Proceedings of the 4th International Conference on Educational Innovation and Philosophical Inquiries
DOI: 10.54254/2753-7048/19/20231385

Cultural Differences, Diagnosis, and the Intervention in Adolescence in Borderline Personality Disorder

Danyang Zhao[1,a,*]

[1]*School of Psychology, University of Ottawa, Ottawa, Ontario, K1N 6N5, Canada*
a. dzhao043@uottawa.ca
**corresponding author*

Abstract: The previous study showed that borderline personality disorder was strongly associated with childhood trauma and developed personality traits into adolescence that could lead to borderline personality disorder. Research also indicated a cultural difference in the psychopathology and diagnosis of borderline personality disorder in both adults and adolescents. A borderline personality disorder is a type of personality disorder that has symptoms around unstable emotions, dissociation and fear of being abandoned. Although having deviant behaviour was a significant risk factor in detecting borderline personality disorder, it could be less potent in non-western cultures like China and India. Merging cultural differences and the criteria of borderline personality disorder could accurately detect borderline personality disorder in adolescence. It helped people intervene and treat it earlier to slow the progression of borderline personality disorder. This study focused on reviewing previous research on cultural differences, detection, prevention, and intervention in adolescents with borderline personality disorder. Cultural differences like different social norms or traditions influence individual identity and interpersonal relationships, which are non-negligible components of the period of adolescence that could induce borderline personality disorder if adolescents have issues with those parts. People need to be aware of the symptoms to intervene in borderline personality disorder in adolescents through multiple treatments with an appropriate plan and management, which should focus on psychotherapy, like dialectic behavioural therapy, supportive psychotherapy, and Mentalization-based therapy.

Keywords: borderline personality disorder, psychopathology, adolescence, transcultural psychiatry

1. Introduction

Although people in this society already pay attention to the understanding of mental disorders and their treatments, personality disorders are less known in the population. Personality disorders are difficult to be recognized and diagnosed compared to other mental disorders due to the wide variety and ambiguous symptoms. Borderline personality disorder is one personality disorder related to extreme mood swings that could threaten patients' and their close people's physical and psychological health and well-being [1].

Borderline personality disorder (BPD) is the most common personality disorder in the world. According to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), American Psychiatric

DOI: 10.54254/2753-7048/19/20231385

Association (APA) described BPD as a personality disorder in which people with BPD experience a strongly unstable period with dysregulation [1]. BPD affects cognition and perception, which are expressed by their thinking ways, such as extreme thinking, fragmented and unstable identity, the intense intention of self-hurting, impulsive behaviours, and rapid emotional swings [1]. Patients with BPD would have difficulties managing and regulating their emotions [2]. Therefore, people with BPD tend to be hard to build stable and healthy relationships with others, even with their family members [2]. They can rapidly switch their emotions without self-controlling, from liking to extremely disliking someone, but they are afraid of being abandoned as meanwhile [2]. People with BPD is unable to trust their partners and frequently argue with their partners even the reason is unnecessary. This unmanageable change and ambivalence damage patients' social life and their emotions, which can cause depression [1,2]. The most common symptom of BPD is that patients tend to experience dissociation, which is a broken self-image and feel that the world and themselves are unrealistic [1]. BPD is a severe mental disorder [1] with one of the highest suicide and self-harming rates [3]. BPD is known for the fairly high rate of misdiagnosis; that study showed that at least 40% of BPD patients were diagnosed with bipolar disorder once in their lifespan [4]. Research also reported that BPD patients have a high possibility of quitting their treatment and have difficulty keeping their plan of regulating themselves to be better without drowning in pain [3]. Therefore, BPD needs people's attention to timely prevent and intervene in patients' conditions to keep them engaged in their social skills, coping with stress, and regulating their unstable emotions. For this reason, it is important to understand the psychopathology of BPD and distinguish its symptoms to make a plan for their treatment.

