Opinion

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Narcissistic And Borderline Personality Disorders in the ICD-11

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ABSTRACT

The narcissistic leader fosters and encourages a personality cult with all the hallmarks of an institutional religion: priesthood, rites, rituals, temples, worship, catechism, mythology. The leader is this religion's ascetic saint. He monastically denies himself earthly pleasures (or so he claims) in order to be able to dedicate himself fully to his calling. There is no diagnosis of BPD in the ICD-11 in any way, shape, or form. The "Borderline Pattern Specifier" in ICD-11 is reminiscent of Kernberg's "Borderline Personality Organization" and Sperry's "Borderline Personality Style".

NARCISSISTIC DISORDERS

The latest iteration of the diagnostic and statistical manual, the DSM, the text revision of the fifth edition published in 2022. Yet, most of the text appears to have been written in the 1990s, not in 2022. And the reason is very simple: it has been written in the 1990s. It has been largely copy pasted from a text that has been authored in the late 1990s, the DSM IV. It is as updated, as accurate, and gets it right as often as what we used to know 30 years ago.

The 11th edition of the international classification of diseases says there are no personality types. There's no such thing as a personality disorder. There's no such thing as narcissistic personality disorder. There's no such thing as paranoid personality disorder. There's definitely no such thing as histrionic personality disorder. There may be a general problem with one's personality, a personality functioning problem which can be described in a variety of ways.

But in the ICD-11, there are no differential diagnoses. There's no categorical list. There are no diagnostic bullet lists. The ICD-11's framework has completely dispensed with personality types. Instead, we have a three layered approach which is modular, much more realistic, captures the clinical picture much better, and is adapted to how human beings function. People are not static, they are constantly in flux. The new classification of the ICD-11 deploys several layers. The first layer is comprised of the severity of the personality functioning. The second layer is the trait domains. In other words, which traits are associated with the personality functioning and then there is the description of the personality functioning based on these two. The ICD-11 allows the clinician to capture the essence of the client, to convert the presenting symptoms and signs into a living dynamic picture of the person in the clinical settings. The person who is seeking help. The person who is complex, who is replete with a life history, with experiences, with dreams, with expectations. The person who cannot be reduced to a single sentence or a bullet list of sentences. The person who has more dimensions than the disorder that feed into the disorder.

The ICD-11 therefore is a far more complex, far more nuanced, far more subtle diagnostic system than the DSM and vastly superior to it. It also reflects the recent cutting edge information and studies in each and every field. So, let's start with the severity of the personality functioning or actually the severity of the personality dysfunction and let's apply it. Let's use the ICD-11 tools and instruments and apply them to what we call pathological narcissism: to what the DSM calls narcissistic personality disorder. The ICD distinguishes between various severity levels. Let's start with what the ICD calls personality difficulty and let's apply this to pathological narcissism.

Someone who presents in therapy, while seeking help, someone in the throes of a marital crisis or a family crisis or a workplace crisis, someone who interacts with the therapist or the clinician or the psychiatrist by describing problems. This kind of person, this client can be analyzed using various levels of severity, personality difficulty. Applied to narcissism, we start with a mild severity description, only intermittent or at a low intensity. The problems are insufficiently severe to cause notable disruption in various relationships and they may be limited to specific relationships or situations. For example: a narcissistic reaction to a self-esteem threatening situation such as serious physical injury, relationship breakup, or personal

failure may involve narcissistic injury: petulant temper tantrums and narcissistic rage, or attempts at self- enhancement, self-aggrandising using usually a fantasy defense. This is the first level of severity of personality difficulty. Then we have a second level which is mild personality disorder. The client is particularly sensitive towards injuries to self-esteem, narcissistic injury, and major or pervasive martyrlike victim style.

So, we're beginning to see the contours of a mild personality disorder emerging from the presentation of the client. This kind of client will be unable to set appropriate goals and to work towards accomplishing or attaining these goals. And this compromised capacity for self-efficacy is what is known as narcissistic procrastination or narcissistic perfectionism. For example: in a mild personality disorder, there would be difficulty persisting in the face of even minor setbacks due to underlying entitlement, a dismissive devaluation of what cannot be easily achieved in order to protect the fragile self. And there will be minor interpersonal conflicts stemming from difficulties with authentic and empathic understanding and connection with others. These mild empathic disturbances and deficits will not be severe. They will not cause serious and long lasting depression. On we proceed to the next level of severity known as moderate personality disorder.

This kind of person, this kind of narcissist has a pervasive and contradictory self-view (self-concept), blending themes of grandiosity, individual exceptionalism, and or vulnerability, for example, being morose or passive-aggression. And none of this can be modified with evidence to the contrary.

