relying on a single form, combining multiple therapies may lead to better outcomes. Unfortunately, most of the existing literature focuses on the effects of single treatment methods on BPD, and there is still relatively limited research on combining different therapies to form multi-modal or integrative treatments. Therefore, future clinical research should further explore the possibility of combining multiple treatments to form a highly flexible and comprehensively covered treatment plan to better heal adult BPD patients.

After discussing various effective psychotherapies, it is worth noting that adult BPD patients usually have a high comorbidity rate, which further complicates the treatment process. The results of an epidemiological study in the United States show that BPD patients have a high lifetime prevalence of anxiety disorders (84.8%), mood disorders (82.7%), substance use disorders (SUD; 78.2%), and eating disorders (ED; 33.7%), as well as other mental disorders with a relatively high comorbidity rate, including

PTSD, ADHD, and bipolar disorder [11]. These comorbidities exacerbate the emotional distress and self-regulation difficulties of adult BPD patients, making them often face multiple physiological and psychological pressures. In today's routine clinical practice, many medications are often defaulted for BPD patients, regardless of whether they have comorbidities. Data from research in the United States and some European countries show that more than 80% of BPD patients in these countries are receiving drug treatment, and 50% of the patients are taking three or more medications [11]. However, new research shows that regardless of the presence of comorbidities, psychotherapy should generally be prioritized as the first-line treatment for almost all BPD patients, and medications should preferably be used only as an auxiliary means [11]. One reason is to consider the side effects of medications. The other is that research shows that the improvement of comorbidities leads to a little reduction in BPD symptoms, but the improvement of BPD symptoms always has a significant positive impact on comorbidities [11]. Except in cases of severe episodes of major depressive disorder (MDD), substance use, or life-threatening anorexia nervosa, which must be treated with medications, psychotherapy for BPD symptoms should take precedence over drug treatment for comorbid symptoms [11].

In addition, the McLean Study of Adult Development (MSAD) reported that occupational function failure is the primary cause of rehabilitation failure among young adult BPD patients [12]. The young adulthood period from 20 to 30 years old is usually a crucial stage for individuals to achieve social independence and establish occupational identities. However, the symptoms of BPD patients (such as unstable interpersonal relationships) might severely affect occupational stability—patients may leave their jobs due to frequent interpersonal conflicts. This not only leads to unstable financial sources and damaged social status for patients but also makes them feel a psychological gap and a sense of incompetence, further exacerbating their unstable symptoms and the risk of self-harm, and even intensifying comorbid symptoms, ultimately forming a vicious cycle. It is worth noting that compared with occupational failure, the outcomes of interpersonal relationship failures are comparatively less severe [12]. Although interpersonal relationships are fragile, they can often be compensated to some extent by establishing new relationships, and the resulting effects are also relatively minor. In contrast, the impact of occupational failure is more profound and long-lasting, having a greater impact on patients' social functions.

However, few existing treatment programs incorporate occupational function into their attention scope. By considering the instability of interpersonal relationships among adult BPD patients, it is recommended to introduce "workplace social advice" in treatment by focusing on patients' specific workplace scenarios. To illustrate, it can include training in resolving colleague conflicts and role-playing exercises to help patients clarify how to handle interpersonal relationships at work. Meanwhile, for unemployed BPD patients, therapists should provide support in self-efficacy and career planning to ensure that patients can smoothly return to the workplace.

At the same time, early intervention in occupation should be carried out among adolescent BPD patients. More attention should be paid to the occupational exploration of adolescent BPD patients. For example, career tests and job counseling can be used to help adolescents discover career directions that match their interests and abilities, avoiding blind decision-making and heightened anxiety in career choice and thus preventing further instability in self-identity and emotions.

However, most of the above-mentioned clinical suggestions for the treatment of adult BPD patients are put forward based on the recent research with the theme "differentiated symptoms of BPD patients at different ages." Given the limited practice-oriented literature, there is currently no direct clinical evidence to prove the effectiveness of these suggestions. Therefore, future research on adult BPD patients can focus on clinical practices in these aspects to further explore more comprehensive treatment methods for adult BPD patients.

3.3 Older Adult BPD Patients

Currently, there are few longitudinal studies on BPD patients over 50 years old, so the understanding of the late-stage development of BPD remains limited. Some cross-sectional and longitudinal studies, such as the SPAN study (St. Louis Personality and Aging Network), show that the prevalence of BPD continues to decline in old age [13]. This may be because the unhealthy lifestyle associated with young BPD patients is linked to a relatively high risk of premature death [13]. Some other studies claim that the externalizing symptoms of BPD patients will indeed be alleviated in old age, especially the symptoms common in young adulthood (such as impulsivity, emotional instability, identity disorder, etc.). Conversely, some inner symptoms (such as fear of abandonment and emptiness) will become more severe. Moreover, the self-harm ways of older BPD patients may also change, such as turning to violating medical advice rather than harming themselves physically [14]. These indicate that the apparent symptom alleviation of older BPD patients is likely to be largely due to the deep internalization of implicit symptoms rather than real symptom relief.