However, previous research reported that cultural difference exists in the symptoms of BPD that should be considered an important element in the criteria for BPD [5]. Culture means context that is understood by considering social and environmental elements together [5]. Choudhary and Gupta argued that different cultures have different patterns from four components: first, the way of interpreting others' emotions and interaction between humans; second, the society structure, which are rules or norms that regulate people's behaviour and stipulate the possibilities of accessing the social resources; third, the environment that can provide resources; and the last one is the individual situation like their socioeconomic status [5]. Due to cultural differences, the way of expressing emotions and different types of relationships, for example, if it is more individual or dependent. Therefore, individual characteristics of BPD patients are varied because the standard and stipulation of behaviours differ from the individual conditions of BPD [1,5,6]. APA mentioned clinicians in DSM-IV that personality disorders' criteria refer to the inner experience of individuals, which is variable due to cultural differences [1]. The biggest difference between Western and non-western cultures could be how people interact with others in relationships, especially the comparison between American families and Asian families like between America, Canada, India, and China [5,7,8]. Besides, the limitation of accessing social resources differs in the pattern of deviant behaviours affects the diagnosis of BPD, which might let BPD patients to receive delayed treatment compared to others [6,8]. It is important to distinguish symptoms and patterns of BPD when the patients are from non-western cultures to get psychotherapies and medical services from society in time.

Mental disorders in Adolescence are an important topic based on the available research. Previous research showed that the prevalence of mental illness was rapidly increasing among adolescents [9,10]. The mental and physical health of adolescents are the symbols of well-being in a country so the study of adolescent psychopathology and intervention is necessary [11]. According to previous research, the symptoms of BPD would start to appear during adolescence, such as dissociation [9,12]. The study showed that 3% of the population of adolescents had BPD, and a large proportion of them were diagnosed until their adulthood [10]. The delayed diagnosis leads to the growth of disease and the delaying of treatments which could affect the well-being of life among those adolescents,

DOI: 10.54254/2753-7048/19/20231385

particularly with their social life in school [9,13]. Psychotherapy, like dialectic behavioural therapy, is the primary treatment for adolescents because medicines might cause side effects that make adolescents' physical health uncomfortable [10]. The symptoms of BPD, such as affective fluctuations and unstable self-identity, could be devastating stress to adolescents, which means the importance of diagnosis for getting treatment in time [10]. The lack of supporting medical resources and the stigma of BPD could urge many adolescents with BPD to give up the treatment, which was creating a vicious cycle of progression of BPD [11]. Previous research and the devastating damaged effects of BPD on adolescents follow the importance of accurate diagnosis during adolescence, which leads to a thorough and appropriate plan of treatment and management of BPD.

Although the evidence of BPD among adolescents and cultural differences during the diagnosis of BPD was a controversial and attractive topic in the studies on BPD, there is a handful of research that considered the interaction of cultural differences and the diagnosis and intervention of BPD among adolescents. This study is a review of previous studies in the field on the cultural differences in BPD and adolescent BPD, which focuses on the diagnosis and intervention of BPD. This study will discuss: first, how non-western culture affects the symptoms of BPD and the different diagnosis criteria of BPD compared to Western culture; second, the symptoms and signs of BPD among adolescents, how people intervene in BPD, and if there is a cultural difference in adolescent BPD. According to previous research, this study will provide the future direction of the research on BPD and advice for intervention in adolescents and people in different cultures. This study will use China and India as the examples from non-western cultures.

2. The Cultural Difference in BPD's Symptoms and Diagnosis Criteria

Cultural differences lead to different significant symptoms in people with BPD [1]. APA mentioned that clinicians and psychotherapists should pay attention to the individual variation of BPD; the reason is that previous research showed that personal context could affect personality traits [1]. Personality traits refer to individuals' perceptions and cognitions of themselves and the environment, which change by different cultural contexts and are potent criteria for the diagnosis of BPD [1]. Clinicians should pay attention to the cultural background of people with BPD because the core symptoms of BPD, particularly with dysregulated emotions, risky behaviours and hypersensitivity, were varied by cultural differences [5].

2.1. Interpersonal Relationships and Non-western Cultures

The interpersonal relationship shows a social association that connects two or more people together, and the expressing way of interpersonal relationships is different between Western and non-western cultures [5]. Choudhary, Shalini and Gupta argued that the emphasis on interpersonal relationships differs among Western and non-western cultures [5]. In Western cultures, like North America, people require and wish people to be independent and separated, even family members; however, in non-western cultures, such as China and India, people are more dependent and tend to live together or near to them, particularly between family members. Non-western cultures like Asians pay attention to and give high value to the interdependence between close people in their friend zone and families [5]. The interpersonal relationships, particularly between close people, were deeply enmeshed, and most parents would never evict their children, whatever how their children react like a person with BPD [7]. Therefore, collectivistic thought in non-western cultures leads to a significant cultural difference in how people relate to each other, which can affect the assessment of the mental health of non-western people. Nevertheless, BPD's most significant symptom and effect is destroying interpersonal relationships [13].