The ICD as distinct from the DSM recognizes vulnerable narcissism and also incorporates the latest research that shows that all narcissists are both overt and covert at different times and in reaction to changing circumstances and environmental cues. The ICD is really outstanding in reflecting current knowledge. In moderate personality disorder, the narcissistic person may persist unreasonably to pursue goals that have no chance of success. Narcissistic vanity, narcissistic perfectionism come into play. This kind of person will exhibit little genuine interest or efforts towards sustained employment. There is overt entitlement, nihilistic devaluation. There will be a lack of mutually satisfying relationships because of limited ability to appreciate other people's perspectives resulting in unbalanced, unhinged relationships in which the individual is highly dominant. And finally, in moderate personality disorder, relationships are highly conflictual, highly antagonistic, and there is persistent avoidance and devaluation of other people. The narcissist or the narcissistic person is always disappointed and let down in relationships by others. Again, the victimhood part: I'm a victim.

Finally, we come to what the DSM calls narcissistic personality disorder and is known in the ICD-11 as severe personality disorder. So, we have a severe level of personality disorder in conjunction with narcissism. This kind of individual would have a self-view, a self-concept that is very unrealistic and typically highly unstable or contradictory with polarized extremes of self-aggrandisement on the one hand and shame and self-loathing on the other hand. This approach is also cutting edge research. We are beginning now to understand that all narcissists and all form of narcissism are compensatory. It compensates for a kernel, a core identity which is a repository of intolerable life-threatening shame.

In severe personality disorder, the emotional experience is dominated by envy, resentment and hatred - negative effects. There's serious difficulty with regulation of self-esteem resulting in exquisite interpersonal sensitivity to slights or unwavering despair, hypervigilance coupled with what could be easily described as depressive illness. The relationships lack mutuality and are extremely one-sided. Interpersonal conflict may involve serious verbal abuse on rare occasions violence either directed towards others or towards the self via self-destructiveness. So here we have a borderline element in narcissism and this is the greatness of the ICD-11: it does not have categorical demarcated diagnoses, polythetic issues, and rampant co-occurrences or comorbidities. The manual actually acknowledges the fact that every narcissist is sometimes borderline and sometimes a psychopath. That every borderline is sometimes a narcissist and sometimes a psychopath. And every psychopath is sometimes a narcissist. This this acceptance, this acknowledgment that what the DSM calls personality disorders segue into each other seamlessly, are intermixed, places the ICD11 apart as a far superior diagnostic text.

One of the presenting elements of severity in narcissism according to the ICD-11 is self-destructiveness, self-harming which in the DSM is exclusively reserved to borderline personality disorder and wrongly so: narcissists are highly self-defeating and self-destructive. According to the ICD, in the severe variant of the personality disorder, interpersonal conflict may involve serious violence and other forms of externalized aggression, verbal or otherwise and this is a psychopathic element. This kind of clinical feature in the DSM appears only in antisocial personality disorder, which is clinically counterfactual. Narcissists and borderlines are highly abusive, highly aggressive. They externalize aggression and often can become violent. So to say as the DSM does that only antisocial people, people with antisocial personality disorder externalize aggression runs contrary to everything we know. It's a mistake simply. The ICD-11 equally suggests that these kinds of people are unwilling to sustain regular work due to entitlement, a lack of interest of or effort, parasitism, feats of temper, insubordination, in other words: psychopathic defiance and contumaciousness.

In the ICD11, therefore, there's no distinction between narcissist, borderline, and psychopath. The elements which are used to describe the severity of pathological narcissism in an individual include critical clinical components, clinical features of borderline personality disorder and antisocial personality disorder in the DSM. And that's the right way to look at it because all narcissists are sometimes borderline and sometimes psychopathic. Having specified the severity of the personality functioning, the clinician then proceeds to rate and describe personality trait domains. The traits to focus on in the case of someone who is suspected of pathological narcissism are negative affectivity (for example: emotional lability, exactly like in borderline, negativistic attitudes, passive aggressive in many cases, low self-esteem, and mistrustfulness). Another trait domain is detachment: social withdrawal, emotional avoidance.

A critical feature of pathological narcissism is dissociality which is not the exact equivalent of antisocial features in the DSM.

Dissociality includes antisocial clinical features, but it has other additional manifestations such as self-centeredness, egotism, and lack of empathy. Another element is disinhibition, impulsivity, destructibility, irresponsibility, recklessness, usually attributed by the DSM to psychopaths and Anankastia (obsessive compulsive features such as perfectionism, emotional and behavioral constraint and so on. The ICD-11 recognizes something called the borderline pattern specifier with which individuals who meet the diagnostic criteria for borderline personality disorder in the DSM-5-TR can be identified and this addition is very pragmatic. It facilitates treatment choices. It is very helpful to the clinician.

