Research Article

Integrative multi-framework assessment of borderline personality disorder in a late-adolescent male: a case report

Miss Sukhsiddhi D. Pol[1*], Prof. Dr. Anand Prakash[2], Dr. Rupesh Rajan[3]

[1]Ph.D. Scholar, Assistant Professor, Amity Institute of clinical psychology, MPhil (NIMHANS); C block, SP-1 Kant Kalwar, NH11C, RIICO Industrial Area, Rajasthan 30300, Achrol - 303002, Rajasthan; Email: sukhsiddhipol@gmail.com; Phone -
[2]Professor in Clinical Psychology & Behavioural Sciences ; Xavier University School of Medicine, Oranjestad, Aruba, Netherlands. Email: anandprakash72@yahoo.com;
[3]Clinical Neuropsychologist, B46 BMHRC Campus, Bhopal Memorial Hospital and Research Centre, Raisen BY Pass Road, Bhopal 462038 Madhya; Email: dr.rupeshranjan@gmail.com

Abstract

Objective: To present an integrative, gender-sensitive assessment model for borderline personality disorder in a late-adolescent male, combining categorical diagnosis, psychodynamic defense analysis, mentalization theory, and projective narrative data.

Case description: A 23-year-old man with a clinically confirmed diagnosis of borderline personality disorder, established through the International Personality Disorder Examination, was assessed using a single-case, mixed-methods design. Responses to the Sacks Sentence Completion Test were thematically coded with NVivo 12, with substantial interrater reliability (kappa = 0.85). The dominant themes were parental rejection (28%), identity confusion (22%), interpersonal mistrust (20%), emotional numbing (18%), and resentment toward authority figures (12%). These narratives were cross-mapped with diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision and the International Classification of Diseases, 11th Revision, as well as with primitive defenses—including splitting, projection, dissociation, and denial and mentalization difficulties, including psychic equivalence, epistemic mistrust, teleological thinking, and reduced reflective functioning.

Comments: The findings illustrate how externalizing presentations in late-adolescent males may obscure borderline personality disorder and contribute to misdiagnosis, particularly as antisocial personality disorder. Integrating projective narratives with diagnostic, psychodynamic, and mentalization-based frameworks can deepen clinical formulation, contextualize symptoms within the patient's subjective experience, and guide interventions such as mentalization-based therapy, dialectical behavior therapy, and transference-focused psychotherapy. The model offers a replicable approach to gender-sensitive personality assessment during the transition to adulthood.

Keywords: Adolescent; Borderline personality disorder; Mentalization; Projective techniques; Case reports; Gender identity.

1. Introduction

Borderline Personality Disorder (BPD) is among the most clinically challenging personality disorders, characterized by profound dysregulation across affective, interpersonal, cognitive, and self-image domains (American Psychiatric Association [APA], 2022; World Health Organization [WHO], 2022). With a lifetime prevalence estimated between 1% and 6% in the general population (Grant et al., 2008; Leichsenring et al., 2011), BPD exerts a substantial burden on individuals, their social networks, and healthcare systems. Yet, despite comparable prevalence rates across genders when assessed with structured diagnostic instruments (Gunderson et al., 2018), the disorder remains markedly under-recognized and under-diagnosed in men a disparity with significant clinical, ethical, and therapeutic consequences.

Three converging factors are primarily responsible for this gap. First, gender socialization patterns

predispose men to express psychological distress through behavioral externalization — aggression, substance use, antisocial conduct rather than the affective and relational expression more stereotypically associated with female presentations (Sansone & Sansone, 2011; Coady & Marinus, 2020). Second, historical diagnostic bias in BPD research has predominantly recruited female samples, producing prototypical templates ill-suited to male presentations (Paris, 2013; Barnicot et al., 2011). Third, symptom overlap with Antisocial Personality Disorder (ASPD) particularly impulsivity and hostility frequently leads to misclassification (Becker & Grilo, 2007; Paris, 2013).