DOI: 10.54254/2753-7048/19/20231385

People with BPD have a great fear of abandonment, even in the relationships between them and others are already fragmented [2]. They are afraid of loneliness in both physical and psychological accompanies [2]. In Western cultures, people with BPD were relatively separated and independent, so it would be more challenging to get the supporting from their close people [5]; therefore, the symptom of lacking accompanies was a frequent phenomenon in Western cultures [5]. However, people with BPD in non-western cultures were less likely to show this symptom because collectivistic thought affects Asian cultures [5]. The research showed that parents in India tended to support or control their children who showed significant misbehaviours in their views (e.g., bullying others, intimidating their peers or close people, and harming others) [5]. In China, the researchers reported that Chinese BPD patients showed less fear of abandonment, at least in the physical or material [7]. As a controversial symptom of BPD in different cultural contexts, people should be cautious about BPD patients' experiences to identify their mental state. How people deal with their interpersonal relationships should not be the only phenomenon to be paid attention to in BPD treatment.

2.2. Deviant Behaviours and Non-western Cultures

Deviant Behaviours are behaviours that offend the laws in society or are against social norms, which are breaking the rules or traditional thoughts in society [5]. Although most laws are much muchness in most cultures, whether in Western cultures or Asian cultures, there are still cultural differences in a branch of the law [8]. The attitudes and results of drugging are an example of cultural differences in the definition of deviant behaviours. In China, drugging is an absolutely offensive crime, whatever kind of drug people are using; in Canada, drugging is still a crime, but there are exceptions. Although it is illegal in Canada to inject oral controlled substances, cannabis is not on the list of prohibited drugs, which is completely different compared to Singapore or China. Due to the difference in laws, the way of accessing the resource of drugs can satisfy people to do deviant behaviours. In Canada, stores of legal cannabis are common even though there can be more than three Cannabis stores in a short street; sometimes, there can be one store just nearby the school area. The lack of access to enough social resources influences people in non-western cultures to be unable to achieve their behaviours like drugging cannabis. Social norms are another element that the cultural context influences the probability of risk behaviours [5]. In Eastern cultures, particularly in China and India, under the influence of collectivistic thought, people are less likely to express their emotions because they believe that showing emotions could be a symbol of individualism, which can offend the social norms in non-western cultures [5,7,8].

Doing deviant risky behaviours is one of the most significant characteristics of BPD patients [1,2,6]. People with BPD tend to do extreme things to fill their emptiness, escaping the fear of abandonment, threatening people close to them not to leave them, expressing their rapid fluctuation of emotions, or losing their self-identity [2]. The common deviant behaviours of them known by most clinicians could be risky and unsafe sex, dangerous driving, or drugging [2]. However, the details of the experience of deviant behaviour could be different in non-western cultures due to the limitation of accessing resources due to laws and different social norms [5]. In China and India, the research showed that people with BPD would be less likely to express their emotions, particularly with depression and mania, because of the belief of their cultures that showing strong emotions is a weakness and offend the social norms in their cultures [5,8]. In Singapore and China, the researcher reported that people with BPD in their cultures might not do deviant behaviours like reckless driving, promiscuous sex, and overdosing due to there being severe crimes in their culture and less able to access the resources of controlled substances [8]. Instead of deviant behaviours like drugging, frequent unnecessary arguing would be more often characteristic of deviant behaviours in the non-western cultures in the region like China and India [5,8].

DOI: 10.54254/2753-7048/19/20231385

2.3. Difference of Other Damaged Functions

The research on Chinese patients with BPD showed that compared to other symptoms, the impairment in self-image and the difficulty of acting before thinking of a plan are the better criteria for diagnosing BPD [14]. Due to the lack of consideration for variation, the treatment of people with BPD in non-western cultures would be delayed, and people with BPD were less likely to get accurate supporting resources at the appropriate time [14]. Clinicians and psychotherapists should choose treatment according to different cultural contexts for better effects, such as Chinese people with BPD reacting better to mindfulness therapy [14]. Clinicians should use screening tools for BPD which match the personal cultural background to diagnose and plan the treatment.