So, the clinician who is using the ICD-11 and is presented with a client starts by determining how severe a case is it? How difficult? How invasive and pernicious is the disorder? How ubiquitous and or pervasive? The clinician rates the severity of the alleged personality disorder. In the second stage, the clinician identifies traits presented by the client. Is the client disinhibited? Is the client dissocial? Detached? Is a client a perfectionist or reckless or whatever? The clinician categorizes the various traits. This process yields a compounded picture: the severity of the disorder coupled with the traits that are typical of the specific client. At times the clinician can apply what Kernberg called borderline personality organization or, in the ICD-11, the borderline pattern (see below).

When the clinician believes that despite a high severity and despite a confluence of trait domains which are intractable and difficult and onerous, the patient can be treated, s/he recommends a treatment modality which might be useful and beneficial for the patient. In such a case, the clinician usually applies another diagnostic layer, the borderline pattern because borderlines can be treated. The prognosis is good actually.

At this stage, the clinician can create a perfect picture of the client or patient, known as "clinician rating" based on personality functioning assessment: different aspects of personality functioning come into play and the clinician generates essentially a somewhat literary description of the patient. Let's have a look at a typical clinician rating of personality functioning in a typical pathologically narcissistic client.

Start with identity. There's a grandiose expression of identity: inflexible, rigid identity, the conviction of a grandiose self or self-concept. And there's a vulnerable expression: this kind of person feels empty, lacks a core identity, oscillates and contradicts his own self-view and self-concept. The self-concept is highly volatile, highly labile.

Another element in personality functioning is self-worth. In the grandiose expression, the person feels superior, devalues other people, is haughty, arrogant. In the vulnerable expression, the person feels worthless, incompetent, humiliated, and shamed. All narcissists oscillate between these two modes of expression, between an overt (grandiose) state and a vulnerable state. All narcissists sometimes are in a in overt mode sometimes they are in a covert, fragile, vulnerable mode. This depends crucially on the uninterrupted flow of narcissistic supply from the environment which forestalls a state of collapse. But when the narcissist is mortified or even severely injured; when the narcissist endures a state of collapse, there is a transition from an overt state to a covert state. During the personality functioning clinician rating, the clinician creates a table. The next item in this table is self-appraisal. In the grandiose expression, this person believes that he has no weaknesses, minimizes personal failings, failures, defeats, wrong decisions and so on. And vulnerabilities are projected onto other people who are subsequently devalued. The vulnerable expression of self- appraisal: the person is relentlessly self-critical, anticipates other people to be similarly critical, has a fantasy of an ideal ego, an omnipotent self, and this ideal sharply contrasts with the actual self (discrepancy between implicit and explicit self-esteem plus what I call the grandiosity gap between the fantastic, inflated self-concept and reality)

The next element in personality functioning is self-direction. In its grandiose expression, the client sets unrealistically high expectations consistent with a grandiose and entitled self-concept ("ego ideal"): expectation of achieving goals without any commensurate efforts. The vulnerable expression of self-direction: this kind of person sets unrealistically high expectations that confirm the person's inadequacy and incompetence. Uses the inability to accomplish anything as a justification for entitlement and lack of effort. Next in personality function is relationship interest. The grandiose expression: the client is extroverted yet detached. The relationships are superficial, on the surface. The person acutely devalues other people and yet is dissonantly dependent on other people for the purposes of self-esteem regulation and self-enhancement. In other words: even though this kind of narcissist depends on other people for narcissistic supply, he tends to hold them in contempt, is contemptuous, disdainful, and he devalues them.

On the vulnerable expression side, when it comes to relationship interests, this kind of person is needy and even clinging in relationships and yet withdrawn and ambivalent, superficially idealizing others yet chronically devaluing and dismissing them in the same breath. What about empathy? It's another element, another ingredient, another component of personality functioning. What's the grandiose expression of empathy?

Dismissive of the thoughts and feelings of other people. Unwilling to authentically engage with alternative perspectives. What's the vulnerable expression of empathy? Preoccupied with thoughts and opinions of other people, but only as related to oneself. Very self-centered. This leads of course to mutuality as a dimension of personality functioning. The grandiose expression of mutuality: the client is selfish in relationships with others, instrumental in using relationships to bolster self-esteem needs and personal satisfaction, and is highly transactional. The vulnerable expression: the client is dependent and passive in relationships yet resentful and antagonistic of this perceived chronic victimhood. And finally, in personality functioning: conflict management. As usual, there's a grandiose expression and a vulnerable expression of conflict management.

