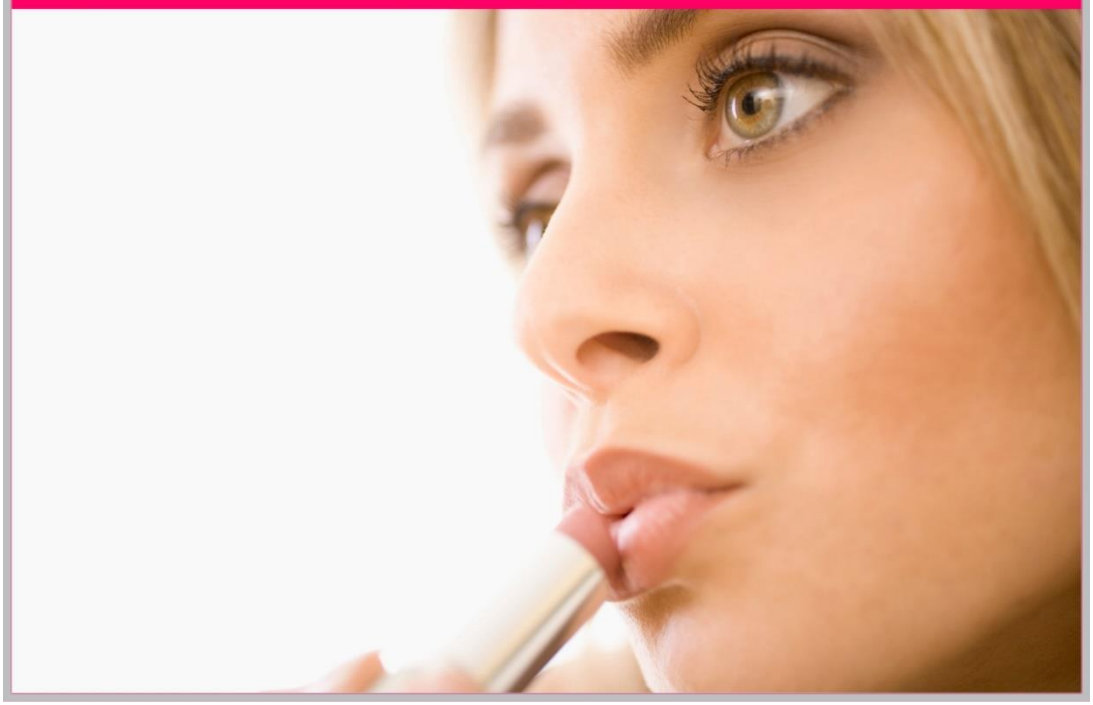
Borderline Personalities

SAM VAKNIN



Borderline Personalities

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Warning and Disclaimer

The contents of this book are not meant to substitute for professional help and counselling. The readers are discouraged from using it for diagnostic or therapeutic ends. The diagnosis and treatment of Narcissistic Personality Disorder can only be done by professionals specifically trained and qualified to do so – which the author is not. The author is NOT a mental health professional.

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The Vaknin-Rangelovska Foundation Presents:

Borderline Personalities

Seminar with:

Prof. Sam Vaknin

Our Gratitude to the Commonwealth Institute of Advanced Professional Studies (CIAPS), Cambridge, UK for its sponsorship.

Watch Borderline Personality Disorder (BPD) Reconceived Playlist

https://www.youtube.com/playlist?list=PLsh_y_ett4o064nEQL4gRqxg4MHqfMfdq

Thursday, November 12, 2026

15:00 Sexuality in Cluster B Personality Disorders (BONUS LECTURE)

Friday, November 13, 2026

10:00-12:00 Borderline Personality Organization vs. Borderline Personality Disorder: Nature, Nurture, Sociocultural

13:00-14:30 BPD in ICD-11 vs. DSM 5-TR

15:00-17:00 Emotion (Affective) Dysregulation and Other Clinical Features

Saturday, November 14, 2026

10:00-12:00 BPD or Complex Trauma (CPTSD), Covert Narcissism?

13:00-14:30 BPD Comorbidities (Co-occurrences) and Dual Diagnoses (NPD, AsPD (Secondary Factor 2 F-2 Psychopathy), HPD, Substance Use, Anxiety Disorders, Mood Disorders)

15:00-17:00 Intimate Relationships with the Borderline

Sunday, November 15, 2026

10:00-12:00 Healing and Recovery, Treatment Modalities

13:00-14:30 The Borderline's Children and Inter-generational Transmission of Trauma

15:00-17:00 The Future of the BPD Diagnosis: New Horizons, Covert Borderline

Introduction

The term “borderline” originated in the 1930s to describe patients precariously balanced on the border line **between neurosis and psychosis**. Though formally no longer the consensus, it is still the view of many practitioners and theoreticians, myself included.

Still, both the BPD Alliance and TARA call for name change.

In younger patient, borderline-like symptoms are common: impulsivity, mood lability, and unstable self-concept, acute sensitivity to rejection.

Ever since its 3rd edition, the DSM offered these **diagnostic criteria for BPD**: fear of abandonment, unstable relationships, identity disturbance, impulsivity, self-harm or recurrent suicidal behavior, emotional reactivity, chronic emptiness, intense anger, and transient, stress-related paranoia or dissociation.

But, diagnosing someone with BPD based on 5 out of 9 diagnostic criteria in the DSM creates a **polythetic problem**: two individuals could be diagnosed with BPD and have only one criterion in common.

BPD is highly **prevalent in clinical settings**: 22% of psychiatric inpatients and 12% of outpatients have a primary diagnosis of BPD.

A 2026 meta-analysis estimated a global community prevalence of 2.4%. BPD occurs **equally in men and women** but is diagnosed 3 times more often in women, possibly owing to gender bias and stereotypes: men are likelier to be diagnosed with substance use disorders, or treated for isolated problem behaviors.

My proposed diagnosis of **covert borderline** addresses this gap.

LITERATURE

Ramos-Suárez I, Guerrero-Jiménez M, Cervilla JA, Gutiérrez B. Epidemiology of borderline personality disorder in the general population: Prevalence, sociodemographic factors, and comorbidities - A systematic review and meta-analysis. J Affect Disord. 2026 Feb 1;394(Pt A):120482. doi: 10.1016/j.jad.2025.120482. Epub 2025 Oct 20. PMID: 41115635.

Borderline Personality Disorder (BPD) is a very **disruptive condition**: repeated hospitalizations are common; powerful, debilitating medications; and years of psychotherapy.

Like other personality disorders, **BPD is all-pervasive**. Every aspect of the patient's life is affected: sense of identity and Self, emotions, relationships, and behaviors (which are often self-harmful). Marsha Linehan, developer of DBT, described the condition as lacking an "**emotional skin**" when every contact is excruciating.

Suicidal ideation is common. More than 80% of the 35,000 subjects in a meta-analysis were found to have experienced suicidal ideation. More than 50% attempted suicide, and 6% actually ended their lives. BPD is the single most potent independent predictor of suicide risk across all psychiatric conditions. Substance use and self-harm are also very prevalent.

LITERATURE

Lak M, Shakiba S, Dolatshahi B, Saatchi M, Shahrbaf M, Jafarpour A. The prevalence of suicide ideation, suicide attempt and suicide in borderline personality disorder patients: A systematic review and meta-analysis. Gen Hosp Psychiatry. 2025 Jul-Aug;95:52-61. doi:

10.1016/j.genhosppsych.2025.04.005. Epub 2025 Apr 21. PMID: 40279864.

Jerold Kreisman suggests that BPD is a "**chameleon effect**". Identity diffusion (which is reflexively reactive to the environment) colludes with mimicry of conditions such as depression, PTSD, and Bipolar Disorder to mislead diagnosticians.

But, as distinct from Bipolar Disorder, in BPD **mood swings** and shifts are rapid, shallow, and triggered by stressors. 40% of Bipolar patients are misdiagnosed and actually suffer from BPD.

LITERATURE

Ruggero CJ, Zimmerman M, Chelminski I, Young D. Borderline personality disorder and the misdiagnosis of bipolar disorder. J Psychiatr Res. 2010 Apr;44(6):405-8. doi: 10.1016/j.jpsychires.2009.09.011. Epub 2009 Nov 3. PMID: 19889426; PMCID: PMC2849890.

Luckily, **BPD is highly responsive to treatments** (such as DBT, MBT, or TFP) and **remits with age**.

(DBT=Dialectical Behavior Therapy; MBT=Mentalization-based Therapy; TFP=Transference-focused Psychotherapy)

In 2024, the **APA published updated practice standards for BPD**.

(APA=American Psychiatric Association, also the publisher of the DSM=Diagnostic and Statistical Manual of Mental Disorders)

The new guidelines are revolutionary: **talk therapy in**, **long-term medications for core symptoms out**. There is no evidence that drugs resolve clinical features.

Psychotropic medications should only be used as adjuncts as anxiolytics or for co-occurrent (comorbid) conditions.

Clinicians should communicate openly with their patients: discuss the diagnosis, track progress, and construct treatment plans as a collaborative effort.

The **education of clinicians** on BPD is paramount. Most patients wait for a decade or more for the correct diagnosis. In 2026, the Journal Of Psychiatric Research published a study that found a median delay of 13.5 years between symptom onset and formal diagnosis. When lived experience is explored in targeted survey, the number ratchets up to 18.

Gunderson constructed a framework for the treatment of BPD by nurses, primary care providers, and social workers (**GPM**=General Psychiatric Management). It is now being applied to young patients.

"GPM emphasizes psychoeducation, practical problem-solving, and what Gunderson called "getting a life." A central priority is building real-world stability: holding down a job, staying in school, and navigating healthy relationships. Clinicians learn to discuss the diagnosis openly, connect emotional crises to immediate stressors, manage suicidality and self-harm proactively, and use psychiatric medications sparingly for targeted symptoms."

Zanarini et al. (of ZAN-BPD fame) led the **McLean Study of Adult Development**. Of 300 participants with BPD who were tracked longitudinally over 24 years, almost all exhibited symptom remission for at least 2 years. More than 77% sustained remission for 12 years.

Similar results emerged from the multisite **Collaborative Longitudinal Personality Disorders Study**. It followed 668 subjects over 10 years. 85% of them achieved remission over at least 1 year. Only 12% relapsed.

Remission starts with the amelioration of impulsivity and self-harm. But inner processes and clinical feature remain: a sense of emptiness, chronic loneliness, anxiety, depressive episodes.

According to the McLean study, at the 24-year mark, only 37-60% of patients are fully **functionally recovered**.

Conclusion

The lack of a cohesive Self undermines life goals and accomplishments. This should be the emphasis of long-term treatment: to finally get a life.

The Borderline: Overview

Overview

Community prevalence of BPD is 2% but 10% in clinical population. Community studies: many undiagnosed and untreated men with BPD (women with BPD tend to seek treatment much more than men with the condition).

Suicide is the leading cause of death among BPD cohorts under the age of 70 (5-11%). Suicidal ideation is constant. Life expectancy is shortened by poor health.

BPD peaks in late adolescence and young adulthood and then it remits or recedes gradually and BPD becomes non-diagnosable by age 35-45 in 81% of cases.

Narcissism and Borderline personality disorders are failures of self-narratives. Narrative therapy helps you to re-author your life.

ICD-11 vs. DSM 5-TR (2022)

The PDM valiantly attempts to straddle psychoanalysis and the DSM as well as neurobiological and genetic etiologies. Judge for yourself how successful it is when it comes to narcissistic and borderline personalities. LITERATURE Psychodynamic Diagnostic Manual: PDM-2 Second Edition https://www.amazon.com/Psychodynamic-..., Publisher: The Guilford Press, Publication date: June 20, 2017

DSM 5-TR

Categorical vs. the dimensional alternative model (section 3)

"Typical features are **instability** of image, personal goals, interpersonal relationships and affects, accompanied by impulsivity, risk taking, and/or hostility." → Identity diffusion/disturbance+F2 psychopathy clinical features (also reactance and defiance

"Characteristic difficulties are apparent in identity, self-direction, empathy, and/or intimacy … along with specific maladaptive traits in the domain of negative affectivity and also antagonism and disinhibition." → Similarities to Narcissistic Personality Disorder (NPD)

"Diagnostic Criteria: A. Moderate of greater impairment in personality functioning, manifested by characteristic difficulties in 2 or more of the following 4 areas:

Identity

Markedly impoverished, poorly developed, or unstable self-image, often associated with excessive self-criticism, chronic feelings of emptiness, dissociative states under stress.

Self-direction

Instability in goals, aspirations, values, or career plans.

Empathy

Compromised ability to recognize the feelings and needs of others associated with interpersonal hypersensitivity. Prone to feel slighted ir insulted. → NPD (Kernberg), hypersensitivity and hypervigilance confused with empathy

Have perceptions of others selectively biased toward negative attributes or vulnerabilities. → Judgmental, catastrophizing, projective identification

Problems with Intimacy

Intense, unstable, and conflicted close relationships marked by (specifiers): mistrust, neediness, and anxious preoccupation with real or

imagined abandonment. Close relationships often viewed in extremes of idealization and devaluation and alternating between over-involvement and withdrawal → twin anxieties, approach-avoidance

Four of more of the following 7 pathological personality traits, at least one of which must be either impulsivity, or risk taking, or hostility → Psychopathy!

1. **Emotional lability** (an aspect of negative affectivity), unstable emotional experiences and frequent mood changes, emotions that are easily aroused, intense, and/or out of proportion to events and circumstances;

2. **Anxiousness** (an aspect of negative affectivity): intense feelings of nervousness, tenseness, or panic, often in reaction to interpersonal stresses. Worry about the negative effects of past unpleasant experiences and future negative possibilities (catastrophizing – SV). Feeling fearful, apprehensive or threatened by uncertainty. Fears of falling apart of losing control;

3. **Separation insecurity** (aka abandonment or separation anxiety, aspect of negative affectivity): fears of rejection by or separation from significant others associated with fears of excessive dependency and complete loss of autonomy;

4. **Depressivity** (aspect of negative affectivity): frequent feelings of being down, miserable, and hopeless, difficulty recovering from such moods or pessimism about the future, pervasive shame, feelings of inferior self-worth, thoughts of suicide and suicidal behavior → No narcissistic compensatory defenses;

5. **Impulsivity** (aspect of disinhibition): acting on the spur of the moment in response to immediate stimuli, acting on a momentary basis, without a plan or consideration of the outcomes, difficulty establishing or following plans, a sense of urgency and self-harming behavior under emotional distress;

6. **Risk-taking** (aspect of disinhibition): engagement in dangerous, risky, and potentially self-damaging activities unnecessarily and without regard to consequences, lack of concern for one's limitations and denial of the reality of personal danger;

7. **Hostility** (aspect of antagonism): persistent or frequent angry feelings, anger or irritability in response to minor slights and insults.

Other traits and personality functioning specifiers that are not required but could be present, such as **psychoticism** (cognitive and perceptual dysregulation).

ICD-10-CM

Emotionally unstable personality disorder (EUPD)

Two subtypes: Impulsive and Borderline (OBSOLETE)

Impulsive subtype: emotional instability and lack of impulse control, outbursts of violence or threatening behavior (mainly reactive to rejection, humiliation, abandonment).

Borderline subtype: emotional instability. The patient's self-image, aims, and internal preferences, including sexual preferences are unclear or disturbed, chronic feelings of emptiness, liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment in a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)

Pervasive instability and intensity in interpersonal relationships, in self-image, self-perception, labile moods and impulsive behavior.

Feelings of emptiness, impaired functioning, lack of identity, unstable moods and relationships, intense fear of abandonment, dangerous impulsive behaviors including episodes of self-harm, attempted suicide.

Rapid fluctuations (cycling) between confidence and despair, but not as rapid as bipolar disorder.