Critically, standard categorical diagnostic systems while offering the advantage of standardized, inter-rater consistent criteria operate largely at the level of observable symptom endorsement. They do not, by design, illuminate the covert intrapsychic processes that drive and maintain symptom expression: attachment injuries, primitive defense operations, and deficits in reflective functioning. For male BPD patients whose externalizing defenses obscure relational vulnerability and affective dysregulation, this diagnostic ceiling is particularly costly.

The present study addresses this gap by proposing and empirically demonstrating an integrative multi-framework assessment model that systematically combines (1) DSM-5-TR categorical diagnosis, (2) ICD-11 dimensional personality functioning descriptors, (3) psychodynamic defense mechanism coding within Kernberg's object relations framework, (4) mentalization profiling using Fonagy and Luyten's model, and (5) projective narrative data derived from the Sacks Sentence Completion Test (SSCT). Through the analysis of a clinically diagnosed male BPD case, the study demonstrates how these frameworks triangulate to produce a richer, more clinically actionable formulation than any single system can yield in isolation.

1.1 Theoretical Rationale for an Integrative Approach

The case for integration is both theoretical and empirical. DSM-5-TR provides categorical validity and criterion-based consensus (APA, 2022). The ICD-11 Borderline Pattern Descriptor extends this with dimensional profiling of personality functioning identity instability, affective dysregulation, negative self-concept, impulsivity, and interpersonal dysfunction enabling clinically nuanced characterization (WHO, 2022; Mulder et al., 2021).

Kernberg's object relations theory positions borderline pathology as fundamentally organized around primitive defense mechanisms splitting, projection, denial, and dissociation which partition self and object representations into unintegrated, polarized wholes (Kernberg, 1975, 1984). These mechanisms are not merely symptoms but structural maintainers of interpersonal instability and identity diffusion.

Fonagy and Luyten's (2009, 2018) mentalization theory conceptualizes BPD as rooted in disrupted reflective functioning the capacity to understand behavior in terms of underlying mental states. Mentalization deficits in BPD manifest as psychic equivalence (conflating internal experience with external reality), teleological thinking (reducing mental states to observable behaviors), epistemic mistrust (inability to receive and integrate social knowledge), and identity diffusion. Critically, these deficits emerge from disorganized early attachment and are directly treatable via Mentalization-Based Therapy (MBT) (Bateman & Fonagy, 2010; Luyten et al., 2020).

The Sacks Sentence Completion Test (SSCT; Sacks & Levy, 1950) provides a projective window into these intrapsychic processes. Its 60 open-ended sentence stems elicit unguarded narrative responses across family, interpersonal, self-concept, and sexuality domains — areas directly corresponding to the DSM-5-TR and ICD-11 diagnostic dimensions for BPD. Recent clinical applications have confirmed SSCT's utility in identifying psychological distress, treatment readiness, and personality pathology (Kumar & Jahan, 2020; Korotkova et al., 2021).

1.2 Male BPD: A Clinical Profile

Men with BPD are more likely than women to exhibit explosive temperament, novelty-seeking, prior substance use disorder, and antisocial tendencies (Silberschmidt et al., 2015; Robitaille et al., 2017; Qian et al., 2022). They demonstrate higher rates of externalizing aggression linked to emotional dysregulation (Mancke et al., 2015; Finkel, 2007). Betrayal trauma — particularly high and medium betrayal is disproportionately associated with borderline features in men compared to women, where only high betrayal trauma predicts borderline traits (Kaehler & Freyd, 2009). Gender-specific diagnostic bias is further supported by item-response analyses confirming differential item functioning across DSM-IV BPD criteria by gender (Hummelen et al., 2025).

These patterns are well accounted for within Linehan's biosocial developmental model (Linehan et al., 1993; Crowell et al., 2009), which links emotional vulnerability and environmental invalidation to the progressive development of emotional dysregulation. Extending this model, Gill et al. (2018) emphasize developmental context and the caregiving environment as decisive in shaping the trajectory of BPD pathology across the lifespan.