3. The Symptoms and Intervention in BPD During Adolescence

Apart from the cultural context as a diagnostic reference, age as a factor is still important, especially in adolescence. Understanding symptoms, predictors, and interventions of adolescents with BPD can prevent the delayed treatment. And it is useful to recognize the cultural differences in the development of adolescence which can cause borderline personality traits.

3.1. Major Symptoms of Adolescent BPD

Previous research showed that there is both physical and psychological evidence on adolescents that BPD can be detected among adolescence before their adulthood [9]. The sign of both interiorized and externalized symptoms of BPD appeared during adolescence of people diagnosed with BPD in adulthood [10]. BPD for adolescents divided the symptoms of BPD into three components; the first one is internalized issues, such as the paranoid ideation of stress, disturbing self-identity, and chronic psychological emptiness; the second is emotional issues, such as unstable fluctuation of emotions, which is severe sudden depression and uncontrollable intense anger; the third is externalized issues, such as impulsive behaviours, self-damaging, and unstable interpersonal relationships around people with BPD [10]. The most significant symptoms for clinical adolescent patients with BPD were affective instability and identity disturbance [10]. Affective instability was the core symptom of BPD among adolescents, which represented the rapid changes in dysregulated emotions, and research supported that unstable emotions were one of the key factors that as the same as the diagnosed criteria for adult BPD [10]. Affective instability would negatively influence life [15]. Identity disturbance represented the breaking of indistinguishable self-recognition and self-image, which could be described as people losing themselves; it negatively affected how people recognized their beliefs, social roles, abilities, and temperament or personalities [10]. Identity disturbance is the most common symptom in clinical BPD adolescent patients because adolescence is a period of exploring their identity for adapt futures, and BPD severely damages their ability to self-perception of themselves [10]. Previous studies emphasized that nonsuicidal self-injury (NSSI) was another significant phenomenon of BPD in adolescence due to the fear of abandonment and rapid emotional changes; 58% of BPD adolescents reported at least once NSSI during their progression of BPD, and more than half of them were female [16]. Those symptoms could lead to adolescents experiencing adaptive failure, which made them feel the pain of loneliness due to not integrating into society [17]. Adolescence is a period of transition to adulthood that helps adolescents find their roles in society and goals. BPD damages adolescents' self-perception and cognition, which causes the failure of adaption and interpersonal relationships; therefore, it might stimulate the fear of abandonment, which worsens BPD [17].

Another symptom that clinicians and parents should pay attention to is dissociation. Dissociation disrupts functions like attention, memory, and consciousness [18]. The dissociation discontinues their perceptions of self-identity and brings psychological difficulties to the feelings of the world [18].

DOI: 10.54254/2753-7048/19/20231385

Dissociation perplexes people with BPD, and they might experience detachment; patients reported feeling unreal and detached from the real world to the move-like world under derealization [18]. Recent researchers demonstrated that the experience of dissociation and the level of severity of dissociation in adolescents with BPD were not significantly different compared to adults, which means dissociation was also a key factor for clinicians to diagnose adolescent BPD [19]. Understanding the symptoms of adolescent BPD is the start of the intervention and suits the remedy to the case for better treating adolescent BPD.