Transient psychotic symptoms (border of psychosis and neurosis), including microepisodes of delusions and hallucinations. Paranoid ideation, hypervigilance, and delusions. Hyperreflexivity (resulting in conflation of external and internal objects).

The neurotic part: autoplastic defenses (regret, shame, guilt) which lead to behavior modification, accommodation, and adaptation (BPD more flexible than NPD which is rigid).

Dual diagnoses common: substance use disorder, for instance. Substantial impairment of social, psychological and occupational functioning and quality of life.

ICD-11: traits and severity, but no differential diagnoses.

Borderline Personality Disorder (BPD) can be safely diagnosed in early puberty

Borderline is a failed narcissist because she has had an intermittent mother, not a dead one: intermittent reinforcement allows the borderline to perceive external objects by outsourcing ego functions and even her body despite her huge narcissistic investment.

The narcissist gave up on the externality of separate objects because they are bound to frustrate and hurt. The borderline still has hope: she interacts with separate external objects via merger and fusion, by becoming their internal object.

Some scholars suggest the BPD is a culture-bound, gender-biased mental health diagnosis.

I suggest that there is a single clinical entity Personality Disorder with overlays (narcissistic, antisocial, borderline, histrionic). Each overlay has 3 states: overt, collapsed, covert.

REACTION to CPTSD which involves dysfunctional attachment, dissociative self-states, arrested development (infantilism), cognitive deficits, emotional and affective dysregulation.

Identity disturbance (unstable identity, fragile sense of self)

Emptiness, false self, fantasy defense.

External regulation

Impaired reality testing (e.g., paranoia, overestimation of intimacy like in HPD), psychotic microepisodes

Self-harm, suicidal ideation, self-destructive cognitions and actions: self-punitive, silence internal turmoil, call for help, feeling alive (dead inside)

Recklessness, impulsivity, secondary psychopathy

Emotional volatility, affective lability, emotional dysregulation (DBT): anger, reactive mood shifts and changes

Intense interpersonal relationships involve idealization-devaluation (relational disorder)

Twin anxieties: abandonment/rejection-engulfment/intimacy, approach-avoidance repetition compulsion

ICD-11

No BPD diagnosis or equivalent.

Borderline Pattern (specifier)

Can be diagnosed together with specific trait domains and personality dysfunctions.

“May be applied to individuals whose pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image and affects and by marked impulsivity as indicated by 5 or more of the following:

1. Frantic efforts to avoid real or imagined **abandonment**;

2. 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;

3. **Identity disturbance** manifested in markedly and persistently unstable self-image or sense of self (self-concept – SV);

4. Tendency to **act rashly** (recklessly – SV) in states of high negative affect, leading to potentially self-damaging behaviors (for example: risky sexual behaviors, reckless driving, excessive alcohol or substance use, or binge eating);

5. Recurrent episodes of **self-harm** (example: suicide attempts or gestures, or self-mutilation);

6. **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;

7. Chronic feelings of **emptiness**;

8. 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;

9. Transient **dissociative symptoms** or psychotic-like features, brief hallucinations, paranoia, in situations of high affective arousal.

Other manifestations of a borderline pattern, not all of which may be present in a given individual at a given time, include the following:

1. A **view of the self** as inadequate, bad, guilty, disgusting, and contemptible;

2. An **experience of the self** as profoundly different and isolated from other people;

3. A painful **sense of alienation** and pervasive loneliness;

4. **Proneness to rejection**, hypersensitivity, problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships, frequent misinterpretation of social signals."

Diagnosis of both BPD and Borderline Pattern Specifier via ZAN-BPD (Mary Zanarini et al. 2006) or DIB (Diagnostic Interview for Borderline; Gunderson).

Elements of ZAN-BPD:

1. Assessment of **anger and aggression** (content areas: frustration, irritability, intense angry acts of verbal or physical nature, mildly angry acts, etc.)

2. **Affective instability**, volatility, lability (content areas: proportionality to severity of life circumstances or triggers);

3. **Chronic feelings of emptiness** (content areas);

4. Serious **identity disturbance** (content areas: mild to serious);

5. Stress-related **paranoid ideation** and **dissociative symptoms** (content areas: mild to intense feelings of distrust, sense of unreality, depersonalization, derealization);

6. Frantic overt or covert efforts to avoid the feeling of being **abandoned or rejected**;

7. **Self-destructive behaviors** (including suicide threats, gestures, and attempts, minor to serious self-mutilation: scratching, punching oneself, cutting, burning;

8. Impulsive behaviors (12 content areas);

9. A pattern of **unstable and intense personal relationships** (content areas: alternating idealization and devaluation, dependency, fleeing intimacy-engulfment anxiety, stormy relationships marked by arguments and breakups).

The ICD-11 acknowledge co-occurrences (comorbidities) in the Borderline Pattern: internalizing (depression, anxiety, PTSD), externalizing (substance use, suicidal behaviors, self-harm, self-mutilation, eating disorders, attention deficits) features; psychotic features (transient hallucinations, extreme dissociation, paranoid ideation); as well as interpersonal features (same as DSM's relational approach).

See articles by Paris, especially in 2020 regarding attempts to redefine BPD. Major issues with the coherence and validity of the BP construct. But it is useful to profiling and treatment selection.

LITERATURE

ICD-11 Personality Disorders: Assessment and Treatment, Bo Bach (ed.), Oxford University Press, 2025

Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioral, and Neurodevelopmental Disorders, World Health Organization (WHO), 2024

Kernberg, O. (1967). Borderline Personality Organization. Journal of the American Psychoanalytic Association, 15(3), 641-685. (Original work published 1967)

Borderline Personality Organization (Kernberg)

Characterized by instability in identity (identity diffusion), emotion dysregulation, intense and fluctuating moods, lack of stable and integrated sense of self (shifting and contradictory self-perceptions), volatility of intense unstable relationships marked by idealization and devaluation cycles, affective lability, primitive immature defenses (such as splitting and projective identification, denial), impulsivity which leads to recklessness and self-harm (e.g., substance use), personality

functioning between neurotic and psychotic (brief psychotic episodes), distorted reality testing in times of stress, pervasive fear of abandonment or rejection which results in clingy or preemptive-avoidant behaviors

Empty Schizoid Core

We are all born with empty schizoid core, compensate by introjecting Mommy (symbiosis and primary narcissism).

Borderline's introjection failure and consequent introject inconstancy is what gives rise to his/her sense of emptiness (described by Kernberg). She compensates by over-reliance on external objects (anaclitic personality).

Narcissism is compensatory and infantile: object inconstancy, ceaseless introjection and incorporation of internal object MASK the emptiness, compensate for it (introjective personality).

Black hole in autistic children first suggest by Frances Tustin in 1972.

Metaphors of narcissisms and borderline personalities: rot, vampire, virus, cancer, black hole, quantum objects (uncertainty and information)

Bad memories are the tuition fee we pay in order to learn from our mistakes and grow. Narcissists and borderlines are dissociative: they

have vast memory gaps and are, therefore, incapable of growth and learning.

Fast scramblers of information brought into the (quantum) system (e.g., black holes)

LITERATURE

The ‘black hole’: a significant element in autism, Frances Tustin, (1988).Free Associations,1L(11):35-50

Eshel O. 'Black holes', deadness and existing analytically. Int J Psychoanal. 1998 Dec;79 (Pt 6):1115-30. PMID: 10036623.

Clark, G. "A black hole in psyche." Harvest 29 (1983): 67-80.

The “Black Hole” as the Basic Psychotic Experience: Some Newer Psychoanalytic and Neuroscience Perspectives on Psychosis, James S. Grotstein, Journal of the American Academy of Psychoanalysis Vol. 18, No. 1, March 1990

'Black holes': escaping the void, Sharn Waldron, J Anal Psychol, . 2013 Feb;58(1):99-117. doi: 10.1111/j.1468-5922.2013.02019.x.

Pecotic, B. (2002). The “black hole” in the inner universe. Journal of Child Psychotherapy, 28(1), 41–52.

Like supernova: Empty schizoid core seat of pathologies and addictions which substitute for core identity.

These pathologies and addictions are persistent and misidentified with identity.

Halo personality: periphery of void (remnant of supernova) comprises what in healthy people constitutes identity or personality: beliefs, values, traits, cognitions, emotions.

The halo personality elicits external regulation and generates a hive mind. These are last ditch attempts to become, to put Humpty-Dumpty back together, to reconstitute the shattered being.

But behaviors determined by core, not by periphery – by the void, not by the halo personality. Similar to generation of elementary particles in the vacuum of deep space: potentials become fleeting realities and then vanish again.

Asking who is the void or who is the False Self or who does the observing is like asking who is your smartphone or AI bot. Nothing there but programmed reactive routines.

LITERATURE

Hatred, Emptiness, and Hope: Transference-Focused Psychotherapy in Personality Disorders by Otto F. Kernberg, M.D.

The Empty Core: An Object Relations Approach to Psychotherapy of the Schizoid Personality by Jeffrey Seinfeld

Schizoid Phenomena, Object Relations and the Self by Harry Guntrip

Borderline Personality Style (Sperry)

In his foundational work, Handbook of Diagnosis and Treatment of Personality Disorders, Dr. Len Sperry conceptualizes personality on a continuum where **personality "styles" represent the adaptive, functional versions** of traits that, when rigid and extreme, become "disorders".

Unlike distinct personality types like narcissistic or dependent, Sperry—building heavily on the work of Theodore Millon—views the **borderline personality type as a pathological extension or decompensated state** of other underlying active styles, such as histrionic, dependent, or passive-aggressive styles. When an individual with this baseline personality structure is subjected to severe or chronic stress, they display highly specific behavioral, interpersonal, and cognitive patterns.

In psychiatric and psychological frameworks like those described by Dr. Len Sperry, a personality "style" refers to a distinct, flexible

configuration of traits, whereas a "disorder" is rigid and maladaptive. The borderline pattern features intense emotional shifts, relationship instability, and profound fears of abandonment.

Core Characteristics of the Borderline Style

- **Affective (Emotional):** Rapid, intense mood shifts, often swinging between deep despair, high anxiety, and anger.
- **Interpersonal:** Paradoxical patterns of clinging to others while simultaneously fearing rejection or devaluing them.
- **Behavioral:** Impulsive reactions and strong distress responses when faced with real or perceived triggers.

Inner Child Dynamics

Borderline's inner child is not his/her true self: it is a compendium of needs, especially the need to find a “rock”: a constant, reliable, unconditionally loving and accepting presence. A constant state of terror.

Surrealistic paracosm: Impaired reality testing (e.g., paranoia, overestimation of intimacy like in HPD), psychotic microepisodes

External regulation and opposite-sex parent issues.

Twin anxieties: abandonment/rejection-engulfment/intimacy, approach-avoidance repetition compulsion.

These anxieties plus the intensity of the interpersonal relationships devolve into idealization-devaluation (relational disorder)

IDEALIZATION in shared fantasy

Partner is ... GOOD MOTHER (breast)

Perfect, ideal, all good

Secure base: safe, trustworthy, reliable, resilient, responsive

Loves unconditionally: forgiving, accepting, authentic, rewarding

Power couple

Psychopaths groom, narcissists lovebomb and then idealize, borderlines idealize

Grooming and lovebombing are conscious, idealization unconscious

Grooming is about fostering bonding

Allogrooming (mutual, social grooming)

Lovebombing is goal-oriented: to prepare the ground for idealization, to create an internal object, to audition potentials, and to establish a shared fantasy

Idealization is about object acquisition (in the shared fantasy via the dual mothership, in borderlines via narcissistic supply and control from the bottom)

Idealizing transference

DEVALUATION in shared fantasy

Partner is ... BAD MOMMY (breast)

Imperfect, all bad, persecutory

Unsafe, untrustworthy, unreliable, fragile/weak/vulnerable

Manipulative, transactional, fake, denying, rejecting, frustrating

Traitor, envious, passive-aggressive

Identity disturbance (unstable identity, fragile sense of self)

Emptiness, false self, fantasy defense.

Clinical features of inner child:

Self-harm, suicidal ideation, self-destructive cognitions and actions: self-punitive, silence internal turmoil, call for help, feeling alive (dead inside)

Recklessness, impulsivity, secondary psychopathy

Emotional volatility, affective lability, emotional dysregulation (DBT): anger, reactive mood shifts and changes

Core Dynamics under Stress

Inhibited grieving (or grief), unrelenting crisis, active passivity, apparent competence, emotion(al) vulnerability, self-invalidation: the six ways that borderlines (people diagnosed with BPD) abuse themselves.

When an individual with a borderline personality style encounters specific psychological triggers, their adaptive functioning deteriorates into distinct patterns:

- **The Primary Trigger:** Real or perceived threats of **abandonment or relationship loss** act as the primary catalyst for psychological distress.
- **Emotional Dysregulation:** Rapid, unstable, and intense shifts in affective state occur, most commonly swinging violently **from extreme depression to extreme anxiety**.
- **Loss of Anger Control:** Extreme, volatile outbursts of anger manifest as behavioral coping mechanisms break down.
- **Desperate Recovery Measures:** In the event of a real relationship loss, the individual will deploy **extreme, frantic measures** to restore the connection and avoid abandonment.

Style Versus Disorder

- **Personality Style:** Mild or adaptive traits that shape how a person reacts to stress without destroying their daily functioning.
- **Personality Disorder:** Extreme, rigid patterns that cause ongoing distress and severe disruption in life and relationships.

Millon's subtypes of Borderline Personality Disorder

Theodore Millon identified four informal clinical subtypes of borderline personality disorder (BPD). These variants—**discouraged**, **impulsive**, **petulant**, and **self-destructive**—demonstrate how core BPD traits like emotional instability mix with other personality styles.

The Four Subtypes

Discouraged Borderline

- Blends with **dependent** and **avoidant** features.
- Clingy, passive, and deeply fearful of being alone.
- Turns anger inward, leading to intense guilt, shame, and feelings of helplessness.
- Often overlaps with the modern term "quiet or shy BPD".
-

Impulsive Borderline

- Blends with **histrionic** and **antisocial** features.
- Energetic, fickle, and easily bored.
- Acts without thinking and chases intense thrills.
- Prone to reckless behavior, rage when let down, and poor emotional control.

In BPD, secondary psychopathy, histrionic PD – but not in NPD (especially malignant narcissism), AsPD/primary psychopathy

Alloplastic defenses: anger at the source of ego-dystony

Reaction formation

Affective Matching (justifying and validating the negative affects: "That's who I am and there is nothing I or anyone else can do about it")

Narcissistic rage mediates the transition from narcissistic to borderline or psychopathic self-states.

Petulant Borderline

- Blends with **negativistic** (passive-aggressive) features.
- Irritable, impatient, stubborn, and resentful.
- Unpredictable mood shifts and quick to feel mistreated.
- Alternates rapidly between clinging to people and pushing them away.

Self-Destructive Borderline

- Blends with **depressive** and **masochistic** features.
- Internalizes anger and directs it straight at the self.

- Engages in chronic self-sabotage, self-punishment, or self-harm.
- Plagued by intense self-hatred and bitter despair.