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Some case studies and clinical experiences show that the probability of elderly people suffering from BPD continues to rise after they enter nursing homes or geriatric psychiatric hospitals [13]. This may be due to poor interpersonal communication skills, which lead many older BPD patients to become estranged from their families or former friends. In that way, entering a new environment and needing to rely on others' care re-triggers the fear of anxious attachment and abandonment. Other studies also mention a kind of "late-onset BPD" [13]. That is, the first appearance of BPD symptoms in the elderly may be related to the loss of social support that previously compensated for personality disorders [13]. The specific triggers may be the loss of relatives, physical decline, etc.

However, the diagnosis of elderly BPD patients still remains a trouble. The old generally have a relatively conservative understanding of modern psychology and psychiatry concepts. Especially for a disorder like BPD, which is complex and lacks obvious somatic disorders, it is often regarded as a "stress problem" or "character defect" rather than a psychological problem caused by physiological or social factors. Due to the mismatch between patients' cognition and the medical system, the mental health problems of many elderly BPD patients do not receive sufficient attention, causing them to be ignored in clinical diagnosis and treatment and further intensifying the stigmatization of mental illness in their minds [15]. Therefore, the popularization and destigmatization of mental disorders in the elderly population are very important. For specific diagnosis, considering differences between the symptoms of elderly BPD patients and those of young BPD patients, a dimensional model may be better for diagnosing the BPD late-stage characteristics [13]. To be specific, the dimensional model is a diagnostic method different from DSM-5c [13]. It believes that the symptoms of mental disorders are not binary but present in continuous dimensions, and the severity of each dimension can vary due to factors such as an individual's age and environmental changes [13]. Compared with DSM-5, it better takes into account the development and the changes of BPD. Thus, it can avoid underestimating the true prevalence of BPD in the elderly to an extent [13].

Regarding the internalization of BPD symptoms, schema therapy may be a relatively effective treatment because it focuses more on deeply exploring and improving long-term emotional distress (already discussed in detail in the young adult part). A study conducted in the Netherlands used a multiple-baseline case series design [14]. Ten BPD patients over the age of 60 were selected, and changes in negative core beliefs were recorded once before the 52 weeks of schema therapy and repeatedly during the six-month follow-up after treatment in order to evaluate the therapeutic efficacy [14]. The preliminary results of the study show that schema therapy can indeed weaken the intensity of negative beliefs [14]. In addition, the study also evaluated the changes in patients' quality of life and psychological distress through a series of tools (such as WHOQOL-BREF, BSI, etc.) [14]. The results show that, in these two aspects, patients have also improved [14]. Although the sample size of this study is small, the research method and the multiple-baseline case series design enable it to obtain relatively effective results.

In addition, for elderly BPD patients, standard treatments such as MBT and DBT need to be adjusted [13]. MBT focuses on improving patients' mentalization ability. For elderly BPD patients, the treatment focus should be on dealing with dependence and attachment relationships to help them cope with the anxiety of being abandoned and the relationship between themselves and their children. DBT aims to help patients stabilize their emotions and behavior patterns and thus reduce the tendency of suicide and self-harm. Considering two factors: the physiological degeneration of the elderly, that is, the cognitive function and mobility of the elderly will be impaired to a certain extent; the specific age-related stressors of elderly patients: the death of relatives and friends or estrangement from children. The first factor limits the changeability of elderly patients, and the second factor is difficult to change, indicating that the application of DBT in the elderly needs to pay more attention to "acceptance" rather than "change." (This study will not elaborate more on suggestions for other therapies due to the lack of clinical study evidence on elderly BPD patients now.)

Moreover, older BPD patients' improvement of social function is also important. From the family perspective, the family therapy should focus on educating family members to help them understand the symptoms and needs of BPD relatives and learn how to interact effectively with the relatives in order to reduce neglect and conflicts among family members. Also, elderly BPD patients should be encouraged to improve their social networks, specifically by encouraging them to participate in community activities. This can not only enhance their social interaction and sense of belongingness but also relieve the feeling of loneliness and the fear of abandonment.

4 Discussion and Suggestion

This study understands BPD as a mental disorder that changes dynamically with individual development and thus explores the differences in symptoms and corresponding intervention focuses from three stages: adolescence, young adult, and older adult. In general, the results show that the treatment and prevention of BPD must take into

account the unique needs of patients at different development stages rather than adopting homogeneous interventions.