3.2. Predictors and Intervention in BPD for Adolescents

Confirming the predictors of BPD could be a powerful understanding to intervene in the progression of BPD in time. Current research suggests that childhood trauma and adversity in families were the key predictors of adolescent BPD [20]. Childhood traumas include three components; like physical, such as beating up kids, psychological, such as verbally abusing kids and being ignored by parents, and sexual abuse [20]. Frequently bullying by peers made people more likely to have borderline personality traits [21]. Research showed that family adversity, a dilemma people experience in a period like poverty, directly influences negative personality traits, particularly with BPD, because of insufficient and inappropriate parenting skills and lack of cognition functions [20]. Therefore, clinicians, psychotherapists, and staff in the community and schools should pay attention to the adolescents who experienced maltreatment, poverty, bullying, and sexual abuse in the past to intervene in borderline personality traits before it turns to become BPD. BPD is highly likely to appear as a complication with other mental disorders during adolescence; therefore, the mental disorders that the adolescent is diagnosed with can also be a predictor of BPD [12]. Previous research emphasized that eating disorders, the reason is binge eating, could be a symptom of BPD's risk behaviours among adolescents [12]. The study also indicated that PTSD could be another common complication of BPD due to childhood trauma that the adolescent experienced in the past, and the symptoms of BPD might appear early in adolescence if that adolescent had PTSD [12]. The mental disorder of externalized issues in adolescents, particularly with ODD, would negatively affect the development of personalities of BPD [22]. Clinicians should consider the possibility of BPD as a complication when they diagnose adolescents with other mental disorders to intervene before the borderline personality traits become BPD.

BPD negatively impacts adolescents' physical and psychological well-being, which influences their lifespan; therefore, it is necessary to make a plan of treatment to intervene in the conditions to prevent the deterioration of BPD. The current study suggested that the treatment of adolescent BPD should be based on psychotherapy rather than medicine; nevertheless, medication, such as second-generation antipsychotics, was still a potent and useful adjunct for adolescent BPD [12]. Nonpharmacological, which focuses on psychotherapy, is preferable because of fewer physical adverse side effects [12]. Previous studies showed supportive psychotherapy (SP), dialectic behavioural therapy (DBT), and mentalization-based therapy (MBT) [12]. As a therapy related to emotional support and appropriate encouragement, SP is positively working on adolescent BPD [12]. DBT also showed a successful adaption in adolescents, which focused on exercises on mindfulness and regulation of emotions and pains [12]. MBT refers to the process of social cognition among adolescents, which BPD damages the most; it is the understanding of minds themselves and others [12]. The study demonstrated that a full 1-year MBT leads to significant improvements in the progression of BPD [23]. Clinicians' treatment planning is important as well. People should show the action in the crisis of suicide, the impacts of current disorders, and family risk factors like their parent's mental disorders [12]. Clinicians should mention the risk of adolescent BPD when adolescents consult oppositional deviant behaviours, particularly with females [24].

DOI: 10.54254/2753-7048/19/20231385

3.3. Cultural Differences and Adolescent BPD

As the cultural difference among BPD patients between Western and non-western cultures is introduced in the second part, cultures also differ among adolescents with BPD. The focused predictor on BPD in non-western cultures could differ from Western cultures. The previous studies, which focused on Chinese BPD adolescent patients, showed that child maltreatment was the most significant environmental factor in inducing BPD [25]. Family adversity, particularly with divorced families, was another environmental factor that increased the risk of BPD during adolescence [25]. Childhood maltreatment leads to an insecure attachment style in adolescents which could also deteriorate the level of severity of childhood maltreatment that induces BPD among adolescents [25]. Most people with BPD in China, who had symptoms in their adolescence, reported that they intensely experienced emotional abuse and emotional neglect during adolescence [25]. The report of emotional neglect and physical abuse differs adolescent BPD from other personality disorders among Chinese adolescents, which differs from the non-western culture [25]. Although emotional neglect is the most risk predictor for adolescent BPD, unduly controlling parents due to the enmeshed interpersonal relationship, which frequently appears in Eastern cultures, can also cause adolescent BPD [26]. In China, overprotection as childhood trauma, which differs from Western cultures, predicts adolescent BPD [26]. The reason is that overcontrolling from parents caused a lack of awareness in adolescents which led to borderline personality traits [27]. India's idea of the force of krama also induces feelings of helplessness in adolescents with BPD, which prevents them from asking for help from their parents and society [28]. Therefore, the unsupportive environment leads to fewer effects on psychotherapy like DBT because adolescents with BPD tend to give up the treatment and the chance of seeking resources to support them [27,28].

4. Conclusion

It is important to understand BPD because BPD can influence their social skills and learning abilities, which directly impact the life quality and well-being of patients [13]. The rate of misdiagnosis in Eastern cultures is high due to the cultural difference in the symptoms of BPD [5]. Especially in China because China did not admit BPD as a mental disorder and used impulsive personality disorder (IPD) to replace it; however, IPD is different from BPD, so misdiagnosis often occurs in China like diagnosing bipolar disorder rather than BPD [13] Different values and laws in Western culture and non-western cultures cause misdiagnosis; deviant behaviours like overdosing due to limitation of social resources are examples of cultural difference [8]. The neglect of cultural differences in diagnosis criteria leads to delayed intervention in people with BPD in non-western cultures [5].