The Four BPD Subtypes

Subtype	**Core Traits**	**Common Interpersonal Dynamic**	**Overlapping Personality Features**
Discouraged Borderline *(Also known as "Quiet BPD")*	• Internalized anger • High vulnerability to depression • Pervasive feelings of inadequacy • Obsessive-compulsive elements	Clingy, needy, and highly dependent, but secretly harbors deep resentment and easily feels disillusioned by others.	Dependent and Avoidant traits
Impulsive Borderline	• High energy and charisma • Thrill-seeking and spontaneity • Superficial behavior • Sudden behavioral outbursts	Highly flirtatious and attention-seeking; becomes quick to anger or enters severe conflict if others let them down.	Histrionic and Antisocial traits

Petulant Borderline	• Chronic irritability • Stubborn and defiant attitude • Intense passive-aggression • Drastic, unpredictable mood shifts	Alternates rapidly between a desperate need for affection and complete rejection or defiance toward loved ones.	Negativistic (Passive-Aggressive) traits
Self-Destructive Borderline	• Bitter and inward-facing anger • Deep-seated self-hatred • Poor healthcare/negligence • High-risk behaviors	Tends to engage in self-sabotaging and self-defeating patterns, punishing themselves to manage emotional pain.	Depressive and Masochistic traits

Key Clinical Considerations

- **Fluid Boundaries:** An individual diagnosed with BPD may display overlapping traits from multiple subtypes, and these patterns can shift over time based on stress levels, life stages, or environments.
- **Clinical Utility:** Mental health experts use Millon's evolutionary framework to select precise therapeutic interventions (such as

targeted Dialectical Behavior Therapy or specialized psychotherapies) that match a patient's dominant emotional style.

Shy/Quiet Borderline

“SHY” or “QUIET” BPD vs. CLASSICAL BPD

I reject the “diagnosis” of shy borderline. All borderlines are sometimes shy and introverted ("act in") and sometimes act out aggressively.

Someone who is “shy” ALL the time is not a borderline. She is either a covert narcissist or has CPTSD.

Reality vs. fantasy: impaired reality testing is not the same as no reality testing. Fantasy is not a hallucination: fantasy borrows elements from reality and builds around them.

The narcissist, borderline, paranoid, schizotypal cannot tell the difference between reality and fantasy because they share elements, have a lot in common.

NPD fantasy is infantile (phantasy). In the absence of a fully constellated and integrated self and ego, the fantasy is limited to self-regulation via cognitive distortion and to the resolution of early childhood conflicts (separation-individuation). All the rest is intact.

BPD fantasy involves and revolves around external regulation and outsources ego functions: outsourcing her internal psychodynamics to an intimate partner or a special friend.

When fantasy fails in NPD the outcome is shame dysregulation and mortification, when it fails in BPD the outcomes are dysregulation and lability.

In NPD shared fantasy, the partner is unreal (internal object). In BPD shared fantasy the partner is hyperreal. Borderlines perceive themselves and their lives as Unreal (dissociation). This is why borderlines cling, hoover ferociously, won't let go. They leverage every opportunity and contact to reconstitute the shared fantasy. Example: We all seek closure. But borderlines abuse this quest in order to hook you yet again.

Dissociative Symptoms

Recent studies of the brain (neuroscience) demonstrate thar traumatic experiences – especially Adverse Childhood (early life) Experiences (ACEs) – cause dissociation (depersonalization, derealization, amnesia) and lead to a disruption in the sense of self (which is the main clinical feature in NPD and BPD).

Symptoms of depersonalization and derealization

BPD: Intact reality testing; NPD not

BPD: Reaction to stress, substance abuse; NPD reaction to deficient supply, injury, and mortification

Disrupted integration of self-perceptions with sense of self (estrangement). BPD: situational and reactive; NPD: constant

Both: Watching oneself from a distance, as if in a movie

BPD: Out of body and mystical experiences; NPD not

Both: Auto-pilot (going through the motions, automatism, roboticism)

Both: Acting vs. observing (BPD's bad object, NPD self-audiencing)

Both: Dream, fog (BPD trauma response; NPD fantasy defense)

Both: Body dysmorphia, detached from mirror image, organs, whole body (especially cerebral NPD)

BPD: Out of control speech or locomotion, ventriloquist's dummy; NPD grandiosity defense

BPD: Alien or intrusive thoughts; NPD only after injury or mortification

Both: Memory retrieval issues, alien memories

Both: Numbed emotions (BPD intermittently and defensively, NPD all the time)

Both: Unfamiliarity or detachment from surroundings, people, objects, time (BPD after rejection; NPD at the devaluation-discard phase of shared fantasy).

NPD: Hypoemotionality plus unreality, unfamiliarity

From “Dissociation and the Dissociative Disorders: Past, Present, and Future”, 2023

“Depersonalization (DP) describes a disrupted integration of self-perceptions with the sense of self so that individuals experiencing depersonalization are in a subjective state of feeling estranged, detached, or disconnected from their own being.

The following are common descriptions of depersonalization experiences (Sierra & Berrios, 2000): feeling strange, as if not real or as if being cut off from the world; feeling as if parts of one’s own body do not belong to one¬self; having the feeling of being a ‘detached observer’

of oneself, including the feeling of being outside of one's body or watching oneself from a distance; perceiving the body as very light, as if floating on air; perceiving one's own voice as remote and unreal; feeling detached from autobiographical memories as if not having been involved in them; not feeling any affection towards family or close friends; feeling as if not in charge of movements, as if moving automatically or like a robot; perceiving one's own image in the mirror as strange and unreal; feeling the need to touch oneself to make sure that one's body is real and exists; feeling disconnected from one's own thoughts and feelings.

Depersonalization is frequently accompanied by derealization (DR) – a sense of unfamiliarity, alteration or detach¬ment from one's own surroundings, other people, and objects. The following are common descriptions of DR: seeing the surrounding as 'flat' or 'lifeless' as if looking at a picture; feeling detached from surroundings or perceiving them as unreal, as if there is a veil between the person and the outside world; impression that objects seem to look smaller or further away; experience of familiar places looking unfamiliar, as never seen before (Sierra & Berrios, 2000).

Notably, all the above experiences are "as if" experiences, meaning that an individual with DP/ DR has intact reality testing; this point is crucial to the differentiation from psychosis.

Dissociation: internalized (amnesia, depersonalization) and external (derealization) Amnesia is a form of numbing, avoiding triggers

Amnesia signifies an integration failure and gives rise to dissociative identities or fragments.

LITERATURE

Lanius RA, Terpou BA, McKinnon MC. The sense of self in the aftermath of trauma: lessons from the default mode network in posttraumatic stress disorder. Eur J Psychotraumatol. 2020 Oct 23;11(1):1807703. doi: 10.1080/20008198.2020.1807703. PMID: 33178406; PMCID: PMC7594748.

Eroglu TE, Coronel R, Halili A, Kessing LV, Arulmurugananthavadivel A, Parveen S, Folke F, Torp-Pedersen C, Gislason GH. Long-term stress conditions and out-of-hospital cardiac arrest risk: a nested case-control study. Open Heart. 2023 May;10(1):e002223. doi: 10.1136/openhrt-2022-002223. PMID: 37147025; PMCID: PMC10163588.

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Etiology

Heredity, brain abnormalities, esp. in the frontal limbic network (chicken and egg), and ACEs (Adverse Childhood Experiences)

Behavioral genetic studies using community samples of twins found that nearly half of the variance in BPD is heritable. No genetic markers for BPD. BPD would probably involve hundreds or thousands of interacting

genes. Even so, the current thinking is that genetics accounts for less than 5% of the variance in non-twin BPD.

Most BPD patients have been exposed to an adverse, abusive childhood or adolescence, dysfunctional families, emotional neglect (Porter). Sibling studies show that siblings – even twins – are rarely concordant for BPD (rarely develop it simultaneously).

Nature-nurture interplay and differential environmental sensitivity. A biosocial theory of BPD has to account for its prevalence in developed vs. less developed countries (where BPD is rarer owing to traditional support frameworks and lack of diagnostic infrastructure).

Psychosis is the natural state in childhood: hyperreflexivity and internal objects=external ones.

If the external is terrifying (abuse, trauma), the child transitions to BPD where internal objects are external (psychoticism) and with a False Self which starts as external (special friend) and ends as internal.

This Self fragment or figment prevents full-fledged psychosis (a state of no self).

If the BPD False Self is attacked and disabled by abuse and trauma, the child attempts to transition to NPD.

Childhood Sexual Abuse

Childhood sexual abuse often results in BPD, DID (mainly OSDD) in adulthood.

Victims of sexual abuse in childhood dread and sexualize intimacy and being loved because they misidentify and conflate those with pain and boundary wrecking abuse.

Sex becomes an anxiety reaction or stress response.

The strategies used by these children, starting in adolescence involve: self-objectification, absenting oneself from sex and intimacy via dissociation (most notably derealization, depersonalization, and amnesia), and self-punitive choices intended to restore the good object (by penalizing and subduing the bad one).

Defenses

Defenses separate internal reality (instincts, pain, guilt, shame, fear, anxiety) from external reality to avoid conflict, real dangers, interpersonal failures, and anxiety (they are anxiolytic). They are, therefore, dissociative.

Narcissists have no functioning ego and only primitive defenses. Borderlines have a functional ego, but their defenses are either primitive or compromised.

They reflect an internal working model of a bad object (I am inadequate, will catastrophically fail, am a danger to myself, need to be defended from myself).

To avoid ego dystonic conscious contact with the bad object, the defenses remain unconscious. To affect reality and render it ego-congruent, they operate via behaviors.

Separation Insecurity (Abandonment/Separation Anxiety)

Rejection, abandonment trigger separation insecurity and constitute extreme narcissistic injury (trigger grandiosity cognitive distortion).

The cognitive dissonance is resolved via a mix of aggression and passive-aggression.

Drama linked to hyperemotionality, fills the existential void, a simulated and compressed life

Entitlement to be unique and exclusive as measured via currency of attention.

Splitting (I am all good, s/he is all bad).

Projection

Hoovering is the ultimate goal unless mortification sets in (Borderline: unsafe, Narcissist: publicly shaming)

Aggressive techniques (histrionic and psychopathic comorbidities):

Revenge fantasies (rarely translated to action beyond ostentatious demonstrative acts like a smear campaign because the fantasy is perfect and action might fail and exacerbate the narcissistic injury).

Delusional reframing (I rejected him/her).

Actual violence.

Passive-aggressive techniques:

Triangulation (esp. emotionally injurious with best friend, worst enemy, colleagues, stable of exes, and so on)

Setting you up for failure (undermining, sabotaging, defeating, handicapping you):

Unrealistic demands or expectations.

Engineering situations that are bound to trip you up.

Motivating others to withhold help, support, or collaboration or to actively conspire against you.

Fostering an environment that requires talents, skills, or knowledge that you do not possess or do not excel at.

NPD is mirror image of BPD

Othering failure is a defense against the risk of acknowledging the superiority of other people.

By introjecting-incorporating idealized versions of others, the narcissist accomplishes two psychodynamic goals: 1. Self-idealization (self-idolatry); and 2. Avoidance of narcissistic injuries and mortifications, assertion of control and utter self-sufficiency, amounting to efficacious self-regulation (avoidance of the underlying Borderline Personality Organization).

Covert narcissism is an adaptation toa state of collapse, but the narcissistic dynamics and structures remain intact.

BPD is a failure to develop these narcissistic defenses. So, the Borderline is acutely dependent on other people for self-regulation (external regulation).

Being grandiose, s/he is also much more vulnerable to narcissistic injuries and mortifications.

Ironically, her constant emotional dysregulation is the outcome of her desperate attempt to avoid emotional dysregulation by depending on other people, her external regulators.

External objects are internal (fantasy and delusionality) and False Self which starts as internal (grandiosity) and ends as external (true self vanishes).

This solution fails when reality intrudes and cannot be reframed and the False Self remains internal.

The child then transitions to psychopathy where only external objects exist and there is no false self or any self (unimpaired reality testing).

Decompensation reverses this sequence. Therapy can leverage decompensation to affect regression and fix the failures (second chance).

Borderline Personality Disorder is a form of CPTSD (complex trauma) and, in many cases, gives rise to compulsive sexual ideation and hypersexuality ("sex addiction").

In early childhood, the Borderline had learned to associate sex, pain, and love inextricably, sometimes owing to a history of childhood sexual abuse. Hereditary brain abnormalities are at play, too, predisposing the child to develop emotional dysregulation and mood disorders and lability.

The Borderline sexualizes her emotions and her needs: to be loved, to belong and be accepted and valued, to feel safe, empowered, irresistible, in control, and "at home".

Even in one night stands turned ugly - and she goes through many of these - she is likely to embed the dissonant experience in a fantastic narrative of love, redemption, and rescue.

Her litany of failed relationships - the inevitable outcomes of selecting for all the wrong mates - predisposes the Borderline to anticipate the worst: acrimonious and agonizing abandonment and rejection. She often cheats her way out of such calamitous dyads.

She catastrophizes in all her liaisons and then, at the first sign of discord or sexual rejection, she decompensates and acts out: becomes violent, promiscuous, deceitful (cheats), or psychopathic (defiant, impulsive,dysempathic, and reckless).

To cope with overwhelming shame and guilt having egregiously misbehaved, she dissociates: becomes amnesiac, depersonalizes, or derealizes.

People with personality disorders who are high-functioning are very disconcerting: they compartmentalize their promiscuous, antisocial, addictive, sadistic, and defiant behaviors.

During the day, they are competent professionals, diligent students, pillars of the community, responsible citizens and fathers or mothers, loving husbands or wives, and thriving entrepreneurs.

Come evening, the mask drops, the drink and drugs are out, replete with dissolute reckless sex with virtual strangers, gambling, or any number of self-trashing and dysfunctional, even self-destructive behaviors.

What baffles scholars is that all these self-states are a part of the personality. There is no faking involved. The switching is abrupt but seamless. Dissociation is often involved, but never to the point of rupturing continuous autobiographical memory and core identity.

Cleckley called it the “Mask of Sanity”. It challenges everything we thought we knew about psychology.

Everyone advises that falling in love with broken, damaged people is self-destructive: they are bound to hurt you and traumatize you for life. Ruination awaits in such an affair of the heart.

But this blanket advice is often wrong and self-defeating.

The corresponding pathologies of the members of a couple can either cancel each other out, bringing a sense of safety, anxiety reduction, and even healing - or they amplify each other, exacerbating the underlying conditions of everyone involved.

The shattered are much more open and vulnerable: their “innards” are on full display. They are skinless and defenseless.

But exactly this susceptibility renders the interactions and emotions in such relationships both deeper and more intense.

Loving the mentally ill is an exasperating technicolor wild ride - not the black and white tones of healthy boundaries.

The hurt and the traumatized know each other’s lingering volcanic agony intimately, better than any outsider can. The same way alcoholics

sponsor their kith and kind in AA 12 step programs, the broken see each other through the howling miasmas of their souls.

It is a gamble with one's life and sanity. Yet, so many take it because loving such the wounded is the most selfless act there is and a hyperdrive of personal growth even through adversity.

Such tortured relationships go south when we want our partner either to wound us further (affirm our victim status) - or we expect them to "fix" us.

Women who possess both strong, unfulfilled maternal instincts and abandonment anxiety find in the narcissist the perfect solution: a child who will never grow up and separate from them.

These intimate partners subtly encourage the narcissist's infantilization, immaturity, learned helplessness, and dependency.

They frown upon and disincentivize - even punish - any attempts to transform, break away, or display adult behaviors (including having sex).

Sometimes, they even give up on having children of their own to dedicate themselves exclusively to this "safe" child at home.

Clinical Features and Psychodynamics

Like both narcissists and psychopaths, borderlines are impulsive and reckless. Like histrionics, their sexual conduct is promiscuous, driven, and unsafe. Many borderlines binge eat, gamble, drive, and shop carelessly, and are substance abusers. Lack of impulse control is joined with self-destructive and self-defeating behaviors, such as suicidal ideation, suicide attempts, gestures, or threats, and self-mutilation or self-injury.

The main dynamic in the Borderline Personality Disorder is abandonment anxiety. Like codependents, borderlines attempt to preempt or prevent abandonment (both real and imagined) by their nearest and dearest. They cling frantically and counterproductively to their partners, mates, spouses, friends, children, or even neighbors. This fierce attachment is coupled with idealization and then swift and merciless devaluation of the borderline's target.

