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Characterological Suicidality in Comorbidity With Bipolar Spectrum Pathology: Its Psycho-Structural Diagnostic Evaluation and Therapeutic Approach

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Abstract

The contemporary incorporation of the alternative model of the DSM-5-Section III (2013), a hybrid system that combines categorical and dimensional considerations for the evaluation of personality disorders, in terms of levels of self and interpersonal functioning; as well as the current proposal of the ICD-11 (2018), which also integrates dimensional aspects; have allowed the alignment of conventional psychiatric nosology, with psychodynamic theoretical-clinical frameworks, which have long used the same dimensions in the diagnostic assessment and empirical research of personality disorders. In this regard, the contemporary systematized operationalization of Transference-Focused Psycho-therapy–Extended (TFP-E), as a supraordinating and transdiagnostic theoretical-clinical framework allows, not only its correlation closely aligned with DSM-5 and the ICD-11; but also provides a conceptual bridge between neurobiologically mediated dimensions of personality, on the one hand, and the psychostructural organization of personality, on the other. In this work, TFP-E is applied to the methodology of Kernberg´s "Structural Interview"; as well as to illustrate its use in a clinical vignette. Subsequently the differential diagnosis between characterological suicidality and depressive and bipolar spectrum suicidality is explored; and finally, treatment considerations, as well as frequent errors and inaccuracies in this difficult task are underscored.

Keywords: Characterological suicidality; specific psychotherapies; non-specific psychotherapies; hybrid models; categorical and dimensional diagnosis.

Introduction: Categorical, Dimensional, and Hybrid Models

An old clinical apothegm states that a well-founded diagnostic conceptualization is the first step towards an effective or remedial treatment (Kernberg, & Yeomans, 2013; Garza Guerrero, 1989, 2017, 2022 a, b). However, a diverse concatenation of impediments continues to obstruct the comprehensive diagnostic assessment of severe personality disorders (SPD) or borderline personality organization (BPO), beyond phenomenological considerations. Some of these obstacles derive merely from circumstantial pressures such as time constraints, the urgency of deciding on a possible hospitalization, or the need to refer to an auxiliary containment program. Others, ironically, come from the defensive need to collude with patients and relatives in an only descriptive and symptomatic diagnostic conception, and the oversimplified expectation that some contemporary drug, or some psychotherapeutic modality, brief and non-specific, will resolve what otherwise corresponds to very complex mental situations (Garza-Guerrero, 2022a; Ghaemi, 2022).

In the case of the clinical examination of characterological suicidality in SPD, in the context of comorbidity with bipolar spectrum pathology (BSP), the clinical challenge is even greater. Many of the errors in relation to over-or-under-diagnosing borderline personality disorder (BPD) and BSP could be considerably reduced if the functioning of the self (i.e., identity) and the quality of interpersonal relationships were considered over time; as well as the level of self and interpersonal functioning (LSIF) (Kernberg &Yeomans, 2013; Caligor , Kernberg, Clarkin, Yeomans, 2018).

The comorbidity of SPD with affective disorders is 50% to 58% (Patel, Manikkara, Chopra, 2019). And suicidal thoughts and suicidal gestures are almost universal in borderline personality disorder (BPD). The literature on suicidality in general is very abundant in terms of demographic variables and descriptive constructs, however, underlying motivations of the behavior are usually not defined, nor is the LSIF specified. Consequently, in most studies and programs for suicide prevention, the subgroup of people with characterological suicidality (CS) is

not mentioned or delimited, who would obviously require a different management and containment approach (Yeomans Clarkin, Kernberg, 2015; Garza-Guerrero, 2022 a, b, 2023)

Contrary to solely categorical and descriptive diagnoses, most contemporary methodologies for the comprehensive diagnosis of personality disorders (PD) explore and articulate three areas of information (OPD, 2007; PDM, 2006; Garza Guerrero, 2017; Caligor Kernberg, Clarkin, Yeomans, 2018): a) The perception of subjective experience (i.e., symptoms such as anxiety or depression); b) observable or inferable behaviors (e.g., quality of personal investment in intimate life, sexuality, and education or work); and, c) the psychological structure and mediating processes of self and interpersonal functioning (e.g., identity, quality of object relations, defenses, control of aggression, moral integrity, and reality contact). The psychological structure of the personality and its corresponding organization at a certain level, along a spectrum from normality to frank psychopathology, consolidates and provides continuity and stability to a person's mental functioning (Kernberg, 2023). However, considering the challenge of integrating the complexity and centrality of these three dimensions — subjective experience, observable or inferable behaviors, and mediating mental processes and functions, as well as their level of characterological organization—it is not surprising that most of the errors and misguided actions in the diagnosis of SPDs are directly or indirectly related to this difficult task (Caligor, Levy, Yeomans, 2015; Caligor, Stern, 2020; Clarkin, Caligor, Sowislo 2020; Garza-Guerrero, 2022 a, b).

The diagnosis of the underlying psychostructural substrate responsible for personality functioning is of fundamental importance, because it determines the way in which patients integrate and organize their subjective and behavioral experience. Regardless of the characteristics of symptomatic constellations (e.g., anxiety, depression, addictions); or the different areas of their identity and interpersonal functioning involved (e.g., identity, sexuality, aggression control); its clinical manifestations vary along the different levels of personality organization (i.e., mild, moderate, severe); as well as the focus, process, and results of the treatment (Garza-Guerrero, 2017, 2022 a, b; Caligor, Kernberg, Clarkin, Yeomans, 2018). The inquisitive and delicate exploration of peculiarities in the subjective experience of patients, together with the explicitness of their corresponding level of organization of their personality structure; as well as the singularity of their intrapsychic defenses and conflicts, is imperative, because together they co-determinate, not only the protean clinical manifestations of personality disorders, but also the individualized specificity of their different meanings (Caligor, Kernberg, Clarkin, Yeomans, 2018; Caligor & Stern, 2020; Clarkin, Caligor, Sowislo, 2020; Hörz-Sagstetter, Ohse, Kampe, 2021; Garza-Guerrero, 2022 a, b).