The grandiose expression: the person is highly conflictual, exhibits an antagonistic style of relating, has regular intense disagreements with other people. The vulnerable expression: the person avoids direct conflicts with other people and is chronically passive-aggressive, relates to other people in a hostile way, undermines and sabotages them. This is the clinician rating of the personality functioning of the narcissistic client or patient.

The ICD-11's clinical protocol is straightforward:

A client or patient presents to a clinician, a therapist, a psychiatrist. The clinician notes presenting signs and symptoms (there's a client's presentation).

The clinician first asks himself or herself: how severe is what I'm witnessing right now? Is it mild, moderate, severe, or very severe? The clinician rates the patient for severity. The clinician then proceeds to describe the patient in terms of specific traits (trait domains). Next, the clinician creates a clinical picture regarding the patient's personality functioning using a variety of determinants and variables and then he divides these variables into grandiose expression vs. vulnerable expression.

The clinician attempts to understand at which stage is the patient. Is the patient right now being overt, grandiose or is a patient right now in a vulnerable state, fragile, and shy. The last phase is the clinician's rating of the personality traits. This is done by gauging the frequency of the appearance of the traits, their manifestations, the expression of the traits in clinical and other, nonclinical settings. How often do they appear? Each trait is given a number in terms of a percentage: this trait appears 94% of the time, for instance.

Imagine that the patient is always complaining, always depressed, always morose, always sees a negative side, is always pessimistic and so on so forth. This kind of patient would have 94% negative effectivity. All other traits are given percentages and then the clinician creates a clinician rating trait domains. In a typical narcissist, we would have the following percentages, more or less: Negative affectivity characterizes 32% of overt narcissists and 94% of vulnerable narcissists. Emotional ability: 27 versus 21. Depressivity: 5 versus 89. Anxiousness: 7% in grandiose narcissists versus 80% in vulnerable narcissists.

It is clear that, in the vulnerable phase of narcissism, the person is depressed and anxious, but not overly emotionally labile. Actually, emotional ability is much higher in overt narcissism because these people (narcissists in the overt phase) are much more sensitive to criticism, they are much more easily narcissistically injured. Thus, their emotional ability is higher. What about detachment? 33% of overt narcissists are detached. 72% of vulnerable narcissists are. Six percent of overt narcissists are socially withdrawn vs. 54% of the vulnerable variety. .32% of overt narcissists avoid intimacy. 44% of vulnerable one. And 16% of overt narcissists and 34% of vulnerable narcissists are affectively restricted. They have reduced effect display. They don't show emotions very well. Dissociality, antisocial elements plus other restrictive or constrictive elements: 91% of overt narcissists are dissocial, but only 12% of vulnerable narcissists. Manipulativeness: 60% of overt grandiose narcissists are manipulative but only 3% of vulnerable narcissists. Machavelianism scores in vulnerable narcissism are dramatically lower than in overt narcissists. Overt narcissists are much more manipulative than covert narcissists. Grandiosity: 90% of overt narcissists are grandiose, only 5% of vulnerable narcissists.

This, however, is not exactly accurate because the grandiosity of the vulnerable narcissist masquerades, disguises itself. So, it's very difficult to spot, but it's there. Hostility: 64% of overt narcissists are hostile. Only 8% of vulnerable narcissists are hostile.

What about this disinhibition?

Acting in ways which defy social norms and conventions and mores and scripts, recklessly. This behavioral repertory is reminiscent of someone under the influence of drugs or alcohol. 44% of grandiose overt narcissists are disinhibited but only 4% of covert narcissists. 32% of overt classic narcissists are irresponsible. Only 1% of vulnerable narcissists are irresponsible. 28% of overt classic narcissists are impulsive. Only 4% of vulnerable narcissists. What about attention? Attention deficits. 4% of overt narcissists have attention deficits. Only 2.5% of vulnerable narcissists suffer from same.

Regarding anankastia: obsessive-compulsive personality dimensions. 58% of overt narcissists are anankastic vs. 53% of their vulnerable covert counterparts. When it comes to orderliness - being orderly, neat and organized - 2% of overt narcissists versus 4% of covert narcissists.

Rigidity: 44% of grandiose overt narcissists are rigid, not open to learn or change. They will never admit to a mistake. They're stubborn. Only 19% of covert narcissists are rigid. Finally, perfectionism: 47% of overt narcissists are perfectionist. 49% of covert narcissists. With this, the clinician's work is done, having produced a comprehensive and thorough clinical picture of the patient or the client, something that can absolutely not be accomplished with the diagnostic and statistical manual unless one uses somehow a conjunction of the diagnostic criteria and the alternative models. But the DSM offers only very few alternative models: for narcissistic, borderline, and antisocial personality disorders.