1.3 Aims of the Study

The present study pursues two interrelated aims:

- To demonstrate the validity and clinical utility of an integrative multi-framework assessment approach for male BPD, using a single confirmed case as a clinical prototype.
- To examine how SSCT projective narrative data systematically coded via a multi-step thematic coding process enriches categorical diagnosis by exposing intrapsychic defense operations, mentalization deficits, and attachment processes that structured interviews cannot readily access.

2. Methodology

2.1 Research Design

This study employs a single-case, mixed-methods exploratory design. The case is presented not as anecdotal evidence but as a clinical prototype to illustrate the validity and practical utility of a structured integrative coding framework. Qualitative thematic analysis is systematically operationalized via a multi-step coding procedure with quantified interrater reliability, enabling partial replication and cross-cultural extension in future research.

2.2 Participant and Clinical Profile

2.2.1 Sociodemographic Information

The participant (O.P.) is a 23-year-old, unmarried Hindu male from an upper-middle-class urban background, residing in a hostel in Jaipur, Rajasthan, India, and enrolled in the first year of a Master of Business Administration (MBA) program at the time of referral.

2.2.2 Presenting Complaints and History

Chief complaints at presentation included: frequent crying spells, forgetfulness, decreased interest in social interaction, reduced appetite, and multiple episodes of deliberate self-harm in the preceding month. Onset was insidious and course continuous. The proximate precipitant was perceived betrayal by a romantic partner, following which O.P. experienced persistent low mood, anhedonia, social withdrawal, and recurrent self-harm in contexts of emotional numbing.

Family history reveals a strained relationship with his mother, characterized by perceived maternal rejection and favoritism toward a younger sibling. Substance use commenced at age 13; current use includes 2 cigarettes per day with occasional alcohol and cannabis. Premorbid interpersonal history

demonstrates the capacity to initiate but not sustain friendships, marked by chronic perceptions of betrayal and emotional withdrawal.

2.3 Assessment Instruments

2.3.1 Sociodemographic Sheet

Recorded initials, age, sex, relationship status, educational status, and location.

2.3.2 International Personality Disorder Examination (IPDE; Loranger et al., 1999)

The IPDE is a semi-structured diagnostic interview assessing personality disorders according to both DSM-IV and ICD-10/ICD-11 criteria. O.P. scored 17 on the Borderline Personality scale, indicating a confirmed BPD diagnosis. The diagnostic framework was updated to cross-validate findings with DSM-5-TR (APA, 2022) and ICD-11 (WHO, 2022) criteria.

2.3.3 Sacks Sentence Completion Test (SSCT; Sacks & Levy, 1950)

The SSCT is a projective assessment instrument comprising 60 open-ended sentence stems administered under standardized conditions. Items assess attitudes and conflicts across four major domains: family, sexuality, interpersonal functioning, and self-concept. Responses are scored on a distress continuum: 0 (no distress), 1 (mild distress), and 2 (severe distress).

The SSCT's theoretical basis rests on the projective hypothesis: responses to ambiguous stimuli reveal the individual's dominant personality patterns, unexpressed conflicts, and underlying relational schemas. As Stein (1949, as cited in Edwin, 2014) observed, the requirement to respond spontaneously with the first idea elicited by an unstructured situation typically produces material that bypasses conscious censorship.

2.4 Multi-Step Thematic Coding Process

All 60 SSCT responses were analyzed through the following six-step process, designed to maximize both qualitative richness and quantitative rigor:

Codebook Development: Two advanced clinical psychologists constructed a comprehensive codebook integrating DSM-5-TR and ICD-11 diagnostic criteria, psychodynamic defense mechanisms, and mentalization impairments. Each code included operational definitions, inclusion/exclusion criteria, and exemplar SSCT responses.

Independent Coding: Raters independently coded all SSCT responses across three domains: diagnostic, defense mechanism, and mentalization. Raters were blinded to each other's work.

Software-Assisted Analysis: Anonymized transcripts were imported into NVivo 12 (QSR International) for systematic coding, frequency counts, and cross-tabulations linking SSCT responses to diagnostic indicators, defense mechanisms, and mentalization impairments.