The contemporary incorporation of the Alternative Model of the DSM-5-Section III (AMPD) (2013), a hybrid system that combines categorical and dimensional considerations for the evaluation of PD, in terms of levels of self and interpersonal functioning; as well as the current proposal of the ICD-11 (2018), which also integrates dimensional considerations, have allowed the alignment of conventional psychiatric nosology, with psychodynamic theoretical-clinical frameworks, which have long used the same dimensions in the diagnostic assessment and empirical research of SPD treatment (Clarkin, Caligor, Sowislo, 2020; Blüml & Doering, 2021; Bach & Simonsen, 2021). However, considering that the AMPD is a strictly descriptive derivation from Trait Theory, it does not provide a theoretical framework that explains the how and why of certain behaviors, nor how to interrelate categorical and dimensional criteria (Caligor, Kernberg, Clarkin, Yeomans, 2018; Clarkin et al., 2020). Consequently, the AMPD does not provide guidance regarding the specificity of strategies, tactics and techniques for the therapeutic approach to SPD.

In contrast, Kernberg's (2018, 2022) hybrid model, from an Object Relations Theory perspective, proposes a supraordinate theoretical-clinical framework (i.e.,Transference-Focused Psychotherapy-Extended-TFP-E), with the theoretical and clinical principles that guide and orient the evaluation and treatment of personality disorders (PD); as well as the prognostic anticipation of their possible outcomes (Caligor, Kernberg, Clarkin, Yeomans, 2018; Clarkin, Caligor, Sowislo, 2020). In addition, and unlike the AMPD, the TFP-E also provides the principles that guide the exploration of moral functioning and value systems, as well as the control of aggression. Essential dimensions to integrate in the diagnosis and treatment of SPDs; and that in the AMPD they are minimally attended, and only from a non-specific perspective (Caligor, Kernberg, Clarkin, Yeomans, 2018).

Finally, the configuration and systematized operationalization of the TFP-E as a supraordinating and transdiagnostic theoretical-clinical framework, allows not only its correlation closely aligned with the DSM-5 and the ICD-11 (Horz-Sagstetter, Ohse, Kampe, 2021; Kraus, Dammann, Rudaz, 2020); it has also provided a conceptual bridge between neurobiologically mediated dimensions of personality, on the one hand, and the psychostructural organization of personality, on the other (Lenzenweger, McClough, Clarkin, Kernberg 2012; Caligor, Kernberg, Clarkin, Yeomans, 2018; Garza-Guerrero, 2022 a, b).

In what follows, a brief introduction to the basic aspects of the methodology of the psychostructural diagnostic assessment by Kernberg, for TFP (Caligor, Kernberg, Clarkin, Yeomans, 2018); it will be followed by the presentation of a clinical vignette, which illustrates the difficulties and vicissitudes in the exploration of characterological suicidality (CS), in the context of its comorbidity with bipolarity. By CS I will refer to: a) a repetitive pattern of threats and/or suicidal gestures, in the service of the omnipotent control of others; and that occur when the patient is in volitional control of his life and circumstances; b) which allows for coldly calculated planning and execution of the moment, as well as the how, when, where, and to who or whom to affect; c) motivated by the ego-syntonic expression of sadism, reflected in fantasies of blaming (and even inculpate),

torturing, punishing, or hurting, those people of whom they feel victimized because they have not understood them, or whom in some way failed them; finally, d) the consubstantial contradiction of all SC: even when the suicidal behavior would actualize the desire to detach or distance oneself from others; ironically, their behavior also reveals the underlying desire for others to preserve the mental representation of themselves, recriminating towards them, forever (Garza-Guerrero, 2023). Considerations on the differential diagnosis of C.S. and depressive and bipolar spectrum suicidality (BSS); as well as the pointing out of frequent errors and some treatment and prognostic considerations, conclude this work.

Psycho-Structural Diagnostic Evaluation in SPD

Kernberg's structural interview (SI) Kernberg (1984); Caligor, Kernbreg, Clarkin, Yeomans (2018); Kernberg (2023), shares some aspects of the conventional psychiatric interview, and the classic psychoanalytic interview. But unlike the psychiatric interview, it is not limited to the descriptive anamnesis of symptoms, rather extends the clinical exploration of them, to the subjective experience of the patients, in the context of their self and interpersonal functioning, including their relationship with the clinician who currently interviews them, here and now; and in dimensions that define the quality of life of the person and consequently co-determinate their sense of direction. Also, in contrast to the traditional psychoanalytic interview, SI is not oriented towards the understanding of the past, in search of a comprehensive formulation of the present. On the contrary, *the SI*, maintains its focus on the mental structure that mediates the continuous and stable configuration of mental functions and their corresponding processes, which organize the subjective experience and behaviors of a patient, at the current moment of the interview (Yeomans, Clarkin, Kernberg, 2015; Hörz-Sagstetter, Caligor, Preti, 2017).

The most significant vital aspects about a person's past, of relevance for the purposes of a clinical evaluation, is what is manifested and revealed in their interactions with others in the present, and especially with those who evaluate them now (Garza-Guerrero, 2017, 2022a, b, 2023). This is particularly true in the context of SPD, who by the nature of their primitive and pre-repressive defenses, distort the evocation of their past, hence the disconcertingly changing nature of their narratives. The lower the level of personality organization, the greater the gap between present and past. On the contrary, the higher the level of personality organization, the greater the continuity and closeness between present and past (Garza-Guerrero, 2017; Kernberg, 2018, 2023).

SI does not replace the classical mental examination (CME), it only extends and complements it, by virtue of integrating the self and interpersonal functioning, in dimensions of crucial relevance for character psychopathology such as intimate life and sexuality, education and work, as well as creative and recreational aspects (Kernberg, 2023; Garza-Guerrero, 2022 a, b, 2023). In addition, and unlike pre-structured interviews, algorithms and "branching decisions", depending on the preliminary nature of cardinal symptoms and observable behaviors, SI allows the selective application of CME to clinical manifestations that might require immediate exploration (e.g., psychotic decompensations, or organic disorders, with alterations in intelligence, memory, or sensorium). If this is not the case, SI moves directly to the exploration of self and interpersonal functioning (Kernberg, 1984; Yeomans, Clarkin, Kernberg, 2015; Hersh, Caligor, Yeomans, 2016).