Patients with the Borderline Personality Disorder and Dependent Personality Disorder both suffer from abandonment and separation anxieties and are clinging, demanding, and emotionally labile - but their sexual behavior is distinguishable. The borderline uses her sexuality to reward or punish her mate. The dependent uses it to "enslave" and condition her lover or spouse. The borderline withholds sex or offers it in accordance with the ups and downs of her tumultuous and vicissitudinal relationships. The codependent tries to make her mate addicted to her particular brand of sexuality: submissive, faintly masochistic, and experimental.

Persecutory object and internalized bad object lead to self-harm.

Borderlines suffer from emotional dysregulation and, like narcissists, they often exhibit inappropriate affect (understandable when emotions get misconstrued).

Regulatory Regimen

In Borderline, regulation is external, dysregulation is internal (even though it appears to be externally-determined). Dysregulation is the default background state, so regulated states are perceived by the borderline as dysregulated ego-dystonic, vaguely menacing aberrations (hence engulfment anxiety)

External locus of control, alloplastic defenses, anxiolysis (no responsibility, guilt, shame, or adverse consequences)

Group regulation (in group, peers)

Narratives (symbols, morality plays, religion)

Intimacy and regulatory outsourcing (e.g., in BPD, NPD, DPD)

External regulation by the intimate partner: of emotions and moods (borderline), of needs (codependent), or of narcissistic supply (inverted narcissist, a subtype of covert narcissist).

Regulatory system

Regulation of consciousness

Ego functions

Regulations of emotions and moods

Cult-like psychology or paracosm shared fantasy

Sense of unitary completion, holistic (benign) perfection, symbiotic merger or fusion

Balance, homeostasis: secure base, safety, stability, predictability all via mere object constancy (to counter introject inconstancy)

Pain avoidance and mitigation via infantilization and assumption of parental roles and discourse

Structure, order, contractual but not transactional (rights and corresponding or commensurate duties)

Nurturance, needs satisfaction, gratification, wishes, aspirations, accomplishments, horizon, hope

Intercession and intermediation of reality: vicarious reality testing

Regulatory focus theory (Proposed in 1997 by U.S. psychologist E. Tory Higgins)

Dysregulation is induced by both positive and negative affects.

Anticipatory (anxiety or catastrophising) vs. reactive (triggered) dysregulation.

Dysregulation is a-regulation (absence of regulation, unregulation), not chaos/disorganization, instability (EUPD is bad choice), or amplification. It is internal decompensation and disinhibition.

Appraisal failure (catastrophizing)

emotional charge

emotional blocking

emotional conflict

emotional cognition

emotional disturbance

emotional dissemblance

emotion

Feeling

Affect

Positive Affect

Negative Affect

Affective tone

dysregulation

self-regulation

self-regulatory resources theory

volition

ego depletion

self-management

self-control

self-discipline

immediate gratification

delay of gratification

pleasure principle

reality principle

self-regulated learning

metacognition

Identity Diffusion/Disturbance

Types of identity disturbance or diffusion in Borderline and Narcissistic patients: Cyclical, Allotropic, Object-related.

Autobiographical memory (narrative), dissociation, and core identity.

Splitting and other primitive defenses and their role in identity disturbance.

LITERATURE

1. Deutsch H. Some forms of emotional disturbance and their relationship to schizophrenia. Psychoanal Q. 1942;11:301–321.

2. Autobiographical memories, identity disturbance and brain functioning in patients with borderline personality disorder: An fMRI study, Paola Bozzatello,

Rosalba Morese, Maria Consuelo, Valentin Paola Roccae, Francesca Boscob, Silvio Bellinoa, Heliyon, Volume 5, Issue 3, March 2019

3. Psychiatry Research, Volume 271, January 2019, Pages 76-82Facets of identity disturbance reported by patients with borderline personality disorder and personality-disordered comparison subjects over 20 years of prospective follow-up, Mohammad A.Gada, Hannah E.Pucker, Katherine E.Hein, Christina M.Temes, Frances R.Frankenburg, Garrett M.Fitzmaurice, Mary C.Zanariniac

4. Identity Disturbance, Feelings of Emptiness, and the Boundaries of the Schizophrenia Spectrum, Maja Zandersen, Josef Parnas, Schizophrenia Bulletin, Volume 45, Issue 1, January 2019, Pages 106–113, https://doi.org/10.1093/schbul/sbx183

5. Journal of Personality DisordersVol. 35, No. Supplement B, At the Junction of Clinical and Developmental Science: Associations of Borderline Identity Disturbance Symptoms With Identity Formation Processes in Adolescence, Shawna Mastro Campbell, Melanie Zimmer-Gembeck and Amanda Duffy, Published Online:June 2021 https://doi.org/10.1521/pedi_2020_34_484

False Self

Kernberg described narcissism as a defense against borderline personality organization. This is why borderline is described as failed narcissism.

Borderlines have a False Self but it fulfills different roles to the narcissist and co-exists and conflicts with the True Self. This conflict leads to emotional dysregulation and other clinical features of BPD.

Identity diffusion or disturbance: not experiencing the Self, life as no one, a mask, fake. It is an impulsive attempt to fill in, counter, or distract from the emptiness or absence by experimenting with different identities and thus engendering unpredictable outcomes (trying on roles). Borderlines are obsessed with finding an organizing narrative (who am I).

Instead of a failed external constitution of the True Self (via interactions with Others, selfobjects, mother) - external regulation via a False Self: inauthenticity, pretend play. Borderlines recreate themselves on the fly (grandiose fantasies) because they distrust reality to do it for them (Helene Deutsch's "as if" personality).

False Self is dynamic, primary and also conscious and secondary as a role, a defense.

Borderlines are capable of lying and gaslighting because, unlike narcissists, they can tell the differences between fantasy and reality. But this gives rise to an impostor syndrome.

Living via other people or experiencing other people's lives leads to chronic feelings of incoherence, inauthenticity, guilt, estrangement,

dissociative processes, terror, vagueness, uncertainty (hence catastrophizing abandonment), helplessness, and stasis.

Still, not psychosis. Closer to DID:

False Self coopts all the optimal or maximal resources (e.g., the intellect) and suppresses suboptimal ones (e.g., the sensorimotor or psychosomatic). This creates a disconnect, a dissociation between the 2 classes of resources and identity problems.

True Self feels real and is creative. False Self is fantasy-based and is regurgitative.

But: there is no narrative without identity! Narrative is created by an identity to maintain its sense of diachronic unity and cohesiveness and to get to know, discover itself. There is no self-knowledge and self-discovery without an antecedent Self.

However, how do the various Agents know that they belong to the same Team? In BPD, they fail to realize it!

So, Borderlines inability to generate a self-narrative is the outcome not the cause of their diffuse or disturbed identity.

Preverbal Self (Bollas's unknown thought) as tacit organizing principle or template (Laszlo Tengelyi's archaeology of the self and dan Zahavi's minimal self). These are metaphysical speculations, not grounded in clinical or laboratory observations.

LITERATURE

Bois C, Fazakas I, Salles J, Gozé T. Personal Identity and Narrativity in Borderline Personality Disorder: A Phenomenological Reconfiguration. Psychopathology. 2023;56(3):183-193. doi: 10.1159/000526222. Epub 2022 Sep 22. PMID: 36137507.

Mortification

Borderline reacts with injury or mortification to abandonment or engulfment.

The False Self in Borderline Personality Disorder (BPD) is akin to the host personality in Dissociative Identity Disorder: to moderate and to switch between self-states is a secondary psychopath and to regulate the resulting repression, denial, splitting, dissociation, and other infantile defenses in an attempt to maintain self-constancy rather than object constancy. Mortification is an extreme and intolerably painful form of shame-induced traumatic depressive anxiety.

Consequently, the Borderline patient seeks mortification in order to feel alive, not free: she seeks to introduce novelty, thrills, and reckless risk taking into her life via chaotic drama. It is the only way she can experience transformation and also the only method open to her when she feels like self trashing, self-punishment, or self-mutilation). Mortification in Borderlines is self-inflicted in preemptive abandonment and the Borderline then copes by becoming dissociative (disappearing) or by displaying traits and behaviors of a secondary psychopath (making others disappear), or, more commonly, both.

Mortification leads to decompensation (deactivation of defenses, including the false self), contact with shame, emotional dysregulation, and acting out (like in BPD).

Shame requires object libido. Narcissist entrains himself to reboot narcissistic libido. Therapeutic hint for BPD.

Abandonment or engulfment provoke borderline mortification: anxiety and emotional dysregulation, decompensation, and acting out. These trigger narcissistic defenses (NPD, secondary psychopathy, covert borderline).

Acting out results in shame and guilt which involve object libido. Therapeutic hint for NPD.

No Narcissistic Supply without Self-supply.

Narcissist’s grandiose fantasy renders input from others narcissistic supply.

When narcissist is mortified, depressed, or otherwise fails to believe his own fantasy, no feedback from others will be perceived as catalyzing supply, only as fake or low-grade supply.

Attachment Styles

Fearful-avoidant (disorganized) “attachment style” is a latecomer to attachment theory: Ainsworth's colleague Mary Main (disoriented attachment). Its authors merely copy-pasted verbatim the DSM 4 diagnostic criteria for Borderline Personality Disorder. So, this is not an attachment style at all! It is a personality disorder.

Insecure attachment styles, attachment disorders and dysfunction are prevalent in cluster B personalities (narcissists, psychopaths, borderlines, histrionics).

On the surface, the Borderline has an anxious preoccupied attachment style. In reality, The Borderline’s engulfment anxiety, self-preoccupation, grandiosity, and preemptive abandonment (reaction to catastrophizing) render her/him dismissive avoidant. Borderlines crave intimacy and love but, at the same time, are terrified of it.

In early childhood, they all loved a dead mother, but they do not dare to think about it or verbalize it (the unthought known). Instead they resort to emotional thinking.

They cathect (emotionally invest in) death and aggression (destrudo, not libido), including in inanimate material goods.

The borderline's acting out is about regaining control over her life and over the abandoning or rejecting person (behavior modification and manipulation). It is more panic than rage. It signals neediness and is codependent.

Owing to hurt-aversion, they place a premium on self-sufficiency, independence, personal autonomy, and unbridled, antisocial self-efficacy. They frequently self-parentify and are auto-erotic.

They can love only a dead mother, so they try to turn you into one. Killing the mother figure in order to be able to love her (snapshotting, merger/fusion, extension).

They have dead inert non-interacting mute introjects which makes it difficult for them to distinguish internal from external objects.

Fantasy and Dramatic Behavior

Constant state of artificial crisis, emotional dysregulation, switching, chaos, disruptive behaviors, identity diffusion/disturbance, mixed signals, inconstancy, indeterminacy, capriciousness, arbitrariness, and unpredictability

Dramatic-erratic cluster

Dramatization

Drama enhances self-efficacy and is a form of external regulation

Drama is addictive (a form of risk-taking and also a challenge or mystery)

Drama is an element of grandiosity, helps to distort cognition

Drama is a narrative that resonates with our sense of childlike wonder and fosters dissociation (like a movie)

Drama imposes huge costs in terms of mental resources (depletes) and renders its recipients more malleable and amenable to manipulation (defenseless), it is Machiavellian.

Reenactment of early childhood conflicts

Approach-avoidance repetition compulsion and the dynamics of insecure attachment

Attempts to generate theories of mind and internal working models by probing, testing, and dismantling the world, others, and relationships - the way a child does with a toy

Intermittent reinforcement and trauma bonding

Monopolizing the presence and attention of others (ersatz object constancy)

Channeling and sublimating aggression, projecting punitive introjects and then projective identification

But not all drama is created equal. The specific content of the drama ties in with the self-concept and is a derivative of the psychodynamics and goals of the underlying disorder. It is a fantasy in a paracosm, except in the case of the psychopath.

Like in codependency, in some cases drama allows to control from the bottom through displays of feigned power asymmetry, helplessness, dependency, and neediness (it triggers the savior/rescuer complex and involves regressive infantilization of the drama-making individual)

Psychopath: control, manipulation (creates information asymmetry, disorientation, anxiety and thus induces dependency on the psychopath in others)

Borderline: drowning out internal drama, recruiting participants and sharing the burden (drama loves company), intensity to avoid intimacy

Histrionic: ostentatious display of hyperemotionality

Narcissist: attention-seeking, self-enhancement, substitute to narcissistic supply in protracted states of reduced narcissistic supply or collapse (hunting for morsels): distraction and self-supply (e.g. in paranoid drama)

Both narcissists and borderlines alternate between fantasy and reality - but their fantasies are very different. The borderline's is object (person)-centred, the narcissist's is process (narrative)-centred. Moreover: the fantasies cater to the narcissist's and borderline's deepest psychological needs.

Three types of Borderline shared fantasy: Fairy godmother, Princess, Damsel in distress. Each fantasy hails a different type of intimate partner: Beneficiary of largesse, Fawning subject, Rescuer/savior.

The Borderline snapshots her intimate partner as a persecutory object and this inexorably leads to decompensation acting out (=borderline mortification).

Borderlines: vulnerability+aggression

Acting/distancing (Karpman Drama Triangle)

Self-esteem via reverting locus of control

Attention seeking: hero (gratitude), victim (pity)

Victim or rescuer mentality

Thrills, novelty-seeking, impulsivity

Provocation (projective identification)

Emotional blackmail

Staging, life as a novel or a movie (theatricality)

Manipulation via stress, brinkmanship

Distraction, decoy: shifting blame, diverting attention

Trauma bonding is an extreme, unidirectional, self-harming attachment.

It is fostered by traumatizing, unpredictable, intermittent reinforcement involving a power asymmetry.

These lead to dissonance and ambivalence (identifying with the abuser).

Narcissist's introject casts the narcissist as a victim. It explains why some victims feel guilty or remorseful or self-doubting for no good reason.

Drama Bond

Trauma bonding is often a form of self-mutilation or self-harm, replete with the same three functions: 1. To numb dysregulated emotions that threaten to overwhelm us; 2. To allow us to feel alive through pain; 3. To punish, defeat, and destroy ourselves.

Drama Bonding is an extreme, bidirectional (collaborative) self-harming attachment.

It is fostered by traumatizing, unpredictable, intermittent reinforcement, object withdrawal, and structural narrative fantasy, uncertainty, indeterminacy, and insecurity involving a power asymmetry.

It leads to anxiety, desperation, and acting out.

When there is a failure to convert idealized object to a persecutory object, this leads to acting out. Borderline legitimizes forbidden, repressed introjects, resonates with pathological parts, becomes a vector of contagion.

The borderline cathects goals, experiences them as emotional states.

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BPD and NPD are not the same as CPTSD. They are different ways of REACTING to CPTSD. Borderline Personality Disorder (BPD) is not the same as complex trauma (CPTSD). BPD is a specific type of a multilayered pattern of REACTION to CPTSD. It is partly genetically- and neurobiologically-determined.

So is pathological narcissism: it is a form of idiosyncratic REACTIVE PATTERN to early childhood CPTSD.

Catastrophizing vs. apocalypting: cognition vs. action (brinkmanship).

Paranoia involves both.

Drama and crisis as control and manipulation tools, organizing and explanatory principles, thrill-seeking and risk taking, defiance and contumaciousness.

Drama and crisis buttress grandiosity, invert locus of control from external to internal (e.g., in mortification).

Narcissist's creative destruction of existing environment and circumstances condition for life transitions.

The masses feel that they are being held hostage and enslaved by rapacious, venal, and mendacious elites. They regard these elites and their values as avowed enemies: the West, governments, academia, mainstream media, science, the finance industry, the Jews.

The enemies of the elites are the friends of the masses: terrorists, antisemites, conspiracy theorists, Russia, China, populists authoritarians, the alt right.

The masses abuse democracy and empowering technologies in order to destroy the established order.