Cross-Framework Integration: Each coded excerpt was simultaneously mapped to DSM-5-TR/ICD-11 criteria, psychodynamic defenses, and mentalization impairments, producing multi-dimensional mappings summarized in Tables 1–4.

Consensus and Reliability: Coding disagreements were resolved through consensus discussion, with remaining disputes adjudicated by a senior psychodynamic clinician (>15 years' experience). Interrater reliability was substantial ($\kappa = 0.85$; Landis & Koch, 1977).

Output and Visualization: Final codes and themes were synthesized into structured tables and thematic frequency charts, creating a transparent audit trail from raw data to interpretation to facilitate replication.

2.5 Ethical Considerations

Written informed consent was obtained from the participant for the use of anonymized data in research and publication. The study was approved by the Institutional Review Board as part of a doctoral research

protocol. All identifying details were anonymized in accordance with the Declaration of Helsinki (2013 revision) and Indian Council of Medical Research (ICMR) guidelines.

3. Results

Results are organized across four analytic layers: (1) categorical-diagnostic confirmation through DSM-5-TR and ICD-11; (2) mentalization breakdown mapping; (3) integrated multi-domain coding; and (4) quantitative theme frequencies. These layers are synthesized within a gender-sensitive interpretive frame.

3.1 Table 1: DSM-5-TR / ICD-11 Cross-Mapping with SSCT Evidence

Table 1. SSCT Responses and Clinical Evidence for DSM-5-TR / ICD-11 Diagnostic Criteria

Criterion / Domain	DSM-5-TR BPD Criterion	ICD-11 Borderline Descriptor	Clinical Evidence (O.P.)	SSCT Exemplars
Fear of Abandonment	Frantic efforts to avoid abandonment	Marked fear of abandonment	Emotional turmoil post-breakup, dependency patterns, social withdrawal	"I like my mother, but she does not love me."
Interpersonal Instability	Unstable, intense relationships	Intense, unstable; fear of rejection	Friendships unsustained; pervasive mistrust of others	"I should not always be scolded for my younger brother's mistakes."
Identity Disturbance	Persistently unstable self-image	Unstable self-image; poor self-worth	Self-described identity confusion; fluctuating goals and values	"I don't really know who I am."
Impulsivity	≥2 self-damaging areas	Impulsivity in self-damaging domains	Substance use since age 13; recurrent self-harm	"I don't talk to people; I am not afraid of anything."
Recurrent Self-Harm	Suicidal/self-mutilation behavior	Recurrent self-harm/suicidality	Multiple deliberate self-injury episodes associated with emotional numbing	Embedded clinically and in affective numbing responses
Affective Instability	Marked mood reactivity	Emotional instability; mood swings	Crying spells precipitated by perceived betrayals	Ambivalent, labile narrative tone throughout
Chronic Emptiness	Subjective feeling of emptiness	Difficulty tolerating aloneness; chronic emptiness	Reports emotional numbing and disengagement from self	"I never thought about this… I don't talk to people."
Intense Anger	Inappropriate, poorly controlled	Intense, poorly controlled anger	Resentment toward family members;	"He is a mother fucker… he was never

	anger		authority figures	there for me."
Paranoia/Dissociation	Stress-related paranoia or dissociation	Transient paranoia/dissociation under stress	Emotional cutoff following self-harm; narrative mistrust patterns	Dissociative numbing described in self-harm context

Note. DSM-5-TR = Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text revision (APA, 2022); ICD-11 = International Classification of Diseases, 11th revision (WHO, 2022); SSCT = Sacks Sentence Completion Test.