Initially, while performing on SI the clinician might imagine himself, as in the center of a circle, on the periphery of which major cardinal symptoms of different nature (e.g., disorientation and confusion; hallucinations or delusional behavior, diffuse identity, memory or sensorium alterations) are situated; and at whose systematized review, the clinician could return to re-explore, as many times as necessary (Kernberg, 1984; Caligor, Kernberg, Clarkin, Yeomans, 2018). SI does not specifically impose what, or how to ask or explore, but rather provides the principles that guide the clinician's communication to the areas to be explored, but from their own idiosyncrasy, temperament and personal style.

SI Comprises Three Parts

1. The first of them introduces the patient to inquisitive questions such as: What led him to seek professional help? What is the nature of his difficulties or problems? How does he understand or explain them?, What expectations does he have from this first interview?

In addition to the search for information, these initial questions have three fundamental purposes:

- The simultaneous exposure of them allows to observe *the integrity of high cognitive functions* such as comprehension, retention and memory; as well as the degree of distractibility due to anxiogenic or depressive components.
- The exploratory nature of these also arouses a certain level of tension, which evokes the *defensive activity* typical of the corresponding level of personality organization (LPO). For example, patients with a high level of personality take responsibility for what they themselves could have contributed to their problems. On the contrary, patients with SPD, with a low level of personality organization (LLPO), could behave defensively as externalizers who blame, and inculpate, their entire environment, for all kinds of past and present calamities in their lives.
- Finally, the proactive quality of these questions incites a *psychoeducational function*, which invites the patient to be a co-participative agent in the exploration of difficulties and the reflective search for solutions; in contrast to the passivity of considering that an evaluation and treatment would be just something, that someone does for them, and for them (Yeomans, Clarkin, Kernberg, 2015; Garza-Guerrero, 2017, 2022 a, b, 2023; Caligor, Kernberg, Clarkin, Yeomans, 2018).

During the preliminary phase, and by virtue of observing the three channels of communication (verbal content, non-verbal attitudinal aspects, and countertransference -TCC), it is important not only to pay attention to the content of what

is referred to, but also to the peculiarity of inconsistencies and incongruities that could alert to problems and difficulties, which the patient would not have been aware of as objectives of his evaluation; and which could now require gradual ego-distonization.

SI could be implemented in two continuous sessions of 45 minutes, or in three individual sessions of 45 minutes, but scheduled in one to two weeks, to capitalize on the momentum of the process. Towards the end of the first interview, the self-applied instruments for the level of Personality Organization and Functioning (IPO –Inventory of personality organization; FIAD-60 –Self-applied initial filter for levels of personality functioning) are delivered; and the minimum terms and conditions to frame and continue with the evaluation are highlighted (e.g., scheduling sessions, planning a joint session with couples or family members, bringing the answered questionnaires, etc.). It is important to clarify, from the beginning, that by the end of their evaluation, the clinician should be better prepared to share *his diagnostic impression and treatment recommendations*. The high frequency of interruptions in the context of initial work with SPD is well known. A clear explicitness of the framework, purposes and structure of the evaluation itself, not only reduces the early abortion of evaluations, but is also a first step in the direction of providing stability and a sense of direction, to what are often authentic chaotic situations in the lives of patients with SPD (Garza-Guerrero, 2017, 2022 a, b, 2023; Caligor, Kernberg, Clarkin, Yeomans, 2018).

2. During the second part, or intermediate phase, the evaluation is extended to dimensions that allow exploring the global functioning of the person in areas of vital importance such as education, profession or work, intimate life and sexuality; as well as in recreational activities, creative, or altruistic interests. Special attention is given to the quality of their affective and cognitive investments in friendships, courtships or relationships; as well as to their degree of reciprocity and mutuality, adherence, commitment and loyalty. In addition, the ability to integrate tenderness and sexual passion in the context of mutually satisfying and stable relationships. Of fundamental relevance in this section is to observe whether the totality of their emotional investments in interpersonal relationships and work activities, in general, are sufficiently functional and valuable to jointly contribute to consolidating an autotelic potential (I will refer to this term in its broader connotations of its Greek roots: as that which gives a sense of foreordination to a person's life), that daily feeds back their sense of direction in their lives. A developed autotelic potential, or in development, not only feeds back into self-esteem and provides inner peace and serenity, but also helps to tolerate the inevitable stumbling blocks that life gives. On the contrary, the absence of a developed autotelic potential, or the absence of life plans and projects towards its eventual consolidation, would indicate areas to begin to render ego-dystonic, and towards their eventual transformation into treatment targets (Garza-Guerrero, 2022 a, b, 2023; Kernberg, 2023).
3. During the termination phase, aspects of the past that could have some relevance for the understanding of the present are selectively explored; as well as for the planning of a treatment strategy, and a prognostic anticipation. For patients at the high level of personality organization (HLPO), the exploration of the past could be more elaborate, given the greater proximity of their narratives in the present to the reality of their past. In patients with a low level of personality organization (LLPO), on the other hand, any exploration of their past has to be filtered with great reservation, given their distorting proclivity for the capricious oscillation between retrospective idealizations of people in their past, or the generalized devaluation of them.