The ICD-11 captures and describes narcissistic subtypes using severity ranking, personality functioning, and trait domains or dimensions. The ICD-11 robustly demonstrates an ability to capture diverse manifestations of the personality and to accept that there are no clean, pure, unadulterated diagnoses and types. That every patient and client has idiosyncrasies which can be attributed to narcissism. other elements attributable to borderline and definitely elements attributable to antisocial or psychopathic or the dissocial type. A client or a patient would be diagnosed as mild, moderate or severe and then grandiose or vulnerable: this would be the clinician rating, the clinical picture with emphasis on trait domains, highlighting relevant treatment options, especially in the presence of a borderline pattern.

The ICD-11 does not make a distinction between male and female clients, male and female narcissists. That is also very correct: it reflects the latest knowledge. We now know that there are no clinical psychonamic or psychological differences between male and female narcissists., they're identical psychologically. However, cultural and societal constraints, expectations, conventions, norms, and mores dictate different

expressions and manifestations of narcissism in females versus males. In other words, society expects women and men to behave differently and penalizes them if they defy these expectations. It is society and the prevailing culture that inform the female narcissist how she is allowed and expected to express her pathological narcissism and informs the male narcissist similarly.

Borderline Pattern

There are two clinical constructs which are related to borderline personality disorder but are not the same. The first one is the borderline pattern first described in the 11th edition of the international classification of diseases the ICD, published in 2022. And the second construct is the borderline personality organization first proposed by Otto Kernburg in 1967. There is no diagnosis of borderline personality disorder in the ICD-11. There is also no substitute for such a diagnosis, no borderline personality disorder by another name. Instead, the International Classification of Diseases, the ICD, introduced a new construct, the borderline pattern. The borderline pattern can be diagnosed together with highly specific trait domains and highly specific personality dysfunctions.

Quoting from the ICD-11:

“The borderline pattern specifier in the ICD11 may be applied to individuals whose pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image and effects and by marked impulsivity as indicated by five or more of the following. Number one: frantic efforts to avoid real or imagined abandonment. Number two: a pattern of unstable and intense interpersonal relationships which may be characterized by vacillations between idealization and devaluation, typically associated with both strong desire for and fear of closeness and intimacy.

Number three: identity disturbance manifested in markedly and persistently unstable self-image or sense of self. known as self-concept. Number four: a tendency to act rashly, recklessly in states of high negative affect leading to potentially self-damaging behaviors. For example, risky sexual behaviors, reckless driving, excessive alcohol or substance use, and binge eating or binge eating.

Number five: recurrent episodes of self-harm. Examples: suicide attempts or gestures, self-mutilation. Number six: emotional instability due to marked reactivity of mood. Fluctuations of mood may be triggered either internally by one's own thoughts, for example, or by external events. As a consequence, the individual experiences intense dysphoric mood states which typically last for a few hours but may last for up to several days. Next: chronic feelings of emptiness. Inappropriate intense anger or difficulty controlling anger manifested in frequent displays of temper, yelling or screaming, throwing or breaking things, getting into physical fights and so on. And finally, transient dissociative symptoms or psychotic-like features, brief hallucinations, paranoia in situations of high effective arousal. The borderline pattern specifier continues to read:

"Other manifestations of a borderline pattern, not all of which may be present in a given individual at a given time, include the following: A view of the self is inadequate, bad, guilty, disgusting, and contemptible. An experience of the self as profoundly different and isolated from other people. A painful sense of alienation and pervasive loneliness, proneness to rejection, hyper sensitivity, problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships, frequent misinterpretation of social signals. So this is the foundation of the clinical assessment of a borderline pattern in patients which otherwise possess trait traits unrelated to borderline. One could present in therapy as a client and the clinician would notice that you have negative affect, you are dissocial, you are antagonistic, you are anankastic (you have obsessive compulsive features), and so on but at the same time you have a borderline pattern.

The clinical interview may lead to a kind of compounded diagnosis without labeling, just capturing the essence of what's going on in the client's mind, the client's psyche, the client's emotions and cognitions. Nowadays, we diagnose borderline personality disorder (BPD) using the ZAN-BPD test which was first proposed by Zaharini and others in 2006. Some clinicians are still using Gunderson's work, the DIIB, the diagnostic interview for borderline patients, but it is going out of fashion. The rating of ZAN-BPD is a threshold for diagnosing a borderline pattern or even borderline personality disorder under the DSM.