For adolescent BPD patients, their symptoms are more acute and explicit. The prominent symptoms include fear of abandonment, unstable self-cognition, emotional instability, and impulse for self-harm. These characteristics may be closely related to the immature development of brain regions, the pressure of identity exploration, and academic pressure. Since adolescence is a high-incidence and non-solidified stage of BPD symptoms, early screening and intervention are crucial. This paper proposes an adaptive revision of the PDQ-4+ questionnaire to improve its applicability in the adolescent population. At the same time, this paper suggests combining DBT-A, MBT-A, and TF-CBT to more comprehensively reduce adolescent BPD symptoms. Future research should further test the feasibility of this multi-modal intervention approach and its impact on long-term prognosis.

The symptoms of young adult patients are more manifested as unstable interpersonal relationships, as well as suicidal and self-harm behaviors. This may be due to the ineffective intervention in adolescence and the internalization and solidification of the disorder. In particular, impaired occupational function is regarded as a key risk factor for rehabilitation failure at this stage. In addition to conventional DBT, MBT, and schema therapy, treatment should incorporate occupational intervention and social function restoration parts to help patients improve self-efficacy and enhance social independence. It is better that occupational intervention could start during patients' adolescence. Since current treatment methods usually only focus on one or a few aspects of BPD, this paper proposes the possibility of implementing different therapies in combination to form multi-modal treatment. In addition, even though BPD patients are generally accompanied by multiple comorbidities, as long as there are no extremely serious comorbid problems, BPD symptoms should be treated prior to comorbid symptoms, and drugs should preferably only be an auxiliary means for psychotherapy. First, future research can further explore how to combine psychotherapy with occupational intervention and promote the long-term social function recovery of patients. Second, conduct clinical practices to explore the possibility of multi-modal treatment for BPD.

In elderly patients, apparent symptomatic remission may mask the deep internalization of negative beliefs and abandonment anxiety, which can be reactivated upon loss of social support or environmental changes. This paper points out that the traditional DSM-5-based diagnosis may have limitations in the elderly population, and the dimensional model may more accurately reflect the characteristics of older BPD patients. In terms of treatment for the old, schema therapy has initially shown the potential to weaken negative core beliefs and improve the quality of life. MBT and DBT need to be adjusted according to the cognitive degeneration and the specific stressors of elderly BPD patients, with the focus shifting from "change" to "acceptance." Meanwhile, social support is particularly crucial at this stage. Family therapy and community activities can help patients reduce the feeling of loneliness as well as enhance their sense of belonging and security. Meanwhile, due to the stigmatization of BPD among the old, the popularization of mental illnesses and their treatments in the elderly population is particularly necessary.

By comparing the symptoms and intervention focuses of BPD patients at three age groups and finding that young patients have a higher cure rate than older patients, it could be firstly concluded that it is better to intervene in BPD patients as early as possible. Through early intervention, patients can start career planning and establish interpersonal relationships in advance, thereby reducing the risk of severer symptoms. Therefore, screening patients during adolescence is especially crucial. In addition, most current interventions for BPD patients are short-term, like from a few months to three years. However, long-term intermittent psychotherapies may be a more suitable treatment model for BPD patients [15]. This long-term treatment model would help BPD patients prevent the risk of recurrence and enable them to receive continuous support at different stages of life challenges. Future clinical practices should introduce a developmental perspective in treatment design and further verify the efficacy of multi-modal and long-term interventions.

It should be noted that most of the clinical practice samples cited in this paper are small in size and regionally concentrated. Future research requires larger and cross-cultural samples to conduct longitudinal controlled experiments on BPD symptoms to further clarify the effectiveness of the treatment suggestions proposed in this paper.

5 Conclusion

This study examines the symptom manifestations of borderline personality disorder (BPD) in adolescence, young adult, and older adult from a developmental perspective. The results show that BPD is not a static disease, and patients will face different psychological and social challenges as they age. Therefore, differentiated treatments for BPD patients at different ages are particularly necessary.

For adolescents, early screening and intervention are crucial for preventing symptom solidification. For young adult patients, the reconstruction of social and occupa-

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tional functions is the core of treatment. For older adult patients, the restoration of social support and self-acceptance needs more focus. Overall, the intervention for BPD should shift from a single-mode to a multi-modal integration, and developmental and long-term perspectives should be incorporated into treatment design.

Therefore, future research and practice should focus on how to implement individualized interventions at different development stages and how to construct a continuous treatment model across age stages. Only in this way can BPD be truly and more thoroughly improved.

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