Towards the end of the SI, it should be asked if the patient may provide any critical observations about the totality of his experience and his interaction with the clinician through the evaluation. He should also be invited to elaborate and explore areas that neither the clinician nor the self-applied questionnaires may have considered. The closure of the SI must culminate with the evaluation of the degree of understanding and assimilation that the patient may have achieved of his or her problems, as a result of having co-participated in the process of his or her diagnostic evaluation. The validation, correction, or expansion of his own synthesis should in turn prepare him for an adequate psychoeducational return of the diagnostic impressions (i.e., both categorical and dimensional); as well as treatment options and prognostic perspectives, and in terms that the patient, partners and family members can fully understand. The judicious and selective use of the statements of the self-applied clinimetric instruments of (e.g., IPO, FIAD-60), which the patient answered, could contribute, not only to explain different dimensions of their personality functioning and diagnosis, but also to add veracity and conviction, since they were answers that he himself selected and pondered, and that describe how the patient sees himself.

Finally, SI must aspire to provoke a reviewing shake-up of the patient's existential status quo. An SI should lead to the development of a reflective pause that allows the systematized exploration of the patient's current situation and life circumstances, towards an integral mutative reorganization that potentially increases their possibilities of cultivating, or developing, their true autotelic potential (Garza-Guerrero, 2022b).

Theoretical-Clinical Articulation in A Vignette*

Phase 1

case ilustration is composite and its has been disguised to protect patient confidentiality.

Having arrived late, to her first appointment, and blaming traffic issues and the "imbecility" of people to drive, 10` thereafter Mrs. IZ was already vehemently immersed in a dispute with me because she did not understand the reason for my refusal to prescribe a prescription for an antidepressant, without having evaluated her first, just as she was about to leave on a trip the following week.

Her anger grew, when she thought that I was questioning the basis of her previous diagnosis, by proposing an evaluation of two to three more sessions. Rising from her chair, she exclaims contemptuously that she was going to think about it, and thunderously closes the door as she leaves. However, at the front desk she tells my assistant that her husband will call her to make an appointment within 12 to 15 days, when she returns from her trip. She gets more annoyed when the assistant kindly asks her to please schedule and confirm the appointment herself. When irritated she asks why, she is patiently explained that in our experience, nine out of ten adult patients, for whom someone else schedules an appointment, do not come to it. Mrs. Z leaves grumbling and angry, however she returns 10 minutes later, to personally schedule an appointment after her trip.

A clinical summary of a recent hospitalization abroad, previously submitted, described Mrs. IZ as a 42-year-old female patient with a history of multiple diagnoses (i.e., panic attacks, persistent generalized anxiety disorder, major depressive disorder, dysthymia, attention deficit disorder, post-traumatic stress syndrome; "complex trauma" and "bipolar-II, subsyndromatic", in his youth); intermittently treated as primary diagnoses, unique or in comorbidity with others, by seven psychiatrists and three psychologists (with a diverse pharmacology: antidepressants, anxiolytics, antipsychotics, and emotional stabilizers; as well as with different non-specific psychotherapies, such as CBT, DBT, STEPPS; a psychodynamic psychotherapy, and another based on mentalization techniques, in addition to a supposed "psychoanalysis").

It is interesting to note that three of the professionals who had treated her in her past had thought about the possibility of a borderline personality disorder BPD, but had not shared it with her, her partner, or family members. One of them, which also diagnosed a situation of "complex trauma" (only, based on the patient's early exposure to a "dysfunctional family" and alleged "unconsented touchings"); recommended an "escalation" approach (i.e., first treating her "traumas" with CBT, DBT, or Eye Movement Desensitization and Reprocessing-EMDR); and then address "alterations of her personality", arguing a low level of reflective functioning and concrete thinking. In addition, he warned not to mention to Mrs. IZ her diagnosis of BPD, to avoid the negative impact of "stigmatization".

Mrs. IZ arrived to her session after her trip, on time. Nevertheless, as in her 1st session, she was unable to adhere to the three conventional questions of the beginning of SI (i.e., nature of the problems, her understanding and expectations). Her communication changed unexpectedly from one topic to another; as well as from a specific context and time, to others of a disconnected content. The most closely coherent in her discourse was in relation to the description evidently learned in her past of "depressive" symptoms: loss of enthusiasm, fatigue, discouragement, insomnia, hopelessness and frustration. However, when asked if she could elaborate more on feeling hopeless and frustrated as to what, or in relation to whom and with what kind of expectations towards them, accusations and recriminations towards others quickly surfaced, with a tinge of hatred and anger, rather genuine manifestations of sadness or depressive feelings.

Also of interest to mention in this preliminary phase of SI, is that woven into the chaos and confusion of her profuse expressibility, and from the perspective of TCC, a relational dyadic aspect, began to glimpse; characterized by a representation of herself, as victim (i.e., weak, impotent, pusillanimous); and a representation of others as, potential persecutors (i.e., ruthless and omnipotent). But also with an ostensible propensity to role reversals, as had been observed in the initial meeting, in which aggressively arrogant and petulant (she then, in the role of persecutor), had related herself towards me and my assistant (i.e., we, in turn, at that time, as victims of her scornfulness and contempt).

Most likely, this same relational dyad defended and protected her from another opposing dyad, characterized by a representation of herself as tenderly cared for and protected, by a representation of others as compassionate and sensitive providers. It is possible that this relational longing was what continued to drive her to repeatedly seek other treatment opportunities. However, the anguishing anticipation of trusting someone, and believing in something that perhaps could never happen, led her to defensively reposition herself in the role of a potential victim of insensitive and indifferent oppressors.

Phase 2

During this phase, the focus of exploration shifted to her interpersonal functioning in general, in dimensions such as: family, couples, work, and friendships. A pattern of "stability in its instability", infiltrated with overt aggresivity, characterized all of them. It is relevant to point out in this context, a noticeable trajectory of self-lacerations and characterological suicidality (CS), as a "modus vivendi", since her youth; motivated by the need to force, torture, punish, or take revenge on someone, in any interpersonal context and circumstances that things did not move in the direction she desired. Apparently, always in situations in which she was in adequate volitional control of her life and her circumstances. Moreover, she had never acted a suicidal gesture that really put her physical or mental integrity at risk. Her CS pattern, however, seemed to have always served as a sadistic instrument of omnipotent control over others; and in addition, it had been a frequent instigator of unnecessary hospitalizations. The enormous disruptive power of her CS pattern, unfortunately, had only increased its secondary gain over the years, self-perpetuating a vicious circle of pathological interactions with her entire surroundings, very detrimental and destructive (Garza-Guerrero, 2019, 2022 a, b, 2023).