This is Jose Ortega y Gasset's "Revolt of the Masses" which always results in ochlocracies and atrocities.

Collapse

Some borderline women (secondary or subclinical psychopaths and emotionally dysregulated), with or without a prior history of promiscuity (sociosexually unrestricted) embark on a spree of sexual self-trashing after they have been discarded abruptly and cruelly by a long-term intimate partner to whom they had been scrupulously faithful and who was the centre and pivot of their world.

Such self-harming can last for years or decades and deteriorate into full fledged sex work.

By letting men - individuals and in groups - do with and to her body as they please, the brutally abandoned borderline is attempting to accomplish three goals:

1. Secure male attention and acceptance, compassion and affection, however fake and even if only for a few minutes;

2. Reaffirm her self-perception as bad, worthless, unworthy, whorish, and incorrigible;

3. Punish her erstwhile partner by cheapening and prostituting his “property”.

Sexual self-trashing is non-autonomous, non-agentic, and self-objectifying. It involves copious and ubiquitous dissociation as well as self-incapacitating and disinhibiting substance abuse intended to help legitimize the self-harm (“I was drunk”) and resolve cognitive and other dissonances.

Self-trashing borderlines, especially those who end up in sex work, create a counterfactual narrative of choice and empowerment. But in reality, such behaviors are lifelong addictions. Studies show that such women are unable to commit in relationships and they break up and cheat much more often than the average.

Comorbidities and Co-occurrences

Overview

Pathological narcissism, borderline personality, and anxious psychopathy involve the only partly successful suppression of cognitions (thoughts) via ironic processes (ironic rebound). Similarly entrained abuse involves ironic processes in the victim's mind.

Depression is the main reason and presentation when borderline patients seek treatment. All borderline patients have a history of depressive illnesses. Unstable mood that is hypersensitive to interpersonal conflict (real or anticipated) and to stressors (generate anxiety as well).

Linehan (1993) suggested that **emotion dysregulation** may be hereditary. It leads to mood lability. Suicidal ideation is constantly there and is not necessarily a depressive feature.

Confusion between BPD and **Bipolar Disorders**. Unlike in Bipolar, in BPD the mood cycling is short-lived. Psychotic and narcissistic features are misdiagnosed as mania. In suggested bipolar spectrum, mild cases lack manic or hypomanic episodes and this led to conflation with BPD.

1. The codependent controls from the bottom. She uses her neediness and clinginess to rule and to extort her intimate partner. The Borderline

surrenders to her intimate partner: he is tasked by her with stabilizing her moods and regulating her emotions.

2. Abuse is the glue that holds dysfunctional relationships together: it is proof of love and identified with it. Healthy people walk away when they are victimized - the mentally ill bond and get attached.

3. The mentally ill prefer objects to people and attempt to objectify others. Objects are more predictable and controllable.

4. Approach avoidance repetition compulsion should not be confused or conflated with intermittent reinforcement. The first is a reactive pattern to the twin anxieties: abandonment vs. engulfment. The second is the coercive control technique that results in trauma bonding.

Borderlines often feel that the only things they have to offer are sex and drama. Their dysregulation is their only asset. They are but a spectacle.

5. The empty schizoid core at the heart of disorders of the self (such as narcissism and borderline) is habituated: gradually it becomes a choice. Absence of being guarantees invulnerability and impermeability.

Invulnerability signaling is at the core of the grandiosity of the psychopathic narcissist: a defiant “see if I care” attitude, no one and nothing have the slightest power over me, I never get attached, emotions are weaknesses, I am a free spirit, a law unto my own.

This attitude leads to some counterintuitive behavioral outcomes.

The psychopathic narcissist never engages in mate guarding. His message to other men: “The women in my life mean so little to me that you can have them, if you wish. They are dispensable, fungible, and interchangeable. They have no power over me, nothing they do matters or has the capacity to hurt me.”

Another example: “Go ahead and plagiarize my work and my ideas. They mean little to me. I can generate revolutionary breakthroughs faster than you can steal them!”

Harvey Cleckley, the author of “Mask of Sanity”, was repeatedly stunned by what he called the psychopathic narcissist’s “rejection of life”.

The ultimate in invulnerability signaling is all-pervasive ostentatious apathy: the profound neglect and abandonment of all personal goals and plans and behaving in ways which are in your face self-destructive - as if one couldn’t care less about one’s wasted life and looming devastation or demise.

ADHD starts in childhood. BPD starts in adolescence.

CPTSD

Cluster B personality disorders are post-traumatic conditions. As such they are indistinguishable from sufferers of CPTSD (complex trauma). But CPTSD is transient and curable.

25-30% of BPD patients have experienced PTSD in childhood (especially sexual abuse). But trauma is not part of the etiology. Emotional neglect and invalidation risk factors, not abuse or trauma (Porter).

BPD is an extreme form of complex trauma (CPTSD) which involves self-soothing behaviors, repetition compulsions, dysfunctional attachment, dissociative self-states, arrested development and infantile defenses (regressive infantilism and splitting), cognitive distortions, emotional-affective dysregulation, decompensation and acting out. The BPD's secondary psychopathy vs. covert narcissism.

The erroneous foundations of contemporary psychology: self, personality, individual should be replaced with seamlessly fluid self-states. Man is a river, not a lake.

Emotional dysregulation (and inappropriate or reduced affect) result in impaired internal reality testing and empathy deficits. In reappraisal and exposure therapies we use cognition to modify emotions.

Covert Narcissism

How to tell the difference (differential diagnosis) between someone with Borderline Personality Disorder (BPD) and a covert Narcissist?

High-functioning Borderlines succeed to regulate their emotions and moods for certain periods of time, giving the impression that they are actually grandiose covert narcissists (Borderlines are as grandiose as narcissists and psychopaths).

Here is how to tell the difference:

Covert (fragile, shy, vulnerable) narcissists never experience suicidal ideation or attempt suicide. They externalize aggression and are typically negativistic (passive-aggressive);

Covert narcissists do not experience separation insecurity (abandonment anxiety) and they maintain object constancy;

Covert narcissists are not clinging or needy;

Covert narcissists are self-efficacious, most borderlines are self-defeating;

Borderlines are self-critical. Akin to neurotics, they have autoplastic defenses and dichotomous thinking (splitting). Covert narcissists have alloplastic defenses;

Borderlines are highly emotive and dysregulated. They are overwhelmed by their emotions. Covert narcissists display only negative affectivity and often have reduced affect display.

ASD (Autism Spectrum Disorders)

There is an affinity between low functioning autism and borderline personality disorder.

In both cases, the sufferer is overwhelmed by stimuli, external (autism) or internal (the borderline's dysregulated affects).

In both cases, self-harm serves to fulfill three self-soothing functions:

1. Reassert control over the dynamic of irritation and aggravation (via the elective act of self-mutilation);

2. Drown out sources of frustration and pain with even greater agony; and

3. Reawaken and feel alive as the self-inflicted hurt negates the erstwhile numbing.

The narcissist experiences periods of collapse: failure to obtain narcissistic supply.

The collapse can be subclinical (protracted and incremental as barely sufficient maintenance levels of supply are at hand) or traumatic (when he loses all his sources of supply simultaneously).

As long as the supply keeps coming, the narcissist is ego-syntonic. The collapse results in severe ego-dystony and dysphoria (often, depression). It resembles decompensation in borderlines (BPD) but, with the narcissist, there is no emotional dysregulation.

The narcissist then transitions from one type to another: cerebral to somatic or overt to covert. This is akin to the borderline switching between self-states when she is abandoned, rejected, humiliated, or stressed.

In the cerebral type, sexual abstinence is a form of self-supply: it makes him feel superior. It is the collapse-induced depression that drives him to become sexually voracious in a somatic phase.

So, contrary to the rest of humanity, in narcissists depression leads to enhanced libido (sex drive).

The types are highly dissociative self-states, almost distinct personalities.

For example: the somatic mourns the years of cerebral sexlessness while the cerebral grieves over the time wasted by the somatic in the relentless pursuit of sexual conquests.

Both of these types fail to recall the bliss they had experienced during the time spent as the other type, regardless of the "sacrifices" made. They misattribute the depression brought on by imminent or actual collapse to the compulsive behavioral constriction of the other type ("I was depressed as a cerebral because I didn't have sex" or "I didn't have sex because I was depressed").

Finally, both borderlines and narcissists experience separation insecurity (abandonment anxiety) owing to object inconstancy. Both also merge and fuse with an intimate partner in a symbiotic phase (the shared fantasy).

But the borderline distances herself from her partner owing to an overwhelming engulfment anxiety while the narcissist devalues and discards his partner owing to his need to separate from a maternal figure.

Psychotic Disorders (Psychosis), Schizophrenia

I have been arguing to reverse Kernberg's hierarchy: I postulate that the Narcissist is far closer to psychosis (his personality is far less organized) than the Borderline. Only the narcissist's rigid grandiosity is keeping him together and when it is effectively challenged, he decompensates, acts out, and disintegrates.

Grotstein postulated that the Borderline is a failed narcissist: the pathology did not progress (or devolve) into narcissism which is a full-fledged form of binary Dissociative Identity Disorder with two selves (the False and the True)

The Narcissist's solution to this duality of selves is to switch off the dilapidated, atrophied, and dysfunctional True Self and relegate it to the deepest recesses of the mind where it has no influence whatsoever on the narcissist's psychodynamics. Only the False Self is left.

In contrast, the Borderline fails to repress and dissociate the True Self and, consequently, never becomes a narcissist. This "failure" causes the Borderline's two selves to compete for control of her identity and memories.

It is this inner struggle that mimics other dissociative disorders and led scholars such as Masterson, Dell, Putnam, Ross, Ryle and many others to suggest that BPD may merely be another label for the identity diffusion and alteration common in dissociative disorders.

Psychosis or Schizophrenia?

Schizotypal, Schizoid, Paranoid Personality Disorders are pre-psychotic.

Role play in (erotic, aggressive, self-aggrandizing) fantasy (e.g., hero) about self (others=self)

Self-directed self-efficacy (wish-fulfilment and substitutive action as self-regulation)

Pathetiology: childhood trauma (PTSD)

Internal vs. External (hyperreflexivity)

Paranoia and Paranoid PD

Magical thinking (persecutory: demons or grandiose: hero, tasked by god)

Delusions (cognitive distortions such as grandiosity)

Hallucinations (stress in BPD)

Derealization and depersonalization

Lability and dysregulation (erratic)

Self-perception (e.g., as victim)

Anhedonia

Reduced affect display

Avolition

Asociality

“Demon possession” and switching

Psychosis neurobiologically determined defense mechanism.

Types of stress (tension) in BPD: abandonment/rejection, engulfment, histrionic, negative affects.

Types of stress in NPD: mortification, injury, abandonment in shared fantasy, collapse, negative affects.

Schizoaffective, Schizotypal, Schizophreniform Disorders.

How stress induces Brief Psychosis?

Acute reactive dissociative psychosis vs. Acute reactive adaptive psychosis (psychotic microepisodes): erase vs. reboot.

Decompensation, dissociation, and hyperreflexivity.

Stress sharing, stress vector, and stress transfer (stress contagion): General adaptation syndrome (GAS).

OSDD (DID) and SWITCHING

Switching between self-states to identity disturbance and intimate relationships.

Some borderlines switch imperceptibly, glacially, and incrementally. They maintain continuity, memory, and a semblance of identity across the various self-states.

Suicide is a form of acting in coupled with acting out (like a temper tantrum), internalized and externalized aggression. It is preceded by switching to another self-state (secondary psychopathy in borderlines and borderline organization in narcissism).

BPD and NPD are prone to switching owing to splitting and self-splitting defenses (previous self-state all bad while new self-state all good), lack of core identity (identity disturbance), and no constellated or integrated self/ego (emptiness or empty schizoid core). They are in constant flux.

When confronted with promise or threat, real, imaginary, anticipated, or recalled.

Responsive to real or anticipated environmental cues (e.g. stress, anxieties, substance abuse, holidays, important events, life crises or traumas, new people, crowds, mortification, medication, even sensa – see Proust).

Preceded by emotional dysregulation (emotional switching – Houben).

Switching: consensual, forced, triggered.

Signs of switching (prodromal phase):

Rigid body posture or pseudo-fainting

Calm before the storm: atypical kindness, reasonableness, submissiveness, conflict aversion

Changes in body self-image

Dramatic change in identity (behaviors, preferences, values, beliefs, emotionality, cognitive style)

Talkativity (hyper-verbalizing), hyperreflexivity (pseudo-psychosis) and hyperactivity followed by a period of subdued, slow motion, hesitant reactivity

Impulsivity

Dissociation

LITERATURE

Houben M, Bohus M, Santangelo PS, Ebner-Priemer U, Trull TJ, Kuppens P. The specificity of emotional switching in borderline personality disorder in comparison to other clinical groups. Personal Disord. 2016 Apr;7(2):198-204. doi: 10.1037/per0000172. Epub 2016 Feb 15. PMID: 26882282; PMCID: PMC4816671.

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.).

European Journal of Trauma & Dissociation, Volume 1, Issue 1, January–March 2017, Pages 63-71, Complex trauma, dissociation and Borderline Personality Disorder: Working with integration failures; By Dolores Mosquera and Kathy Steele

Borderline Personal Disorder and Emotion Dysregulation. 2014; 1: 13, Published online 2014 Oct 14. doi: 10.1186/2051-6673-1-13, Chronic complex dissociative disorders and borderline personality disorder: disorders of emotion dysregulation? By Bethany L Brand and Ruth A Lanius

Is Dissociation an Integral Aspect of Borderline Personality Disorder, Or Is It a Comorbid Disorder? By Marilyn I. Korzekwa, Paul F. Dell

Book: Dissociation and the Dissociative Disorders, 2nd Edition, 2022, Routledge

Depression

Ironically, the comorbidity of depression with Borderline Personality Disorder (BPD) reduces the incidence of reckless acting out and improves impulse control.

Depressed Borderlines have been mistakenly dubbed “introverts” or “shy, quiet borderlines”.

Outwardly, like every other dysphoric, anhedonic, and dysthymic person, the depressed borderline is mostly homebound and listless.

But when the veil of depression lifts, her true character emerges: she becomes gregarious, promiscuous, a novelty-seeker, and a defiant risk-taker.

Secondary Psychopathy

Lopez-Villatoro JM, Palomares N, Díaz-Marsá M, Carrasco JL (2018) Borderline Personality Disorder with Psychopathic Traits: A Critical Review. Clin Med Rev Case Rep 5:227. doi.org/10.23937/2378-3656/1410227

Borderline and Histrionic personality disorders may be manifestations in females of secondary type psychopathy (as measured by Factor 2 of the PCL-R test). In other words: Borderline and Histrionic women may actually be psychopaths. A growing body of recent studies supports this startling conclusion. Survivors of CPTSD also manifest psychopathic and narcissistic behaviors (overlay)

Intimate partners won't not surprised: impulsivity, defiant grandiosity, antisocial and interpersonal aggression, manipulativeness, dysregulated negative emotionality, lack of object constancy (object impermanence),

attachment dysfunctions, hostility, splitting (dichotomous thinking), high levels of distress, anxiety, depression, and substance abuse are all typical of and common among secondary psychopaths - and among Borderlines. These women also defy gender roles and behavioral norms (act masculine). But the Borderline adds a twist to this cocktail: dissociation. Whenever stress levels and inner dissonance become intolerable, she hands over control to her inner psychopath, depersonalizes, derealizes, or develops amnesia.

When the Borderline's life partner is another proud member of the Cluster B tribe (another Borderline or Psychopath, or a Narcissist), he reacts with equal measures of abuse to her frequent misconduct. The relationship ineluctably devolves into a vicious power play and warping cruel mind games, exacerbating traumatic mental health outcomes for everyone involved.