The ZAN-BPD assesses borderline personality disorder but can be applied to the identification and delineation and description of the borderline pattern specifier under the ICD because the ZAN-BPD is very flexible. The elements in the ZAN-BPD include the assessment of anger, especially specific or different content areas, frustration, irritability, intense anger, mildly angry acts, intense angry acts of verbal nature, intense angry acts of a physical nature and so on. So, there's a lot of attention paid to anger, aggression, internalized or externalized.

Number two: the assessment of affective instability, volatility, lability, again incorporating different content areas somewhat or substantially out of proportion relative to the severity of life circumstances and triggers and other parameters and delineators. There's also an assessment of chronic feelings of emptiness divided to different content areas and there's an assessment of serious identity disturbance including different content areas such as mild identity disturbances serious identity disturbances and so on. So, the ZAN-BPD captures the quiddity, the very core and essence – fluctuating and unstable - of borderline.

Other emphases in the ZAN-BPD include the assessment of stress-related paranoid ideation or dissociative symptoms. These are divided to different content areas. Mild feelings of distrust or a sense of unreality, intense feeling of distrust or unreality, depersonalization, derealization and so on. There is an assessment of frantic efforts to avoid feeling the sensation of being abandoned or being rejected and overt or covert efforts to manage these fears. There's an assessment of self-destructive behaviors including suicide threats, suicide gestures, and suicide attempts, different types of self-mutilation, scratching,

punching oneself, cutting, burning. These are all divided into minor or more serious and up to severe.

There is an assessment of impulsive behaviors which is divided to 12 content areas. It's a very powerful test. And then there's an assessment of a pattern of unstable and intense personal relationships: areas that alternate between idealization and devaluation, dependency, fleeing from intimacy, engulfment anxiety, and having stormy relationships marked by arguments and breakups. So, a clinician who uses the ICD is perfectly authorized and feels comfortable to use the ZAN-BPD test, despite the fact that it is associated mainly with the DSM. The test is very good at spotting and ferreting out borderline patterns.

Now the problem with borderline - any type of borderline: borderline personality organization, borderline pattern, borderline personality disorder - with all these borderline aspects of the personality is that borderline is often comorbid. It's often diagnosed with other mental health issues and these other mental health problems obfuscate and cloud the clinical picture. They contaminate if you wish the purity, the unadulterated nature of the borderline construct and they raise multiple major issues. The ICD provides differential diagnosis in a variety of areas, all attendant upon and extensions of the borderline pattern in the ICD.

The ICD tackles comorbidities or co-occurrences in the borderline pattern and touches on a wide range of symptoms of or what are called internalizing features: depression, anxiety, post-traumatic stress disorder PTSD), as well as externalizing features (substance abuse, suicidal behaviors, self-harm, self-mutilation, eating disorders, attention deficits) and interpersonal features which is a domain of what the DSM calls personality disorders. In the DSM, personality disorders, especially cluster B ones, are relational, they have to do with interpersonal relationships but in borderline there's also a co-occurrence, a comorbidity of psychotic features: transient hallucinations, extreme dissociation, paranoid trends.

Dissociation includes amnesia, derealization, and depersonalization, so this there is an overlap between mood disorders and borderline features. When patients present, they can be misdiagnosed with a mood disorder or an anxiety disorder or a substance use disorder or impulsive disorder or psychotic disorder - when the actually issue revolves around borderline features, a borderline pattern, or a borderline personality organization. There have been attempts to redefine borderline personality disorder as a mood disorder or as a mode of emotion dysregulation or as an impulsive disorder or as an interpersonal disorder or as a complex trauma disorder (post-traumatic disorder) or as dissociative identity disorder (for a review of these directions, see the work of Paris, especially the articles published in 2020).

There are therefore major issues with the coherence and validity of the borderline construct. But it seems that the same problem exists with other mental health disorders. We have to balance between lack of clarity, doubts, comorbidities, and co-occurrences on the one hand and on the other hand how useful the construct is. Does it allow us to identify and profile the patient in a way which recommends itself to highly efficacious treatments? If the answer is yes, then we would rather keep the psychopathological construct even if it's a bit fuzzy and this is exactly what the ICD committee and the DSM committee have decided to do. Let's review a few of the co-occurrences and comorbidities.