Phase 3

Ambivalent reminiscences of her past, reverberated in Mrs. IZ's narrative of the "dysfunctional family" of her youth. An "emotional" father and a good provider, but infuriatingly "seductive": "you had to lick his balls to get what you wanted from him". His mother, with an alcoholism problem, and a

series of intermittent separations, always under the threat of a divorce that never took place. With no children in her first marriage, nor in her current one, IZ described her current marital situation as "happily vegetating" and "tolerating each other."

As for categorical diagnoses, IZ did not meet clinical criteria that would substantiate any particular psychiatric disorder. Her depressive and anxiogenic dysphoric manifestations, as well as her irritability and frustration, corresponded to affective and cognitive dysregulation, clearly linked to very conflictive pathological interactions. On the other hand, the evaluation of the two self-applied clinimetric instruments for the level of personality organization and functioning (IPO, FIAD-60), showed a frank borderline personality organization. Both results, in turn, were very consistent with the Level of Personality Functioning Scale (LFPS), of the DSM-5-Section III-AMA (2013), which as well revealed a level three, corresponding to a severe personality dysfunction, with predominant manifestations in the facets of emotional lability (in the negative affectivity domain); impulsivity (in the disinhibition domain); and hostility (in the antagonism domain).

A sensitive and diligent psychoeducational explanation of diagnostic impressions to IZ and her husband was carried out at the end of her SI, in terms that both could understand; in addition to the proposal for two modalities of therapeutic intervention: one pharmacological, and the other psychotherapeutic. As for the first, it was clarified that an antidepressant was prescribed, not because it was thought that she suffered from Major Depressive Disorder. It was solely recommended as an adjuvant, to try to reduce her impulsivity and affect-cognitive dysregulation; and only for a limited time of six to twelve months. Regarding the second recommendation, the general guidelines of a TFP of two sessions per week, for a minimum of 1 1/2 to 2 1/2 years, were clarified; and as well as the framing, terms and conditions applicable to patients who have never worked regularly, and with the complications inherent to CS and multiple hospitalizations.

IZ's immediate reaction was one of bewilderment, but not disbelief, because in her words, she had "sailed" all the last 25 years under the banner of a "chronic depressive disorder refractory to treatment"..."And no one had ever told me, that I could work." However, now she was beginning to understand, why she had never improved or changed. The biggest stumbling block, however, and as expected, was with the impediments to accepting the expectations of the proposed new framework:

1. given that her CS was a disorder that occurred in a clinical context of volitional control of her life and her circumstances (i.e., she decides to do it, or not to do it, when and where); she alone was responsible for preserving her physical and mental integrity, and it was up to her too, to seek help from a hospital, if she felt out of control. And those who would evaluate her there, and at that time, would be responsible for deciding on a possible hospitalization, if necessary, as well as its subsequent management;
2. and given her complacency and passivity, in accepting a lifestyle that was absolutely dependent on others and inactive, she was also warned that she had three months to study, work or join a volunteer program (at least initially).

A well-known experience is that the two most serious threats to the secondary gain in SPD are:

1. Limitations to the sadistic control of others, with the menaces derived from CS
2. The rejection of their chronic parasitism and of being considered as chronically unable to produce, generate, create or work in something. Inactivity consolidates their personality disorder. On the contrary, any step towards a more active lifestyle is part of every genuinely therapeutic process (Yeomans, Clarkin, Kernberg, 2015).

Initially, IZ, argued impetuously that if she could meet those two expectations, she would have had no need to seek help. In addition, she vehemently added, "if you are already threatening me, that if I don't work or study, in three months you will fire me," I wonder "if it is really worth starting." It was made clear to her that if that did happen, she would be the one who would be firing me as her psychotherapist. Her refusal to meet the two expectations would leave no other reading than the message that she was not interested in our treatment recommendations. More thoughtful and reflective, Mrs. IZ ended up considering that if nothing in the past had worked, perhaps it would be worth trying something different. She concluded by expressing that now she comprehended, something that at the introduction to her evaluation, she had not understood: "an evaluation, and an attempt at this type of treatment... it is not something that someone does, for us, and for us,... it's something you have to do with someone else."

Frequent Errors and Inaccuracies in the Diagnostic and Therapeutic Approach to *SPD*

Mrs. IZ's medical history, the information sent, and two calls to professionals who had treated her in her past, revealed multiple universal mistakes in the diagnosis and treatment of patients with SPD. Among others, the consequences of merely phenomenological or symptomatic evaluations, which culminate in categorical diagnoses, but without exploring or specifying the altered and mediating psycho-structural dimensions of personality functioning, nor their corresponding level of organization

Approaches like this, over time, only extend a trajectory of multiple diagnoses treated with non-specific and only symptomatic medications, refractory to treatment (Ghaemi, 2022); as well as to a disabling passivity and chronic parasitism. It should be noted that in many of these patients, the clinicians responsible for their treatment had been alerted to the presence of a SPD, but had not shared it with patients or relatives. Consequently, they had not communicated to them the implications of a negative prognosis, that the presence of a SPD entails for any psychiatric disorder, either due to ignorance, or due to an unfounded fear of a potential "stigmatization". On the contrary, it is evident and incontrovertible now/days, that

sharing a comprehensive diagnostic reconceptualization (i.e., categorical and dimensional), in psychoeducational terms that patients and relatives can understand, is a precondition to be able to take off with any all-encompassing treatment strategy for SPDs (LeQuesne & Hersh, 2004; Garza-Guerrero, 2017, 2022 a, b, 2023; Caligor, Kernberg, Clarkin, Yeomans, 2018; Kernberg, 2023).