Dissociative depersonalization and derealization are common reactions in Borderline Personality Disorder (BPD), in Dissociative Identity Disorder DID, formerly known as Multiple Personality Disorder or MPD), and in patients with post-traumatic stress disorders, such as PTSD and CPTSD.

The experience is variously described as being on auto-pilot, sliding into anaesthesia, or reverting to the status of an empathic or sad spectator. It is provoked by intolerable dissonance (for example: when cheating on a partner, having ambivalent sex, breaking the law, or breaching some deeply held mores and values). The patient distances herself from the events, from her pain, and from anticipated abandonment and rejection

via the mechanisms of estrangement and alienation: "This is not happening to me, this is just a nightmare, not real". Substance abuse and ambient distractions (bar hopping or video games) tend to exacerbate these reactive patterns and the patient often misattributes to alcohol or drugs the behaviors wrought by her alters or the subsequent amnesia.

Dependent Personality Disorder (Codependency)

Borderline, narcissism and codependency involve a fantasy defense. The codependent has a dual role as both parent and child, reflecting her punitive inner parent and inner child.

The codependent's inner parent feels betrayed when the codependent falls in love. It pushes the codependent to punish her partner as a loyalty test, to placate the implacable inner parent. Riven by guilt and shame, the codependent then punishes herself as well. This is a borderline dynamic.

Codependents and their intimate partners engage in co-regulation (via symbiotic merger/fusion).

The codependent suffers from object inconstancy, separation insecurity aka abandonment anxiety, and catastrophizing. She seeks to attach to a secure base via people-pleasing, control from the bottom and emotional blackmail (an external object), and aggression directed at an internal object.

The codependent outsources her ego functions, such as reality testing.

The codependent feels alive only when in a relationship, she maintains a vicarious life. In solitude, she finds her constricted life intolerable. She loves herself by proxy, through the gaze and agency of her intimate partner.

Narcissistic Personality

Comorbidity Hierarchy: primary and secondary or dominant vs. recessive diagnoses in comorbidities.

Secondary disorders are traits and behaviors and amount to subclinical style. They are triggered by environmental stressors and are self-states.

Secondary disorders may be a form of functional overlay (additional symptoms triggered by psychological dynamics) or may even be triggered by the primary disorder (example: ASD and NPD). Similarly, the primary disorder may be a defense against the secondary disorder.

In NPD-BPD comorbidity, NPD is the dominant, primary disorder and is a defense against BPD, the secondary disorder. Only during decompensation does the secondary disorder emerge (affective dysregulation and suicidal ideation).

Covert states are comorbidities: narcissism plus passive-aggression (negativism)=covert narcissist.

Debate since the 1970s: NPD vs. BPD: progression or reaction? (Kerbnerg, Grotstein)

WATCH Borderline=Failed Narcissist: Intermittent Mother, not "Dead" (EXCERPT) • Borderline=Failed Narcissist: Intermittent...

Othering failure is a defense against the risk of acknowledging the superiority of other people.

By introjecting-incorporating idealized versions of others, the narcissist accomplishes two psychodynamic goals: 1. Self-idealization (self-idolatry); and 2. Avoidance of narcissistic injuries and mortifications, assertion of control and utter self-sufficiency, amounting to efficacious self-regulation (avoidance of the underlying Borderline Personality Organization).

Covert narcissism is an adaptation toa state of collapse, but the narcissistic dynamics and structures remain intact.

BPD is a failure to develop these narcissistic defenses. So, the Borderline is acutely dependent on other people for self-regulation (external regulation).

Being grandiose, s/he is also much more vulnerable to narcissistic injuries and mortifications.

Ironically, her constant emotional dysregulation is the outcome of her desperate attempt to avoid emotional dysregulation by depending on other people, her external regulators.

The comorbidity of narcissistic and borderline personality disorders (NPD and BPD) is counterintuitive: they appear to be mutually exclusive.

Both Borderlines and narcissists are grandiose, but the former possess warm empathy and emotions whereas the latter lack them.

The only way to reconcile these contradictions and to square the circle is by assuming the existence of semi-dissociated self-states that come to the fore in reaction to changing circumstances and environments.

In a comorbid state, BPD is always dominant while NPD is recessive.

But the narcissistic structures hijack the borderline's empathy and emotions and leverage them during the lovebombing and grooming phases.

The Borderline finds herself or himself trapped in a narcissistic shared fantasy.

To the Borderline, the narcissistic landscape feels surrealistic, alien, and vaguely menacing. L

The self-states which are narcissistic and secondary (factor 2 or F2) psychopathic regard the borderline with self-destructive contempt for her weakness and vulnerabilities. They seek to "protect" and "rescue" her from herself.

This hardwired ego dystony founded on permanent dissonance between the subpersinalities, results in mood lability, emotional dysregulation, and psychopathic features, which are even more extreme than in a classic presentation of BPD.

The complex of behaviors known as people pleasing emanates from multiple etiologies. In an earlier post, I have mentioned anxiety. Another source is social phobia.

Socially phobic people often become avoidant: they shun all social interactions.

But a small minority of them disinhibit themselves with alcohol and drugs and then proceed to act out and engage in dysregulated, reckless, and unboundaried behaviors, including and especially sexually.

These self-defeating and self-trashing behaviors are intended to accomplish the goals of pleasing others, fitting in, belonging, being accepted, appreciated, “loved”, and liked.

But the phobia never disappears. This constant presence drives an escalation in people pleasing behaviors and the compromising of self-respect, self-esteem, and boundaries which renders the phobia even worse.

It is a vicious cycle which often results in lifelong anxiety disorder, depression, and passive-aggression.

Avoidance and Avoidant Personality Disorder

Covert narcissist is a narcissist who develops Avoidant Personality Disorder in order to cope with a permanent state of collapse.

Major difference between Borderline and Avoidant: ACTING OUT (not the same as ACTING IN or ENACTMENT).

Bowlby's monotropy (**monotropy** proposes that infants have an innate, biological need to form a close, exclusive attachment to one primary caregiver—historically considered the mother. This primary bond is qualitatively different and more important than any other secondary attachments)

Narcissist is bothered by your presence – borderline by your absence

Both try to dissolve you and eliminate your separateness, agency, personal autonomy, and independence

Either by rendering you inanimate and penalizing you for any deviation and divergence

Or by merging and fusing with you while outsourcing to you critical psychological needs and functions.

Both need to devalue and discard you:

The narcissist in order to reenact separation-individuation from a mother figure

The borderline in order to ameliorate engulfment anxiety.

Both of them become avoidant and schizoid at some stage.

The narcissist either because of deficient or negative supply (narcissistic injury or mortification) or to process a corrupted introject

The borderline in order to lick her wounds and develop abandonment anxiety sufficient to trigger another round of approach-avoidance repetition compulsion.

Should not be confused with Avoidant Personality Disorder which is an anxiety reaction to perceived or anticipated rejection – rather than a psychopathic reaction (like the Borderline's).

AvPD is connected to people pleasing, indecisiveness, schizoid states, and to risk and conflict aversion, hesitancy, and extreme self-doubt.

People suffering from Avoidant Personality Disorder feel inadequate, unworthy, inferior, and lacking in self-confidence. As a result, they are shy and socially inhibited. Aware of their real (and, often, imagined) shortcomings, they are constantly on the lookout, are hypervigilant and hypersensitive.

Even the slightest, most constructive and well-meant or helpful criticism and disagreement are perceived as complete rejection, ridicule, and shaming. Consequently, they go to great lengths to avoid situations that require interpersonal contact - such as attending school, making new

friends, accepting a promotion, or teamwork activities. Hence Avoidant Personality Disorder.

Inevitably, Avoidants find it difficult to establish intimate relationships. They "test' the potential friend, mate, or spouse to see whether they accept them uncritically and unconditionally.

They demand continue verbal reassurances that they really wanted, desired, loved, or cared about.

When asked to describe Avoidants, people often use terms such as shy, timid, lonely, isolated, "invisible", quiet, reticent, unfriendly, tense, risk-averse, resistant to change (reluctant), restricted, "hysterical", and inhibited.

Avoidance is a self-perpetuating vicious cycle: the Avoidant's stilted mannerisms, fears for her personal safety and security, and stifled conduct elicit the very ridicule and derision that he or she so fears!

Even when confronted with incontrovertible evidence to the contrary, Avoidants doubt that they are socially competent or personally appealing. Rather than let go of their much cherished self-image, they sometimes develop persecutory delusions. For instance, they may regard honest praise as flattery and a form of attempted manipulation.

Avoidants ceaselessly fantasize about ideal relationships and how they would outshine everyone else in social interactions but are unable to do anything to realize their Walter Mitty fantasies.

In public settings, Avoidants tend to keep to themselves and are very reticent. When pressed, they self-deprecate, act overly modest, and minimize the value of their skills and contributions. By doing so, they are trying to preempt what they believe to be inevitable forthcoming criticism by colleagues, spouses, family members, and friends.

From the entry I wrote for the Open Site Encyclopedia:

The disorder affects 0.5-1% of the general population (or up to 10% of outpatients seen in mental clinics). It is often comorbid with certain Mood and Anxiety Disorders, with the Dependent and Borderline Personality Disorders, and with the Cluster A personality disorder (Paranoid, Schizoid, and Schizotypal).

Covert Borderline

The covert borderline is a new subtype of Borderline Personality Disorder (BPD) more common among men. It is different to the classic and to the shy or quiet subtypes.

Bridge between overt and covert cluster B states via collapse and narcissistic mortification. It is a standard model of personality disorders, akin to the standard model in particle physics: it unifies all personality disorders into a single clinical entity and predicts new diagnoses.

The classic Borderline offers the Covert Borderline an ideal love fantasy which he craves. But his ideal partner is a codependent "shy or quiet" borderline.

Borderline is a failed narcissist because she has an intermittent mother, not a dead one: intermittent reinforcement allows the borderline to perceive external objects by outsourcing ego functions and even her body despite her huge narcissistic investment.

The narcissist gave up on the externality of separate objects because they are bound to frustrate and hurt. The borderline still has hope: she interacts with separate external objects via merger and fusion, by becoming their internal object.

Covert borderline is a child who was first subjected to a dead mother and then to an intermittent but loving mother. He is trying to recreate this love.

Shy or quiet borderline: useful idea miscast as a diagnosis.

Borderline’s anaclitic object choice

Narcissist’s fantasy is to be loved by a mother figure

Covert Borderline’s fantasy is ideal love expressed through children

Borderline’s fantasy is be regulated by secure base, special friend, rock

All experience shadow via their partners (Archaic wounds, V-spots)

LITERATURE

Articles and book by: Grotstein, Kernberg, Masterson, Rinsley, Searles, Gunderson, Rosenfeld, Steiner, Brown, McDougall, Green, Modell, Volkan, Giovacchini, Stone, Boyer, Meissner, Bion, Balint, Khan, Bowlby, Winnicott, Jacobson

Both the Covert and the Classic act out while the shy or quiet acts in. The covert borderline borrows features from the classic narcissist and from the primary psychopath. The classic variant is grandiose and reacts as a secondary psychopath would to stress and ego dystony.

Collapse in covert borderline (substantive failure in relationship or career). In career-related collapse, False Self rendered grandiose (cognitively distorted, impaired reality testing, defiance,

contumaciousness, externalized mainly verbal aggression, recklessness) ◊Malignant Narcissist.

In interpersonal collapse, locus of control becomes external (clinging, needy, codependent, mood labile, dysregulated affects and behaviors, passive-aggression, promiscuity sadistic, punitive, splitting, switching, cycling)

Covert borderline is a child who was first subjected to a dead mother and then to an intermittent but loving mother. He is trying to recreate this love.

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Borderline's anaclitic object choice

Narcissist's fantasy is to be loved by a mother figure

Covert Borderline's fantasy is ideal love expressed through children

Borderline's fantasy is be regulated by secure base, special friend, rock.

All experience shadow via their partners (Archaic wounds, V-spots)

The covert borderline craves love and a family. The covert narcissist deceives him by offering him both. He lets her mislead him and gets addicted to the shared fantasy.

Covert Borderline's fantasy is ideal love expressed through children

Is the covert BPD "typically" more toxic than the classic BPD or covert narcissism?

Is the covert BPD in a shared fantasy of 1 or for 2?

Does the covert BPD experience dual mothership?

Is intermittent reinforcement the same as devalue and discard cycles?

Is the covert BPD in a state of prolonged grief like the narcissist?

When the covert BPD feels slighted, disappointed and hurt by interpersonal communication, circumstances or partner behavior – because the covert is a hybrid does it cause Narcissistic injury? When the covert BPD then goes into a fight/flight attack mode is that Narcissistic rage or symptom of classic BPD?

Interpersonal communication was a huge platform for disagreement, arguments. If a person is chronically feeling slighted, disappointed, hurt

and accusations/ paranoia of lying, withholding using this to justify for the verbal abuse. Is this the chronic victimhood of Covert Narcissism or these traits BPD.

What specific behaviors in the covert BPD are under the category of psychopathy?

Any research to show that some people with covert BPD might traits of both classic and covert elements? If yes, what elements are borrowed from each?

Borderline switch between self-states. Self-states naming, Autopilot, "It wasn’t (like) me, Can’t place myself in the same state of mind or understand it."

Self-states (not the same as Millon’s or others’s typology or taxonomy)

Classic-dissociative: separation insecurity, engulfment anxiety, Relationship obsessive–compulsive disorder, philophobia, low Self-monitoring, impaired transparency estimation

The shy or quiet borderline internalizes her struggles rather than externalize them. She becomes the exclusive target of her own turmoil. She “acts in”.

Psychopathic Borderline/Dark Personality: violent/aggressive

Antisocial (secondary psychopath) Borderline: sociosexually unrestricted, compulsive sexting, transactional sex, promiscuous

Both the classic and covert borderline (many of the latter are men) act out.

LITERATURE

1. Front. Psychiatry, 10 December 2020, Executive Dysfunction Associated With the Primary Psychopathic Features of Borderline Personality Disorder, José M. López-Villatoro, Marina Diaz-Marsá, Blanca Mellor-Marsá, Irene De la Vega and José L. Carrasco

2. APA PsycArticles: Journal Article, Borderline personality disorder as a female phenotypic expression of psychopathy?, Sprague, J., Javdani, S., Sadeh, N., Newman, J. P., & Verona, E. (2012). Borderline personality disorder as a female phenotypic expression of psychopathy? Personality Disorders: Theory, Research, and Treatment, 3(2), 127–139. https://doi.org/10.1037/a0024134

3. Psychopathy and associated personality disorders: searching for a particular effect of the borderline personality disorder? Nioche A., Pham TH, Ducro C, de Beaurepaire C, Chudzik L, Courtois R, Réveillère C, Encephale 2010 Jun;36(3):253-9. doi: 10.1016/j.encep.2009.07.004. Epub 2009 Sep 26

4. The Journal of Forensic Psychiatry & Psychology, Volume 25, 2014 - Issue 6, Antisocial personality disorder comorbid with borderline pathology and psychopathy is associated with severe violence in a forensic sample, Richard C. Howard, Najat Khalifa, & Conor Duggan

5. Personality and Individual Differences, Volume 107, 1 March 2017, Pages 72-77, Students, sex, and psychopathy: Borderline and psychopathy personality traits are differently related to women and men's use of sexual coercion, partner poaching, and promiscuity, Roxanne Khan, PhD, Gayle Brewer PhD, Sonia Kim BSc, Luna C. Muñoz Centifanti PhD

6. Personality and Individual Differences, Volume 57, January 2014, Pages 14-19, Emotional dysregulation and Borderline Personality Disorder: Explaining the link between secondary psychopathy and alexithymia, Leigh E. Ridings, Catherine J. Lutz-Zois

7. Personality Disorders, 2022 May;13(3):288-299. doi: 10.1037/per0000504. Epub 2021 Oct 21. Do my emotions show or not? Problems with transparency estimation in women with borderline personality disorder features, Celine De Meulemeester, Benedicte Lowyck, Bart Boets, Stephanie Van der Donck, Patrick Luyten

Collapse in classic pathological narcissism (failure to maintain appearances) vs. collapse in covert borderline (substantive failure in relationship or career).