Previous studies supported the diagnosis of adolescent BPD [10,12]. The studies demonstrated that affective instability, identity disturbance, and frequent attempt at NSSI are the eeecritical factors of adolescent BPD [10,16]. Recognizing predictors of BPD can help adolescents with BPD before the deterioration of progression. Childhood trauma and family adversity are the most significant predictors of adolescent BPD [20]. Mental disorders can imply adolescent BPD as a complication, such as eating disorders, PTSD, and ODD [12,22]. SP, DBT, and MAT should be the preferable treatment for adolescent BPD [12]. The predictor of adolescent BPD depends on the cultural context, and childhood maltreatment, like emotional neglect and overprotection, is relatively unique in Eastern cultures [25,26].

Clinicians need to diagnose and intervene with the consideration of cultural differences and age, particularly with adolescents with BPD in non-western cultures. The limitation of this study is the lack of enough research on the interaction between cultural differences only on adolescent BPD. In the future, researchers should focus on the particular details of adolescents with BPD who grow up in other cultural contexts rather than only studying Western culture.

DOI: 10.54254/2753-7048/19/20231385

Reference

[1] American Psychiatric Association (2000). Diagnostic and Statistical Manual Of Mental Disorders, 4th Edn, Washington, DC: American Psychiatric Association.

[2] U.S. Department of Health and Human Services. (n.d.). Borderline personality disorder. National Institute of Mental Health. https://www.nimh.nih.gov/health/topics/borderline-personality-disorder

[3] Chang, T., Liu, S., Korslund, K., Lin, C., Lin, Y., Huang, H., Chen, S., Chang, Y., Sun, F., & Wu, S. (2022). Adapting dialectical behavior therapy in Mandarin‐speaking Chinese patients with borderline personality disorder: An open pilot trial in Taiwan. Asia-Pacific Psychiatry, 14(1), e12451–n/a. https://doi.org/10.1111/appy.12451

[4] Ruggero, Camilo J.; Zimmerman, Mark; Chelminski, Iwona; Young, Diane (2010). "Borderline personality disorder and the misdiagnosis of bipolar disorder". Journal of Psychiatric Research. 44 (6): 405–408. doi:10.1016/j.jpsychires.2009.09.011. ISSN 0022-3956. PMC 2849890. PMID 19889426.

[5] Choudhary, Shalini, and Rashmi Gupta. "Culture and Borderline Personality Disorder in India." Frontiers in Psychology, vol. 11, 2020, pp. 714–714, https://doi.org/10.3389/fpsyg.2020.00714.

[6] Cohen, S. (1972). Folk Devils And Moral Panics: The Creation Of The Mods And Rockers. London: MacGibbon & Kee.

[7] Yang, K. S. (1986). "Chinese personality and its change," in The Psychology Of The Chinese People, ed. M. Bond (Hong Kong: Oxford University Press).

[8] Keng, S. L., Lee, Y., Drabu, S., Hong, R. Y., Chee, C. Y. I., Ho, C. S. H., & Ho, R. C. M. (2019). Construct Validity of the McLean Screening Instrument for Borderline Personality Disorder in Two Singaporean Samples. Journal of personality disorders, 33(4), 450–469. https://doi.org/10.1521/pedi_2018_32_352

[9] Miller AL, Muehlenkamp JJ, Jackson CM. Fact or fiction: diagnosing borderline personality disorder in adolescents. Clin Psychol Rev. 2008;28(6):969–81.