Another frequent mistake is not requesting the patient's authorization to communicate with clinicians who have previously treated them. Patients tend to repeat adverse experiences and vicissitudes from their past, even when they currently claim that something like this would not occur in a new treatment effort (Yeomans, Clarkin, Kernberg, 2015; Garza-Guerrero, 2017, 2022 a, b). Similarly, it is imperative to integrate family members or couples into the evaluation process, for at least one joint session, during or towards the end, especially if the patient depends on them to pay for their treatment. These joint sessions are not only bidirectionally informative, but also serve to proactively anticipate the possible management of crises that could threaten the course and objectives of treatment; as well as for the clarification of pathological collusions and distortions that could interfere with the proposed treatment plan (Caligor, Kernberg, Clarkin, Yeomans, 2018).

Many patients with SPD demand to begin treatment "right away," without any consideration of diagnosis, or the terms, conditions, and mutual co-responsibilities of their future working relationship. Patients with SPD suffer from multiple psychostructural alterations that predispose them to chaotic behaviors and crises. Hence, a clear explanation of the structure and duration, as well as the limits and conditions of the evaluation process itself, is indispensable. This is even more essential in complex mental situations complicated by a long history of *characterological suicidality* (CS). The forced acceptance of the initiation of treatment in this type of situations with CS, without a systematized diagnostic evaluation, or an explicitly delineated and co-participatively conceived plan; as well as without a clear idea as to what can and cannot be expected; nor the demarcation of the degree of shared co-responsibilities, is an invitation to navigate towards the "perfect storm" (Yeomans, Clarkin, Kernberg, 2015; Garza-Guerrero, 2019, 2022 a, b, 2023).

One of the many diagnoses attributed to Mrs. IZ in her past had been that of "complex trauma", loosely associated with her growing up in a "dysfunctional family" and with somewhat hazy memories of having been exposed on two occasions to "unconsented touchings" by a gardener. The percentage of patients with BPD or with a borderline personality organization (BPO), who report physical or sexual abuse, varies widely from 26% to 71%, However, it is a well-known fact that only 15% to 20% of individuals who suffer some type of abuse or maltreatment, develop some type of psychiatric disorder (Paris, 2008). Traumatic childhood experiences (TCE) are recalled and recreated by patients in treatment situations, through, and from, their current level of personality functioning. The presence in SPD of primitive defenses and serious intrapsychic conflicts severely distorts both, the original perception of TCE and their subsequent reconstructive narratives of them. Unlike people with a high level of personality organization, patients with SPD are more predisposed to re-experience TCE in a polarized or split way; that is, they identify themselves in a dissociated way with both roles: victim and perpetrator (Yeomans, Clarkin, Kernberg, 2015; Garza-Guerrero, 2019, 2022 a, b, 2023).

There is a natural tendency to overly-identify concordantly with the victims of any abuse. The problem with SPD is the risk of failing to explore and integrate their identification with both roles, victim and perpetrator; in a way that ends up over-emphasizing their role as victims, but at the expense of ignoring their potentiality to actualize in the same way, their oppressive aggressiveness towards others, by virtue of reversing their roles, defensively. This mistake only increases and complicates the tendency in SPD to proactively self-perpetuate its role as "victims". It is only with the systematic and integrative elaboration of both roles -victim/oppressor-, that patients come to have a better control of their aggressiveness; which when they act it out in a dissociated and unconscious way, overwhelmingly oversaturates and dysregulates them (Yeomans, Clarkin, Kernberg, 2015; Garza-Guerrero, 2019, 2022 a, b, 2023). For all of the above stated, it is imperative to emphasize that it is a real aberration to recommend that in patients with SPD and "complex trauma", their TCE should be managed first, and only later their personality alterations: they cannot be separated from each other –they are inextricable. Postponing a reintegrative psychotherapeutic work of split off representations of oneself and others, only extends their chronic self-victimization (Yeomans, Clarkin, Kernberg, 2015; Garza-Guerrero, 2022 a, b, 2023).

Another difficult exercise of differential diagnosis in SPD is that between BPO and post-traumatic stress disorder (PTSD). Typical symptoms of PTSD begin within the first six months after a traumatic event; and they could extend up to two to three years after it. Characteristic symptoms of the event, among others, are: insomnia, irritability, hypervigilance, nightmares, anxiogenic evocations of the trauma, and the repetitive intrusion of fragmented memories of the event. The development, however, of more symptoms, many years after the alleged or real, traumatic situation, such as: somatizations, dissociative symptoms, emotional lability, impulsivity, self-destructive behavior, and particularly chronic interpersonal difficulties and manifestations of emotional immaturity (especially in crucial dimensions such as work, education and intimate life), would correspond rather to an overt BPO; which could have derived from genetic or constitutionally given predispositions, in combination with adverse and disaffiliative traumatic vicissitudes, of early development (Kernberg & Yeomans, 2013; Garza-Guerrero, 2022 a, b, 2023).

Chronic exposure to repetitive traumatic experiences is, without a doubt, one of the etiopathogenic variables of BPO, but it must be differentiated from the singularity and

circumscription of a PTSD. In this regard, it should be stressed that only a third of patients with BPD have a history of an extended exposure to CTE; and only 20%, as I mentioned before, of individuals with a history of serious abuse, end up with significant psychopathology in adulthood (Kernberg & Yeomans, 2013). This demarcation is important because they are entities that require different modalities of intervention. PTSD requires a psychotherapeutic approach that facilitates the re-experiencing elaboration of the traumatic incident, in the context of a psychotherapeutic relationship that protects and provides security and containment. When CTE are part of the origin of an BPO, the psychotherapeutic approach has to promote a prolonged period of exploration, towards the gradual integration in the patient, of their double identification as victim and perpetrator, as part of their early developmental vicissitudes (Draijer & Van Zon, 2013; Kernberg & Yeomans, 2013).