In career-related collapse, False Self rendered grandiose (cognitively distorted, impaired reality testing, defiance, contumaciousness,

externalized mainly verbal aggression, recklessness)→Malignant Narcissist

In interpersonal collapse, locus of control becomes external (clinging, needy, codependent, mood labile, dysregulated affects and behaviors, passive-aggression, primiscuity sadistic, punitive, splitting, switching, cycling)→Borderline

In both states of collapse: dissociation, confabulation, acting out, paranoid ideation, attention-seeking

Dark Pentagram

The elements of the Dark Triad personality include Machiavellianism, subclinical narcissism, and subclinical psychopathy. The Dark Tetrad added everyday sadism. I propose a new construct: the Dark Pentagram Personality which will incorporate borderline personality and covert narcissism, but not everyday sadism (which overlaps psychopathy).

Vulnerable dark triad

The vulnerable dark triad comprises three related and similar constructs: vulnerable narcissism, secondary psychopathy, and borderline personality traits.[53]

LITERATURE

Miller, J.D., Dir, A., Gentile, B., Wilson, L., Pryor, L.R. and Campbell, W.K. (2010), Searching for a Vulnerable Dark Triad: Comparing Factor 2 Psychopathy, Vulnerable Narcissism, and Borderline Personality Disorder. Journal of Personality, 78: 1529-1564.

Gamache, D., Maheux-Caron, V., Théberge, D., Côté, A., Rancourt, M. A., Hétu, S., & Savard, C. (2023). Revisiting the vulnerable dark triad hypothesis using a bifactor model. Scandinavian Journal of Psychology, 64(5), 679–692. https://doi.org/10.1111/sjop.12921

Bruno Bonfá-Araujo, Julie Aitken Schermer, Unveiling the fragile façade: A scoping review and meta-analysis of the Vulnerable Dark Triad, Personality and Individual Differences, Volume 224, 2024, 112659, ISSN 0191-8869

Type Inconstancy

The narcissist outsources his/her sense of existence. When this fails, the narcissist experiences intense, life-threatening negative affects and reverts to a borderline state.

When NPD decompensates, BPD. When BPD decompensates AsPD.

Switching and self-states.

OSDD (Other Specified Dissociative Disorder).

Co-occurrence rates

Genetic and nonshared environmental influences, etiologies

Shared features in AsPD, BPD, psychopathy

Anxious-preoccupied attachment

Similar developmental course

Disinhibition

Gender and sex

Borderline and Histrionic personality disorders may be manifestations in females of secondary type psychopathy (as measured by Factor 2 of the PCL-R test).

LITERATURE

Chun S, Harris A, Carrion M, Rojas E, Stark S, Lejuez C, Lechner WV, Bornovalova MA. A psychometric investigation of gender differences and common processes across borderline and antisocial personality disorders. J Abnorm Psychol. 2017 Jan;126(1):76-88. doi: 10.1037/abn0000220. Epub 2016 Nov 3. PMID: 27808543; PMCID: PMC5217473.

Mohajerin, B., Mohammadi, P. & Howard, R. Comorbidity of borderline with antisocial and narcissistic personality disorders: a multimethod study. bord personal disord emot dysregul 13, 16 (2026).

The Borderline's Interpersonal Relationships

Overview

The Borderline's fantasy revolves around external regulation: outsourcing her internal psychodynamics to an intimate partner or a special friend.

When the Borderline's intimate partner is enmeshed and immersed in her shared fantasy as the external regulator of her dysregulated emotions and labile moods, he is likely to internalize her inner turmoil, thereby ending up amplifying it.

Once he gets disenchanted with her, she is likely to mirror image his newly gained unperturbed equilibrium by reacting with dysregulation to his perceived indifference and rejection.

Finally, the dyad settles into a transactional regulatory valley when the Borderline re-idealizes her partner within a new halcyon fantasy or withdraws into a nostalgic state coupled with desperate attempts to hoover erstwhile partners or descends into a promiscuous whirl.

Engulfment (Enmeshment) Anxiety

The Borderline's engulfment or enmeshment anxiety has to do with her internalized bad object: the lifelong introjects that keep informing her how unworthy, unloveable, and inadequate she is. Borderline's good object is compensatory: her misbehaviors and dysregulation belie it. Uses external regulation and fantasy to avoid the latter and thus affirm the former.

Exposure to messages that countermand the bad object creates dissonance and the aforementioned anxiety. This leads to withdrawal, aggression, and avoidant behaviors.

People pleasers, borderlines, and codependents have a constricted life: they subsist only through others and for others, vicariously, by proxy. Their identity is determined externally and is consequently sometimes disturbed.

If you suffer from this syndrome, to get better:

1. Establish a people-free time and zone. Banish all people from this space and from your thoughts for at least 1 hour a day;

2. Introduce structure into your life by embarking on a consuming task or assignment or by adopting a hobby;

3. Stop being emotionally invested in the past or in the future. Focus exclusively on the present. Use techniques like mindfulness, if need be.

Approach-Avoidance Diathesis (Repetition Compulsion)

When faced with the Borderline's incessant and injurious approach-avoidance, tell her this:

I am always here for you.

You are and always will be dear to me.

If I place boundaries, it is not only for my self-protection but also in order to be strong for both of us

I will accept and respect any decision you make.

When the Borderline’s intimate partner is enmeshed and immersed in her shared fantasy as the external regulator of her dysregulated emotions and labile moods, he is likely to internalize her inner turmoil, thereby ending up amplifying it.

Once he gets disenchanted with her, she is likely to mirror image his newly gained unperturbed equilibrium by reacting with dysregulation to his perceived indifference and rejection.

Finally, the dyad settles into a transactional regulatory valley when the Borderline re-idealizes her partner within a new halcyon fantasy or withdraws into a nostalgic state coupled with desperate attempts to hoover erstwhile partners or descends into a promiscuous whirl.

Borderlines (women and men alike) pendulate between two anxieties: abandonment (separation insecurity) and engulfment (enmeshment). This creates an approach-avoidance repetition compulsion ("I hate you, don't leave me").

During the avoidance phase, the borderline seeks futilely to become more grounded in reality, often through the agency of a sexual partner or friends.

But then she reverts to the approach phase of the cycle and re-enters a fantasy world, a simulation in which her intimate partner provides external regulation: stabilizes her moods and affects (emotions).

She merges with her significant other, fuses into a single organism by outsourcing her mind to him.

EXAMPLE OF AVOIDANT (ACTING OUT) BEHAVIOR: PROMISCUITY

Drunken promiscuity - the most common variant - is often the confluenced outcome of five pathologies coupled with subclinical psychopathy:

1. **Introject or object inconstancy**

Out of sight - out of mind. The inability to maintain introjects of significant others or the incapacity to trust the permanence of meaningful others in one's life.

2. **Transitional or comfort objectifying**

The failure to attach to or bond with or cathect (emotionally invest in) other people (to transition to object relations). Using other people's bodies the way small kids use teddy bears or favorite blankets.

3. **Identity disturbance**

Fluctuating between mutually exclusive beliefs, values, behavior patterns, cognitions, and emotions (schema) owing to the absence of a core identity because of …

4. **Pervasive dissociation**

Amnesia, derealization, and depersonalization (feeling empty and unreal when alone or during sex).

5. **Bad object**

The punishment and denigration of an internalized bad object, egged on by punitive and sadistic introjects and a harsh inner critic (“I am a whore and I should trash myself”).

Put together, these mutually-reinforcing dynamics result in compulsive attention seeking and acquisition (conquests) to the point of indiscriminate people pleasing on the one hand or predatory behaviors on the other hand.

Sex is used as a currency with which to purchase a temporary reprieve from this internal inferno.

Intermittent Reinforcement

Intermittent reinforcement is the core mechanism behind trauma bonding. It covers disparate phenomena such as giving false hopes and

approach-avoidance repetition compulsion in Borderline Personality Disorder.

There are 4 types of intermittent reinforcement: Fixed interval schedule(FI), Variable Interval schedule (VI), Fixed ratio schedule (FR), Variable Ratio Schedule (VR)

Mate Selection

The Borderline hooks up with potential partners using two self-defeating mating strategies : she either offers the full gamut of sex immediately - or she reveals her mental illness by disclosing her personal history, decompensating, and acting out in a dysregulated and unboundaried manner.

The first strategy appeals to predators and players. They use the Borderline sexually, usually only once, and then move on leaving her hurt and dumbfounded, having succumbed to all their kinky and even lurid fantasies on a first encounter.

The second strategy attracts masochistic or savior, fixer, and rescuer types (watch my video on the Karpman drama triangle). But, exposed to her trenchant aggression, approach-avoidance and promiscuity, even they ultimately give up on her.

Healthy aggression is externalized and sublimated: directed outward at people, institutions, and causes in socially accepted ways.

When aggression is internalized, it induces mental illness such as boredom, anhedonia, dysphoria, depression, and even suicidal ideation or suicide.

Infants internalize aggression when frustrated: it feels unsafe to aggress against mommy. When they separate-individuate, they also learn to externalize aggression appropriately and self-efficaciously (regulate their anger).

A failure in separation-individuation engenders fixated grandiosity and, in some cases, narcissism or codependency.

In these mental health disorders, aggression is both externalized inappropriately and internalized self-destructively.

This ambivalent duality is at the source of approach-avoidant behaviors and decompensatory acting out.

Cluster B patients first need to practice externalizing aggression with the aid of a transitory object (such as a punching bag) in a holding or containing environment (like therapy).

Gradually, they can move on to sublimating aggression, for example by becoming social justice activists, moral crusaders, soldiers, cops, surgeons, entrepreneurs, or other similar professionals.

Borderline's POV (point of view) is the outcome of her internal dynamics, especially the compulsive need to approach and then avoid you.

Here is how she sees you:

APPROACH

You are my world and life

You will save me from myself and from others

Everything is meaningless without you

You are a stable rock

You stabilize my moods and regulate my emotions, with you I feel safe and whole (completed)

I will give my life for you (self-sacrificial)

I am bad and evil (bad object) but with you I feel good and worthy because you accept and love me as I am

AVOIDANCE

I am overwhelmed by pain owing to your rejection and abandonment (often projected and anticipated): you are not protective, you don't care, you found someone else to take my place, You are disloyal, You are looking for alternatives

Dissociation (amnesia, auto-pilot depersonalization, derealization)

I have to do something, anything to hurt you and then regain your love

You want me dead, shackled, only yours, to disappear into you

You have changed, You blame-shift, I am the victim

You guilt-trip

You are not self-aware: You are self-destructive and you want to drag me with you

You are just after my sex, looks

Paranoid ideation, persecutory object: You lie, deceive, and cheat, You are out to get me, You entrapped me, You never mean what you say, You gaslight me, You hate me while I love you self-sacrificially, You humiliate me and shame me, you are malicious

Baiting

Drama (boredom, anxiety)

Approach-avoidance (Intermittent Reinforcement)

Suicide threats

Neediness and clinging, helplessness (gratifies grandiosity)

Idealization

Unboundaried Sex

Fantasy and Lies

Triangulation

Twin Anxieties

Borderline twin anxieties: abandonment and engulfment

Both put borderline in touch with her schizoid core (emptiness), negates her existence

Approach-avoidance repetition compulsion

Sudden change in behavior:

At the beginning of the relationship, she feels focus of attention and in control (internal locus)

Then, daily life gives rise to the twin anxieties (external locus) and she reacts with acting out (psychopathic self-state).

Narcissistic-Borderline Dynamics

The borderline patient requires an intimate partner who would partake in her approach-avoidance dance. Only the narcissist fits the bill.

When the borderline is in the throes of her abandonment anxiety (separation insecurity), the narcissist regulates her emotions and stabilizes her labile moods with his lovebombing and idealization.

When the borderline experiences engulfment (enmeshment) anxiety, he obliges by devaluing and discarding her, pushing her away.

The twin cycles are compatible and feed on and off each other.

Narcissist attaches to objects (books, human bodies) and functions (the 4 Ss: sex, supply, services, and safety); borderline attaches to her regulated states.

Different but complementary functions of their shared fantasies: engulfing (narcissist) vs. being engulfed (borderline).

Dual mothership in operation in both types of shared fantasy.

Approach-avoidance (borderline) vs. narcissist's attempted separation (devaluation and discard)

Hoovering for different reasons (introject constancy vs. object constancy)

Dual mothering

In relationships with non-borderlines, narcissist and intimate partners are good enough maternal figures in a shared fantasy (“fake family”).

In relationships with borderlines, the narcissist offers unconditional love and parentifies himself: the borderline is a dead mother and affords him a second chance to fix/heal/rescue/save her and, by extension, himself.

Mislabeling and misidentifying internal dynamics is a common cognitive distortion among cluster B patients.

Self-deceiving mental artifacts and self-gaslighting are the hallmarks of several personality disorders, including Narcissistic and Borderline.

Consider, for example the interpersonal dimension.

The personality disordered are totally incapable of any intimacy and of any emotions whatsoever in sex and, more generally, with people.

They habitually confuse

dependency,

limerence,

novelty,

infatuation (rush),

exhibitionism,

masochism,

defiance,

competitiveness,

possessiveness,

neediness, connection,

and people pleasing

with love and intimacy.

These, of course, are not the same things, not by a long shot. Actually, they are the antonyms of love and intimacy.

It FEELS like emotions and intimacy to these patients because they know no better and no different.

When they attempt to identify and label their dim stirrings, they simply resort to the vocabulary of healthier, normal folk. But this linguistic sleight of hand doesn’t make it so, needless to say.

Low tolerance for uncertainty, a tendency to catastrophize, and generalized anxiety often result in addictive or obsessive-compulsive

behaviors intended to either suppress the discomfort or ritually fend off "bad things", respectively.

Obsession-compulsion and addiction also involve dissociation either as a cause or as an effect. This is why obsessive-compulsives check time and again whether they had locked the door and why addicts have such patchy memories.

Healthy folks transition through phases in life, evolve, grow and develop in a linear, predictable fashion. Not so the Borderline: she cycles between beliefs, behavioral norms, preferences, priorities, and fervent wishes. There is no stable or foreseeable core. This is known as "identity disturbance".

So, the Borderline's sudden adherence to prudery and domesticity is a self-deluding sham, a fantasy, an experiment: she is likely to revert to an earlier, promiscuous, unboundaried, decompensated, and dysregulated form and recurrently pendulate between several mutually exclusive self-states.

Habitual cheaters are masters of evasion and obfuscation. Two of their favorite self-justifying refrains:

1. "The relationship had been already dead when I cheated".

Relationships can be either on or off, nothing else. As long as a dyad is on, it is very much alive. Behaving as if the relationship were off when it is actually on is deception and betrayal at their ugliest and most extreme. Doing it time and again is highly narcissistic and borders on psychopathy.

2. “The relationship was sexless, I wasn’t getting what I needed, so I cheated”.

In the majority of cases, this is a lie: the other partner is attempting to have sex, or the sex is merely unsatisfactory. In many cases, the cheaters are the ones who undermine the sex with passive-aggressive behaviors or by rejecting the partner.

Only in a vanishingly minuscule number of instances, known as “sex aversion”, is sex utterly absent.

Even then, the only right thing to do is to negotiate an open relationship and, failing that, walk away.

Once promiscuous, always promiscuous? Once a cheater, always a cheater? In a relationship with a promiscuous partner, they will always cheat on you? They can’t help it: it’s an addiction to sexual attention? Are all these statements true? Yes, they are, according to all the studies we have.