Depression is the number one. Depressive symptoms are actually the main reason why borderline patients seek treatments or present themselves in clinical settings. There are studies that show that all borderline patients at one time or another suffer from depressive disorders or depressive episodes or depressive symptoms. The crucial issue when we discuss the comorbidity of depression with BPD or with the borderline pattern in the ICD is of course: stability versus instability. Borderline patients describe an unstable, labile mood that is highly sensitive to interpersonal conflict, whether real or anticipated and also reactive to stress. Stressors generate anxiety and depression in borderline patients much more so than in the general population or in patients with other issues. This is what we call emotion dysregulation and it is pro probably a trait and likely heritable, hereditary, genetic. There's work by Linehan as early as 1993 alluding to this.

This failure with regulating emotions explains why so many patients are chronically suicidal, even when they're not depressed. A depressive person with pure major depression may possess suicidal ideation during the depressive episode. In Borderlines, this is basically background noise. It's constantly there. It emerges all the time. A very problematic comorbidity or a very problematic differential diagnosis is between borderline and bipolar disorder. In many countries, clinicians, mental health practitioners and scholars make the egregious mistake of conflating the two.

Emotion dysregulation is the feature that distinguishes BPD from bipolar. In BPD, mood vacillations or swings are frequent, but they are short-lived. In the bipolar patient, the hypomanic episodes can last days or even weeks. The BPD patient can also develop psychosis which may last as long as a few days. And these episodes are usually misidentified as mania.

The medications used for bipolar disorders are totally ineffective in borderline. This demonstrates that the confusion between these conditions seriously damaging to the patient. There were even scholars who suggested a bipolar spectrum where the mild cases are diagnosed in the absence of manic or hypomanic episodes. And this bipolar spectrum was immediately and erroneously conflated with borderline. As distinct from Borderline, Bipolar is a mood disorder. Borderline is a personality disorder or a personality pattern. Bipolar has biochemical antecedents.

What about complex trauma or even post-traumatic stress disorder (CPTSD)? About 25%-30% of people diagnosed with BPD (borderline personality disorder) also experience post-traumatic stress disorder (PTSD, not CPTSD). This comorbidity has to do with childhood maltreatment and a resultant trauma (for example incest, other forms of sexual abuse or worse). To clarify: trauma is not in the ethology of borderline personality disorder, it is not the main cause of borderline personality disorder. Various meta-analyses of studies (Porter, for example), suggest that emotional neglect and invalidation are the most important environmental risk factors

for the disorder - not abuse, nor trauma. Being ignored, being neglected are the key predictors of BPD.

Like BPD, ADHD (attention deficit hyperactivity disorder) also starts pre-adulthood and continues into adult life. But BPD usually starts in adolescence, shortly after puberty, while ADHD starts earlier. Some BPD patients of course can be diagnosed with ADHD. But ADHD is overdiagnosed and is threatening to displace other legitimate diagnoses. It is metastasizing. Especially when childhood onset cannot be confirmed, it's probably not ADHD. When the whole set of symptoms, the symptomatology, started in adolescence, it's probably borderline.

So, there's a huge confusion regarding the possible causes of attention problems with a specific diagnosis reserved for medical conditions or stimulants. BPD is as rare as NPD. The community prevalence of BPD is about 2%. But 9-10% of the clinical population of all people presenting for treatment are diagnosed with BPD. This preponderance gives the wrong impression that borderline is much more prevalent than it is.

Similarly in narcissism about 1.7% of the general population suffer from NPD and they present in therapy only following a collapse or mortification. So, this gives the wrong impression that most narcissists are either covert or that the prevalence is much higher. To this very day, the perception is that most patients with BPD are women. But recent studies, especially community studies, show that there are many men with BPD who are undiagnosed and untreated. It's probably because women seek help for BPD much more than men. It's safe to say that half of all border lines are men and half of all narcissists are women. What about the genetics of BPD? In pathological narcissism, we do not have a convincing, rigorous body of studies that proves that pathological narcissism is genetic, But that is not the case with borderline personality disorder.

Behavioral genetic studies using community samples of twins have found that nearly half of the variance in BPD is heritable (is related to genetics). There are no genetic markers for BPD (or for any other diagnosis in psychiatry). The myth that mental health disorders are hereditary or genetic is just that: a myth. We don't have a single genetic marker for any psychiatric disorder, including even schizophrenia and psychotic disorders, let alone personality disorders. Several studies have shown that if BPD were to be genetically determined, it would probably have involved hundreds or thousands of interacting genes. Even so, all these genes put together account for less than 5% of the variance in borderline (heritability gap). There are many interactive pathways leading towards a disorder and they are not genetically determined. Most but not all people with borderline personality disorder or with the borderline pattern have been exposed to environmental adversity in childhood and in adolescence: adverse childhood experiences (ACEs) or trauma or abuse in a variety of ways. Remember: abuse doesn't have to be physical or verbal or psychological. A parent who instrumentalizes her child, parentifies the child, overprotects the child, spoils the child is abusing the child. Trauma is pretty common in in the borderline ethology, but it's not the main risk or even a causative factor. The most frequent kind of trauma is emotional neglect. There's a high frequency of dysfunctional families in borderline personality.