Finally, another source of mistakes and inaccuracies comes from not differentiating between characterological suicidality (CS), typical of SPD; depressive suicidality (DS) (i.e., as part of a major depressive disorder - MDD), and bipolar spectrum suicidality (BSS) (i.e., during a depressive, hypomanic or manic episode). Consequently, it is necessary to underline a truism, but often ignored: every patient with a Major Depressive episode, or with an *episodic* variant of the *bipolar spectrum,* also has a *personality or character structure* (i.e., between their disfunctional episodes), mediating the totality of their functioning as a person. And this structure stabilizes its functioning in turn, at some level of personality organization, from a dimensional spectrum that goes from: normal, to levels of high, intermediate, or borderline dysfunction. In addition, the comorbidity between SPD and Bipolar spectrum pathology (BSP) is very high. Although there are enormous variations, from one sample to another, roughly speaking, it could be considered that one in five patients, diagnosed with these entities, share both. About 20% of bipolar II patients, and 10% of bipolar I patients, have comorbidity with borderline personality disorder (Patel, Manikkara, Chopra, 2019).

In consideration of the co-occurrence of CS with SPD, MDD, and BSP, the question is not whether a particular patient with CS is depressive (i.e., currently, or for of his or her clinical history); bipolar (i.e., currently, or for his or her clinical history); or whether he or she has a SPD: It could be each of them. From a *heuristic perspective*, the real question should be whether certain *suicidal behavior*, at a certain time and under defined circumstances, in a patient's life; occurred during an *episode of decompensation of a MDD*, or of the BSP, with loss of volitional control of his life and circumstances; or, if it actually occurred during periods in remission of MDD, or BSP, without loss of volitional control of their life and circumstances. In other words, *CS, DS, and BSS could co-occur in the same patient, at different times and circumstances; but they could not co-exist simultaneously in the same patient* (Garza-Guerrero, 2022 a, b, 2023).

Although the exercise of diagnostic differentiation between CS, DS and BSS is an arduous and difficult task, with the help of couples, and relatives in the present, as well as other colleagues, who could have cared for the same patient in the past, it is entirely possible to distinguish with relative assertiveness, one from the other – below is a list of considerations that could assist in this task (Zimmerman, Martinez, Morgan, 2013):

Characterological Suicidality in SPD	***Depressive and Bipolar Suicidality***
It is not episodic	Course and evolution clearly episodic in nature
"Stable in its disruptive instability," it frequently consolidates into a continuous *modus vivendi*.	Stable, non-disruptive functioning between episodes, unless the level of personality organization is borderline
Notoriously linked specifically to emotionally significant interpersonal contexts.	In general, not linked to, or specifically instigated by, an emotionally significant interpersonal context.
Oscillatingly capricious and volatile	Sustainably present during episodic relapses; and absent during remissions, unless the level of personality organization is borderline.
The external world of patients with CS is perceived as dissociated in "good" or "bad", but their appreciation could be reversed unexpectedly from one moment to the next.	The external world is perceived in a more homogeneous way, during episodes. Between episodes, it varies, according to the level of personality organization during remissions, or the degree of previous neurocognitive impairments.
The environment of families, partners and friends is often divided between those who support and empathize with the patient; and those who disapprove and reject all clearly manipulative behavior.	The environment of interpersonal relationships reacts and remains homogeneously stable during episodes. Between episodes varies according to level of personality organization, or the degree of previous neurocognitive impairments.

Since CS occurs in a context in which the patient preserves volitional control of his life and circumstances; only the patient should be responsible for safeguarding their physical and mental integrity. He decides to do it, or not to do it; how, when, and whom to hurt and affect. For the *same reason, it cannot be prevented or predicted*. This predicament must be made explicit to couples and family members.	During episodic decompensations, the patient may lose volitional control of his life and circumstances. Under these conditions, he is not responsible for preserving his physical and mental integrity. The patient has to be protected and assisted by family members, or staff in the hospital environment. DS and BS are more likely to be predicted and prevented.
During hospitalization, if the volitional nature of CS, and the locus of responsibility in the patient himself are not made explicit to patients, partners, and relatives, the risk of acting it out increases.	During hospitalization, close monitoring of the patient reduces the risk of committing suicide.
It usually does not respond to medications; the response to drugs is ostensibly erratic and capricious. It is difficult to define a clear correlation between its use and a given clinical response.	With the use of drugs, a clear response of symptomatic improvement and containment is observed, with a definite correlation between the use of drugs and the clinical response.
SC is frequently used as a *sadistic instrument of omnipotent control over others*, in the service of forcing others to move in the direction convenient for them.	BS and DS, on the contrary, are usually instigated by sadomasochistic expectations of reparation or of atonement for primitive guilt.
CS does not derive from depressive motivations per se, but from psychodynamics linked to anger, hatred, frustration, envy and revenge. It is often incited by the desire to punish, torture, hurt, or take revenge on others.	The mediating psychodynamics of DS and BS are more related to conflicts, desires, or self-referential interests of self-recrimination, self-flagellation and punishment.

Final Considerations Regarding Pharmacological and Psychotherapeutic Approaches in SPD

Pharmacological approaches

Despite the large investment of the pharmaceutical industry in the research of new products that could correct etiopathogenic substrates that mediate disruptive behaviors in SPD, there is still not a single drug approved by the FDA that meets this expectation (Fibiger, 2012; Ghaemi, 2022). However, the routine use of at least one to three drugs in SPD rises to 85%, despite the absence of evidence to support it, which could further reflect the need for clinicians to respond immediately to very desperate situations. However, the use of drugs as adjuvants should not be underestimated, particularly in the treatment of severe comorbid anxiety or affective disorders (Stoffers-Winterling, Storebø, Lieb, 2020; Stoffers-Winterling, Völlm, Lieb, 2021).

Given the merely symptomatic and adjuvant nature of our current pharmacological resources, its use requires a minimum of precepts that guarantee their judicious use:

- they should not be introduced more than one, at a time, if entirely feasible, in order to observe the correlation between their use and the expected clinical response;
- always making explicit the targets or dimensions to be attended;
- specify the expected time to observe the full benefit sought.
- alert about to the potential for certain types of side effects; and,
- precise the estimated date of its eventual withdrawal, if there is a response that justifies its prolonged ingestion.