3.2 Table 2: Mentalization-Based Interpretation of SSCT Responses

Table 2. Mentalization-Based Interpretation of SSC

SSCT Domain	Mentalization Feature	Patient SSCT Response	Clinical Interpretation
Attitudes Toward Parents	Disorganized attachment; psychic equivalence	"My mother loves me, but she always ruins everything."	Inability to hold ambivalence; attachment insecurity undermines secure basing
Sexuality	Teleological / pretend mode	"Sex is just a way to get attention."	Emotional shallowness; relationships construed in functional, non-mentalized terms
Interpersonal Relationships	Epistemic mistrust; hyper-mentalization	"People say they care, but they're always lying."	Vigilant expectation of betrayal; distorted social inference predicting rejection
Self-Concept	Identity diffusion	"I don't really know who I am."	Absence of cohesive self; unstable reflective function and autobiographical continuity
Fears and Guilt	Psychic equivalence	"If I feel guilty, it must be because I'm a bad person."	Conflation of emotional state with absolute reality; absence of mentalization of affect
Future Aspirations	Collapsed agency; impaired temporal continuity	"There's no point thinking about the future."	Hopelessness reflecting collapse of future-oriented self and mentalized agency
Work and Authority	Epistemic vigilance; teleological stance	"Bosses just want control. They don't care."	Social roles reduced to control; authority consistently construed as threatening
Social Norms	Cognitive rigidity; impaired theory of mind	"Rules are for stupid people."	Failure of reflective perspective-taking; rigidity in social cognition

Note. Mentalization features are derived from Fonagy & Luyten (2009, 2018).

3.3 Table 3: Integrated Multi-Domain Coding of SSCT Responses

Table 3. Worked Examples of Integrated Thematic Coding

SSCT Response	Initial Code	DSM-5-TR	ICD-11 Domain	Defense Mechanism	Mentalization Deficit
"I like my mother, but she does not love me."	Parental rejection	Criterion 1 – Abandonment	Fear of abandonment; impaired identity	Splitting	Psychic equivalence; disorganized attachment
"I don't really know who I am."	Identity confusion	Criterion 3 – Identity disturbance	Unstable self-image	Denial	Identity diffusion; impaired self-reflection
"People say they care, but they're always lying."	Interpersonal mistrust	Criterion 2 – Interpersonal instability	Unstable relationships	Projection	Epistemic mistrust; hyper-mentalization
"I never thought about this…"	Emotional numbing	Criteria 5, 6, 7 – Emptiness	Emotional dysregulation	Dissociation	Collapsed mentalizing under stress
"Bosses just want control."	Authority resentment	Criterion 8 – Anger	Disinhibition	Projection	Epistemic vigilance; teleological stance

Note. Each coded response is triangulated across three analytic levels: symptom identification (DSM-5-TR / ICD-11), mechanism explanation (defense coding), and process elucidation (mentalization profiling).

3.4 Table 4: Quantitative Thematic Frequency Distribution

Table 4. Frequency of Thematic Clusters in SSCT Response Set

Thematic Cluster	Frequency (%)	DSM-5-TR Criterion	ICD-11 Domain	Defense Mechanism	Mentalization Impairment
Parental Rejection	28%	Criteria 1, 7	Impaired Identity; Emotional Dysregulation	Splitting	Disorganized attachment
Identity Confusion	22%	Criterion 3	Unstable Self-Image	Denial	Identity diffusion
Interpersonal Mistrust	20%	Criteria 2, 9	Negative Self-Concept; Interpersonal Disturbance	Projection	Epistemic mistrust
Emotional Numbing	18%	Criteria 5, 6, 7	Emotional Dysregulation	Dissociation	Collapsed mentalizing

Anger at Authority	12%	Criterion 8	Disinhibition; Negative Affectivity	Projection	Epistemic vigilance

Note. Percentage frequencies derived from NVivo 12 coding of 60 SSCT responses. Themes are not mutually exclusive; cross-loading is expected given the construct overlap between diagnostic criteria, defense mechanisms, and mentalization domains.

4. Discussion

The present study operationalized an integrative multi-framework assessment of male BPD and yielded convergent findings across all analytic layers. The following discussion addresses four substantive areas: cross-domain diagnostic mapping, psychodynamic mechanisms, mentalization deficits, and gender-specific considerations.