Other studies seem to challenge this. For example, sibling studies: siblings raised by the same parents, even twins, are rarely concordant for BPD. In other words, they rarely develop BPD simultaneously. It stands to reason that there is some gene-environment interplay or interaction here. There's a differential sensitivity to the environment. We probably need to develop a biosocial theory of borderline.

Borderline is also common in developed countries but less prevalent in less developed countries or in developing ones. One possible explanation is that traditional cultures offer more resources for emotional support and they're protective against this form of mental disorders. In the least developed countries, there is a dearth of infrastructure and resources needed to diagnose people. Longitudinal studies found that somewhere between 5 and 10% of patients with borderline die by suicide. Suicide is the leading cause of death in borderline personality disorder under the age of 40. It is notable that almost all these patients suffered from chronic suicidality and all borderlines contemplate suicide, consider suicide, even make preparations for suicide and attempt suicide all the time. Yet only 10% die of suicide.

The lifespan of patients with borderline is shortened but it's shortened by poor health: borderlines live 10 to 20 years fewer than mentally healthy people. Such “penalty” is common in other severe mental health issues (psychotic disorders, for example). Most patients with a borderline pattern first develop clinical symptoms during adolescence and the peak of the psychopathology tends to be in the patient’s late adolescence and early 20s. After this stage the disorder tends to remit or recede gradually and spontaneously with the vast majority of cases no longer diagnosed or diagnosable by age 35 to 45.

The prognosis for borderline is actually extremely good whereas in pathological narcissism it considerably worse. The borderline pattern in the ICD is reminiscent of the work done and a construct proposed by Otto Kernberg in 1967: borderline personality organization (BPO). Kernberg suggested that there is a level of personality organization which is characterized by instability in identity, volatility of relationships, and affect lability as well as the use of what is called in psychoanalytic literature primitive defense mechanisms such as splitting.

BPO a psychoanalytic concept. It describes the structure of a personality functioning that lies between neurotic and psychotic levels. So, while borderline personality organization is somehow related to borderline personality disorder, it's not synonymous with it. It represents a broader spectrum of personality functioning, or, to be more precise personality dysfunctioning. The key characteristics of and features borderline personality organization are very similar to the borderline pattern.

Identity diffusion: a lack of stable and integrated sense of self with shifting and contradictory self-perceptions. Unstable relationships: intense but yet unstable interpersonal relationships, marked by idealization and devaluation of others. Primitive defenses: immature defense mechanisms such as splitting (viewing people as all good or all bad) and projection (projecting one's own unacceptable feelings onto others), and denial, among others. Impulsivity: difficulty controlling impulses leading to behaviors such as substance abuse, reckless

driving, or risky sexual behavior. Emotional or emotion dysregulation: difficulty managing and regulating emotions, often experiencing intense and fluctuating moods, brief psychotic episodes or microepisodes. In times of stress, individuals may experience brief periods of distorted reality testing.

Fear of abandonment (separation insecurity): a pervasive fear of being abandoned or rejected, which can lead to clingy or avoidant behaviors in relationships. Impaired reality testing. While people with borderline personality organization are not psychotic, they may have difficulty to maintain a stable sense of reality, particularly when they are stressed or challenged or rejected or humiliated or abandoned or engulfed with intimacy. There are differences between borderline personality disorder and borderline personality organization. Borderline personality organization is a broad, umbrella concept. It encompasses a range of personality functioning levels and personality dysfunctioning levels. While BPD is a specific clinical diagnosis, more severe and extreme than BPO.

BPD is characterized by a greater degree of impairment in functioning, a diagnosable clinical picture and very conspicuous clinical features. BPO is subclinical: individuals with the organization may not meet the criteria for the disorder. They display some of the core features associated with it but not all. BPO is very reminiscent of Len Sperry's later idea of personality styles. Sperry suggested that there is a borderline personality style. Borderline personality organization represents a level of personality organization characterized by a particular constellation of features and defense mechanisms. It provides a framework for understanding and classifying individuals with varying degrees of personality difficulties including those who may or may not meet the full criteria for borderline personality disorder.

Borderline personality disorder is still a hotly disputed diagnosis. As I said earlier, many scholars are attempting to subsume it under other mental health issues or to conflate it with them. I believe that the borderline pattern or the borderline personality or organization is a valid clinical construct which captures the essence of some individuals the way nothing else can and does.