Deviations in the adherence to these basic precepts, together with the vulnerability of patients with SPD to affect storms derived from their affective and cognitive dysregulation, incites an increase in the prescription of drugs, frequent changes and polypharmacy; which in the substrate of paranoidizing hypervigilance, fears and cognitive distortion of the side effects of medications, only lead to a worsening of the clinical situation, in general. Unfortunately, when this worsening is confused with "refractoriness", or the lack of response of a certain psychiatric disorder; another increase, or another addition, or one more change, usually leads to a mutually self-perpetuating vicious circle, which in addition to aggravating the symptoms in a circular and iatrogenic way, also entails the possibility of a diverse range of serious complications, such as: polyconsulting, chaotic management situations, generalized disruption of the family environment, unnecessary hospitalizations, over-interventionism of multiple specialist; and consequently, the widespread exploitation of patients, in this deplorable predicament (Hersh, Caligor, Yeomans, 2016; Garza-Guerrero, 2017, 2022 a, b, 2023; Ghaemi, 2022).

Psychotherapeutic Modalities

There are currently seven psychotherapeutic approaches for SPD: Dialectical Behavioral Therapy (DBT); Mentalization–Based treatment (MBT); Transference–Focused Psychotherapy (TFP); Shema Focused Therapy (SFT); Dynamic Deconstructive Psychotherapy (DDP); Systems Training for Emotional Predictability and Problem Solving (STEPPS); and Good Psychiatric Management (GPM). If, compared to the proposal of S.N: Ghaemi (2022), to categorize our drugs in psychiatry as *those that specifically modify or transform the mediating substrates of etiopathogenic factors, and merely symptomatic drugs;* in the same way we were to do the same with our contemporary psychotherapeutic approaches, we could say that there is current evidence to substantiate that

of the seven modalities mentioned above, TFP is the one that comes closest to complying with specificity canons , in terms of its applications in SPD (Kazdin, 2009; Clarkin, Levy, Lenzenweger, 2007; Doering, Hörz, Rentrop 2010; Kraus, Dammann, Rudaz, 2020).

In addition, if we take into account that the exploration and conceptualization of self and interpersonal functioning (i.e., criterion A, to evaluate levels of personality organization in the AMPD, of the DSM-5), must articulate a double plane of organismic consolidation (one of a neurobiological order; and the other of a symbolic and representational nature); we would have to conclude that the intentionality expressed in aspects such as identity, empathy, intimacy, or sense of direction; should be definitively considered as emergent properties, irreducible to any particular neural system (Lenzanweger, Mclough, Clarkin, 2012; Kernberg, 2018, 2022; Garza-Guerrero, 2022 a, b, 2023). TFP as a supraordaining theoretical-clinical framework (which integrates the neurobiological and psychostructurally mediated), and as a transdiagnostics perspective (i.e., it includes both categorical and dimensional diagnoses); it is designed to modify and transform in a specific way, psychostructural alterations (e.g., identity diffusion syndrome, primitive defenses, problems with aggression control and affect-cognitive dysregulation, among others), multifactorial and organismically codetermined, responsible for the protean psychopathology of SPD, as well as for their organization at a low level of personality functioning. (Yeomans, Clarkin, Kernberg, 2015; Caligor, Kernberg, Clarkin, Yeomans, 2018; Kraus, Dammann, Rudaz, 2020; Diamond, Keefe, Hörz-Sagstetter, Fischer-Kern, Doering, & Buchheim, 2023).

In contrast to the other modalities, TFP has been shown to increase too, reflective thinking, which in turn, could contribute to continue moderating and consolidating a sense of direction, even after treatment, and adds quality in patients' lives, in areas as important as work, intimate life, and sexuality (Clarkin Levy, Lenzenweger, 2007; Keefe, Levy, Sowislo, 2023). In addition, in patients with low reflective thinking, and with very concrete modes of communicating, TFP has been shown to have a greater impact than other modalities such as DBT, SFT, DDP, or STEPPS (Draijer & Van Zon, 2013; Keefe & DeRubeis 2021; Keefe Levy, Sowislo, 2023).

In terms of prognosis, in our experience, passivity, inactivity and frank parasitism, as well as morbid overweight, are factors of poor prognosis for all psychotherapeutic modalities currently available for SPD. In the case of TFP, and in relation to inactivity, it is recommended as part of the initial framework, and as a prerequisite for the continuity of treatment, the need to study or work (even if in a volunteering program), within a period of no more than three months (Yeomans, Clarkin, Kernberg, 2015). Similarly, with regard to the presence of morbid overweight, if in six months (that is, having ruled out medical variables, beyond the volitional control of the patients), the patient has not been able to position himself in a plan of good eating and exercise habits, which allow him to lose half a kilo a week, the prognosis is very poor (Garza-Guerrero, 2017, 2022 a, b, 2023).

Finally, the entire horizon of SPD is going through a radical change from categorical models to dimensional and hybrid models (DSM-5-AM, ICD-11). It remains to be seen whether all these transformations could be generalized; and whether empirical research on personality disorders could adopt all these changes, or whether the categorical diagnoses of the DSM-5 will continue. At present, drug research for SPD seems to be "fatigued", while the evidence for psychotherapies is accumulating rapidly (Stoffers-Winterling, Völlm, and Lieb 2021). From a *heuristic* perspective that conceives mental processes as *emergent properties*, talking about an anti BPD drug, or worse, an anti-BPD "molecule" is absolutely unfeasible. It is possible, however, that the introduction and generalization of dimensional and hybrid models could stimulate and increase research, both pharmacological and psychotherapeutic, using a supraordaining and transdiagnostic perspective, oriented to symptomatic clusters and specific psychostructural alterations, and across different categorical nosologies (Caligor, Kernberg, Clarkin, Yeomans, 2018; Stoffers-Winterling, Völlm, and Lieb 2021; Garza-Guerrero, 2022 a, b, 2023; Kernberg, 2023).

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