As the author and therapist Kerry Cohen observes, promiscuity (“loose girl syndrome”) is a lifelong condition which is often associated with mental illness and substance abuse.

But where the literature fails is in making the distinction between formative and situational promiscuity.

Formative promiscuity is the learned use of sexual attention to regulate negative moods and affects. It is a form of self-soothing and an attempt to reassert control over a life perceived as adrift and meaningless. In some respects, it is the same psychodynamic that drives the narcissist's solicitation of narcissistic supply.

Formative promiscuity is a process addiction (to an activity, not to a substance) which starts in early adolescence, persists throughout the lifespan, and characterizes all interactions with potential sex partners, regardless of the promiscuous person’s life circumstances at the moment.

Situational promiscuity is a reaction to trauma, most commonly to rejection, neglect, and abandonment by a loved one. It is limited in time and responsive to overcoming grief and depression.

Situational promiscuity also disappears once the circumstances change - for example when a new love interest emerges.

Patients with Borderline Personality Disorder (BPD) suffer from two core issues:

1. They feel much safer with strangers, even when these new acquaintances are unpleasant, than with their intimate partners, especially when these mates are loving.

Being loved provokes in the Borderline a cascade of negative consequences:

1. Pain aversion: a catastrophized fear of ultimate heartbreak, abandonment, and rejection;

2. Paranoid ideation regarding the manipulative hidden agenda of the loving partner;

3. Avoidant behaviors;

4. Passive-aggression;

5. Fear of engulfment, of being consumed by the mate.

Faced with such stressors, Borderlines often act out violently or recklessly.

Some Borderlines cheat in order to preempt intolerable abandonment and undermine intimacy.

Cheating also upholds their view of themselves as “bad, corrupt, hopeless” or “whore”.

Such misbehavior is often coupled with substance abuse.

External regulation

Introject inconstancy

Borderline Triangulates with Rescuer to Silence Pain, Abandonment Anxiety

Borderline: I will dump you before you dump me. I will cheat on you in your presence or abuse you and this way abandon you before you get the chance to hurt me.

Narcissistic-Borderline Couple

Narcissists love borderlines because they can mortify them, like their mothers did. Borderlines hurt narcissists because they love them.

The narcissist regards the Borderline as an enigma, a challenge, walking on eggshells makes him feel alive (a form of self-harming). Their mutual intermittent reinforcement (approach-avoidance) is play for power and control. Both externally regulate: a sense of self-worth (narcissist) or moods, affects, and emotions (borderline).

The narcissist and his borderline partner swap their projected Shadows, seeking to legitimize them and to experience these forbidden aspects of themselves by merging and fusing with the intimate partner. This dynamic involves porous personal boundaries and the mourning of a bad, dead object (like the "dead mother").

In relationships with borderlines, the narcissist offers unconditional love and parentifies himself: the borderline stands in for his “dead” (dysfunctional) mother and affords him a second chance to fix/heal/rescue/save her and, by extension, himself. In relationships with non-borderlines, narcissist and intimate partners both are good enough maternal figures in a shared fantasy (“fake family”).

Borderline women often end up with narcissistic men. But they feel overpowered and overwhelmed in these relationships as the narcissist leverages his cold empathy to push all their buttons cruelly and repeatedly until they are triggered badly, decompensate, and act out. The Borderline partner often claims that the narcissist “made her misbehave” in dramatic or histrionic ways, drove her crazy, and that his very presence bothered her, that “he was too much and everywhere”.

The narcissist's strong and ubiquitous personality compels the Borderline to test boundaries and to mock or challenge his omniscient bloated self-importance.

The narcissist is perceived by the Borderline as a Father figure, or even, in moments of diffusion and dissociation, as an actual father. The narcissist wants to possess the Borderline, reduce her to a mute witness of his grandeur, and transform her into a mere function or extension. This extended mistreatment provokes in the Borderline (often a secondary psychopath herself) reactance and defiance, a re-enactment of a teenage rebellion.

Joan Lachkar is the pioneering author of the groundbreaking, seminal books The Narcissistic/Borderline Couple, How to Talk to a Narcissist, How to Talk to a Borderline, The V-Spot, The Disappearing Male, New Approaches to Marital Therapy, and Common Complaints in Couple Therapy and How to Talk to an Obsessive-Compulsive (2022).

PD suffer from persecutory delusions, paranoid ideation as an instrument to extricate themselves from engulfment/enmeshment anxiety.

The persecutory dynamic is either autoplastic (I am a bad object abuser) or alloplastic (I am a victim).

When there is a failure of the defense allowing the Borderline to convert an idealized object to a persecutory object, she can't regard herself as a victim, but only as bad object, an abuser. This ego dystony leads to decompensation and acting out.

Borderline legitimizes forbidden, repressed introjects, resonates with pathological parts in her intimate partner, becomes a vector of contagion.

Borderline is the mirror image of the narcissist:

She has introject inconstancy, he has object inconstancy.

She considers herself as a bad object externally but not internally, he considers himself a bad object internally but not externally.

The Borderline encourages the narcissist to interact exclusively with his internal objects because she doesn't want him to realize that she is an external, bad object.

She considers herself bad and flawed: "If he gets too close to me, he will abandon me; if he finds out the truth about me, he will run away. Better that he should live in a fantasy".

She incentivizes and reinforces his pathological fantasy defense. Feeds him with drama and conflicts to keep him busy and distracted as he

desperately attempts to realign, reframe, and redefine his internal objects.

Borderline pushes narcissist to become psychotic while narcissist pushes borderline to become a psychopath.

Acting Out and Infidelity

The borderline patient catastrophises and considers every rejection, however minor or justified, as abandonment: she split her partner and escalates her extreme behaviors in a hurtful and dysempathic cascade.

When someone with a Borderline Personality Disorder (BPD) acts out and cheats on her partner (secondary psychopathy self-state), she feels guilty and ashamed in the aftermath.

But she also dreads her mate's reaction (separation insecurity). So, to ease her conscience, she voluntarily confesses but she also lies about what had actually happened.

Typically, she minimizes the transgression: "We just danced, or hugged, or kissed, talked, or drank, or had coffee together for old times' sake".

Or she transposes the event to another place or time, usually conflating it with more innocuous but similar occurrences.

She feels justified to lie because she casts it in terms of self-defense against abusive reactions to her misconduct (interpersonal hypersensitivity).

Gradually, she starts to believe some of her own prevarications and protests vehemently against any attempt to refute them.

She feels exonerated and vindicated, empowered, morally upright, and entitled to repeat her misbehavior and to lie about it, cornered as she is in a dead relationship by her abusive and rejecting partner (alloplastic defenses coupled with an external locus of control).

And since Borderlines read rejection and abandonment into every act of their mate or spouse, recurrent misdeeds and then lying is baked into any relationship with them.

Nothing terrifies the Borderline more than abandonment and rejection, real, anticipated, or imagined.

In the wake of repeated such harrowing experiences, Borderlines react in two ways, often alternating between them:

1. They avoid all contact with potential intimate partners, constrict their lives to work only, and become schizoid; or

2. They sexually self-trash in casual random sex, exclusively with strangers. This way, they never experience heartbreak, they mitigate the pain of having been rejected, restore their wounded grandiosity with their “conquests” (“validation” or “self-esteem”), and self-soothe.

Borderlines self-medicate with anxiolytic predatory men who often victimize and mistreat them egregiously, even in one night stands.

As a defense against the mortification, shame, and guilt involved in acting out and in being maltreated contemptuously, Borderlines immediately impose a romantic or defiant fantasy on the stranger they are with and the unfolding unsavory proceedings.

Borderlines react with derision and hostility to any attempt to undo the fantasy. They cast well-meaning and caring therapists, friends, intimate partners and family members as persecutory objects, almost enemies.

Unfortunately, Borderlines tend to pick narcissists as mates. Narcissists dread true intimacy and regard it as a threat, a permanent challenge to their grandiosity. Borderlines equally undermine intimacy for fear of being engulfed or enmeshed.

The two parties abuse each other as they attempt to cause their partners to decompensate and act out (misbehave), affording them an excuse to

break up. This process of restoring one's comfort zone by modifying the partner's behaviors is known as projective identification.

Relationships Management

DBT, mindfulness effective

Abandonment anxiety → preemption

Rituals and procedures of presence, permanence, stability, and predictability

Object inconstancy → identity disturbance (emptiness)

Mementos

Programmed reminders

Mantras

Decompensation

Techniques to tackle anxiety and panic (breathing, journaling and reading aloud)

Acting Out (Self states, secondary psychopathy): impulsivity and recklessness

Decatastrophizing

Mirroring

Techniques for impulse control (redirection, motivation, reframing)

Emotional dysregulation

Verbalizing

Labeling

Externalizing

Chair work (emotions in chair)/dialog

CBT negative thoughts

Anger management techniques

Cognitive restructuring

Communication protocols

Humor

Mood lability

Physical activity

Sleep schedule

Routines

Stress management techniques

Outsourcing of ego functions

Regain locus of control

Develop and reward autoplastic defenses

Idealization-devaluation

Restore reality testing

Maintain the entire picture (integrate splitting)

Self-mutilation, suicidality

Sexual self-trashing, substance abuse, and reckless behaviors as self-harm

Prevention first involves being able to recognize the warning signs of suicide, which can include:

- Extreme mood swings
- Feelings of hopelessness
- Giving away possessions
- Losing interest in activities
- Talking about death or suicide
- Saying goodbye to family and friends
- Saying that they are a burden
- Withdrawing from friends and family

Do not judge, dismiss, or discount feelings

Listen

Encourage verbalizing

sublimate aggression

Dissociation

Journaling

Mementos

video recordings

programmed reminders

Transient paranoid ideation (persecutory object)

Reality testing: journaling, counter-paranoia (questioning/doubting)

Secret code or exit strategy (suspend/freeze)

Separating-individuating from a Borderline Partner

The borderline's partner develops a benign introject of her (or him) in order to avoid the more difficult aspects of the relationship.

Mirror image of separating-individuating from the narcissist in the wake of narcissistic abuse

Engulfment anxiety and dependency cause the borderline to cast you as an abuser

Admit your contributions as an intimate partner (mate selection, for example, or savior-rescuer complex)

I am not an abuser: your authentic voice, get rid of guilt and shame

Borderlines parentify: Get rid of the maternal function in the shared fantasy

Hand over ownership, regulation

Separation: silence your voice in her mind, enhance your authentic voice

What about individuation?

Once your voice is silenced, both external regulator (“abuser”) and savior, mother and child are gone.

Authentic voice is disembodied.

Embodying.

Individuation requires mind-body work: owning your voice also by connecting it to your body.

Reconstituting three lost functions: self-mothering (self-love), self-saving (agency), choosing and affirming life (negating depression, anxiety, catastrophizing, and ANTS)

Treatment Modalities:
Overview of Psychotherapies

Most patients diagnosed with BPD lose the diagnosis spontaneously or with the help of DBT, but retain the dysfunctional behaviors associated with it.

LITERATURE

Robert S Biskin. The Lifetime Course of Borderline Personality Disorder. Canadian Journal of Psychiatry. 2015 Jul; 60(7): 303–308.

Zanarini MC, Frankenburg FR, Hennen J, et al. The McLean Study of Adult Development (MSAD): overview and implications of the first six years of prospective follow-up. Journal of Personality Disorders. 2005;19(5):505–523.

Skodol AE, Gunderson JG, Shea MT, et al. The Collaborative Longitudinal Personality Disorders Study (CLPS): overview and implications. Journal of Personality Disorders. 2005;19(5):487–504.

Gunderson JG, Stout RL, McGlashan TH, et al. Ten-year course of borderline personality disorder: psychopathology and function from the Collaborative Longitudinal Personality Disorders study. Archives of General Psychiatry. 2011;68(8):827–837.

Paris J, Zweig-Frank H. A 27-year follow-up of patients with borderline personality disorder. Comparative Psychiatry. 2001;42(6):482–487.

Zanarini MC, Frankenburg FR, Reich DB, et al. The subsyndromal phenomenology of borderline personality disorder: a 10-year follow-up study. American Journal of Psychiatry. 2007;164(6):929–935.

Hopwood CJ, Morey LC, Donnellan MB, et al. Ten-year rank-order stability of personality traits and disorders in a clinical sample. Journal of Personality. 2013;81(3):335–344.

Behavior Therapy

Replaces problem behaviors with constructive ones via conditioning and reinforcement

Cognitive Therapy

Changes negative automatic thoughts and schemas that lead to attributional and other biases as well as errors in order to alter problematic behaviors and dysfunctional feelings and behaviors.

CBT

Third wave of behavior therapy:

Primacy of therapeutic relationship, learning principles, analyze triggers and environmental cues, explore schemas and emotions, utilize modelling, homework, and imagery.

Dialectical Behavior Therapy (DBT)

Developed by Linehan in 1993 to treat BPD, but used with other personality disorders and disorders of mood, anxiety, eating, and substance abuse. It is deployed mainly with female patients in inpatient or residential settings.

Emphasizes emotional and affect regulation rather than cognitions.

Concerned with how were schemas formed via dialectic conflicts: seeks to connect affect and need to cognitive inference processes and belief systems so as to be reinterpreted with greater self-awareness

Identifies fixation or perseveration causes by early developmental deprivation and protective attentional constriction

Examines effects of negative reinforcement through emotional avoidance or inadequate coping skills rewarded through the partial reinforcement effect

Involves individual therapy, group skills training, phone contact, and therapist consultation. Focuses on using validation and problem solving to counter severe behavioral dyscontrol, issues of quiet desperation, problems of living, and reducing incompleteness.

Cognitive Behavior Analysis System of Psychotherapy (CBASP)

Developed by McCullough and adapted by Sperry. Not used with BPD.

Clients learn to analyze life situations and manage daily stressors. They evaluate which thoughts and behaviors prevent desired outcomes.

Elicitation and remediation: questions about the situation, the client's role and functioning in it, and the desired outcome lead to a revision of counterproductive behaviors and cognitions.

Replaces emotional reasoning with consequential one.

Mindfulness-based Cognitive Therapy (MBCT)

Developed by Teasdale.

Fosters aware focus on thoughts, feelings, and experiences in the present with an attitude of acceptance and without analysis or judgment.

Pattern-focused Psychotherapy

Developed by Sperry

Pattern: predictable, consistent, self-perpetuating style of thinking, feeling, acting, coping, and self-defense. Can be adaptive (competent) or maladaptive (inflexible, ineffective, inappropriate, cause symptoms, impair functioning and satisfaction).

Therapy consists of replacing hurtful maladaptive patterns (situational interpretations and behaviors) with helpful adaptive ones.

Schema Therapy

Developed by Young

Changes maladaptive schemas: 18 enduring and self-defeating ways of regarding oneself and others, arranged in 5 domains. Schemas are perpetuated through coping styles: schema maintenance, avoidance, and compensation.

Schemas can be reconstructed, modified, interpreted, or camouflaged.

Transference-focused Psychotherapy

Developed by Kernberg

Infants form internal representations of self-others (objects) connected via affect. A personality disorder occurs when positive and negative representations fail to integrate later in life. Such splitting affects all relationships, including the therapeutic one.

Transference to the therapist exposes the faulty relationship template and allows for its empathic correction. Identity integration is accomplished as the patient experiences negative emotions in a safe environment.

Mentalization-based Treatment (MBT)

Developed by Bateman and Fonagy.

Experience secure attachment and enhancing impulse control by empathically and insightfully reflecting on and correctly labelling one's state of mind, especially one's powerful emotions, and cognitive errors. This leads to improves relational skills.

Developmental Therapy

Developed mainly by Blocher, Citright, and Sperry

Regards problems in personal growth and needs satisfaction on a dimensional continuum from disordered to adequate to optimal.

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