[10] Guilé, J. M., Boissel, L., Alaux-Cantin, S., & de La Rivière, S. G. (2018). Borderline personality disorder in adolescents: prevalence, diagnosis, and treatment strategies. Adolescent health, medicine and therapeutics, 9, 199–210. https://doi.org/10.2147/AHMT.S156565

[11] Bozzatello, P., Garbarini, C., Rocca, P., & Bellino, S. (2021). Borderline Personality Disorder: Risk Factors and Early Detection. Diagnostics (Basel, Switzerland), 11(11), 2142. https://doi.org/10.3390/diagnostics11112142

[12] Zanarini, M.C., Martinho, E., Temes, C.M. et al. Dissociative experiences of adolescents with borderline personality disorder: description and prediction. bord personal disord emot dysregul 10, 9 (2023). https://doi.org/10.1186/s40479-023-00217-0

[13] Leichsenring F, Leibing E, Kruse J, New AS, Leweke F. Borderline personality disorder. Lancet. 2011;32:371–90.

[14] Zhong, J., & Leung, F. (2009). Diagnosis of borderline personality disorder in China: Current status and future directions. Current Psychiatry Reports, 11(1), 69–73. https://doi.org/10.1007/s11920-009-0011-3

[15] Arens E, Stopsack M, Spitzer C, et al. Borderline personality disorder in four different age groups: a cross-sectional study of community residents in Germany. J Pers Disord 2013; 27:196–207.

[16] Knafo A, Guile JM, Breton JJ, et al. Coping strategies associated with suicidal behaviour in adolescent inpatients with borderline personality disorder. Can J Psychiatry. 2015;60(2 Suppl 1):S46-S54.

[17] Wall K, Kerr S, Sharp C. Barriers to care for adolescents with borderline personality disorder. Curr Opin Psychol. 2021;37:1–7.

[18] Spiegel D, Loewenstein RJ, Lewis-Fernández R, Sar V, Simeon D, Vermetten E, et al. Dissociative disorders in DSM-5. Depress Anxiety. 2011;28(12):E17–45.

[19] Berhe, O., Moessnang, C., Reichert, M. et al. Dose-dependent changes in real-life affective well-being in healthy community-based individuals with mild to moderate childhood trauma exposure. bord personal disord emot dysregul 10, 14 (2023). https://doi.org/10.1186/s40479-023-00220-5

[20] Newnham, E. A., & Janca, A. (2014). Childhood adversity and borderline personality disorder: a focus on adolescence. Current Opinion in Psychiatry, 27(1), 68–72. https://doi.org/10.1097/YCO.0000000000000028

[21] Erazo, M., & Vaillancourt, T. (2021). The Cumulative Effects of Bullying Victimization in Childhood and Adolescence on Borderline Personality Disorder Symptoms and Post-Traumatic Stress Disorder in Emerging Adulthood. Université d'Ottawa / University of Ottawa. https://doi.org/10.1007/s42380-022-00122-0

[22] 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.

[23] Bo S, Sharp C, Beck E, Pedersen J, Gondan M, Simonsen E. First empirical evaluation of outcomes for mentalization-based group therapy for adolescents with BPD. Personal Disord. 2017;8(4): 396-401.

[24] Haltigan JD, Vaillancourt T. Identifying trajectories of borderline personality features in adolescence: antecedent and interactive risk factors. Can J Psychiatry. 2016;61(3):166-175.

DOI: 10.54254/2753-7048/19/20231385

[25] *Wu, Y., Zheng, Y., Wang, J., & Zhang, T. (2022). Specific type of childhood trauma and borderline personality disorder in Chinese patients. Frontiers in Psychiatry, 13, 936739–936739. https://doi.org/10.3389/fpsyt.2022.936739*

[26] *Wu, Z., Liu, Z., Jiang, Z., Fu, X., Deng, Q., Palaniyappan, L., Xiang, Z., Huang, D., & Long, Y. (2022). Overprotection and overcontrol in childhood: An evaluation on reliability and validity of 33-item expanded Childhood Trauma Questionnaire (CTQ-33), Chinese version. Asian Journal of Psychiatry, 68, 102962–102962. https://doi.org/10.1016/j.ajp.2021.102962*

[27] *Luo, M., Huang, X., & Su, D. (2010). Influence of Confucian culture on current practice of mental health Services in China. Advances in Psychological Science, 18(09), 1481– 1488.*

[28] *Antic, A. (2021). Transcultural Psychiatry: Cultural Difference, Universalism and Social Psychiatry in the Age of Decolonisation. Culture, Medicine and Psychiatry, 45(3), 359–384. https://doi.org/10.1007/s11013-021-09719-4*