4.1 Cross-Domain Symptom Mapping: DSM-5-TR and ICD-11

Results reinforce the substantial overlap between DSM-5-TR and ICD-11 frameworks across all nine BPD domains. Both systems converged on O.P.'s presentation of abandonment fears, interpersonal instability, identity disturbance, affective dysregulation, impulsivity, chronic emptiness, anger dysregulation, and dissociative features. However, the clinical depth achieved by each system differed.

SSCT narrative data served as a critical contextualizing layer. The response "I like my mother, but she does not love me" simultaneously confirmed DSM-5-TR Criterion 1 (abandonment fears) and ICD-11 impaired identity while revealing the attachment injury substrate maternal rejection as a formative relational wound inaccessible to structured interview alone. This exemplifies the added construct validity that projective data contributes to categorical assessment.

Identity disturbance confirmed across both classification systems via the response 'I don't really know who I am' was identified as the central organizing vulnerability. This finding aligns with contemporary research positioning identity diffusion as a transdiagnostic risk factor for personality disorder severity and treatment resistance (Gunderson et al., 2018; Leichsenring et al., 2011).

4.2 Psychodynamic Defense Mechanisms: Structural Maintainers of Pathology

Consistent with Kernberg's object relations theory (1975, 1984), O.P.'s SSCT narratives demonstrated reliance on four primitive defense operations:

Splitting: polarized representations of maternal care ('she loves me / she always ruins everything'), consistent with the inability to integrate ambivalent object representations.

Projection: attribution of intolerable internal mistrust to external others ('they're always lying'), externalizing intrapsychic conflict.

Denial: avoidance of distress linked to identity diffusion and self-incompetence.

Dissociation: detachment from unbearable affective intensity, particularly surrounding self-harm episodes and periods of emotional numbing.

These are not merely symptomatic features but structural mechanisms driving and maintaining interpersonal instability and emotional dysregulation. Crucially, recognizing these mechanisms helps clinicians discriminate BPD from ASPD: where ASPD involves genuine indifference to others, O.P.'s defenses reveal profound underlying relational insecurity defended against through projection and epistemic withdrawal.

4.3 Mentalization Deficits: Process-Level Explanation

Fonagy and Luyten's (2009, 2018) mentalization model provided the deepest explanatory layer, revealing the process-level mechanisms sustaining BPD symptomatology. Five specific impairments were

identified:
Psychic equivalence: conflation of subjective experience with objective reality ('If I feel guilty, it must be because I'm a bad person').
Teleological thinking: reduction of intimate relationships to observable, functional outcomes ('Sex is just a way to get attention').
Identity diffusion: absence of stable autobiographical self-continuity.
Epistemic mistrust: chronic refusal to receive and integrate social knowledge or care.
Collapsed reflective functioning: hopelessness reflecting failure to mentalize temporal self-continuity and personal agency.
These deficits illuminate why DSM/ICD symptoms are maintained: interpersonal instability persists because projecting mistrust precludes accurate interpretation of others' intentions; affective instability arises because psychic equivalence precludes reflective modulation of emotional states. Critically, these impairments map directly onto MBT treatment targets — epistemic trust restoration, identity coherence building, and reflective function enhancement under stress — enabling precision treatment planning rather than generic assignment.

4.4 Gender-Specific Manifestations and Clinical Implications

Consistent with existing literature (Sansone & Sansone, 2011; Paris, 2013; Qian et al., 2022), O.P.'s presentation is dominated by externalizing patterns: anger at authority, substance use, mistrust, and defensive projection rather than the relational dependency, identity enmeshment, and overt affective expression more frequently associated with female BPD prototypes.
This externalizing style creates a specific and well-documented misdiagnosis risk. Without an integrative framework, the behavioral surface of O.P.'s presentation impulsivity, hostility, authority resentment could readily be attributed to ASPD. However, SSCT narratives expose the profoundly relational substrate: maternal rejection, peer betrayal, post-breakup dependency collapse, and attachment hyperreactivity. These are the hallmarks of BPD, not the callous interpersonal indifference characterizing ASPD.
This finding has direct clinical relevance: misdiagnosis as ASPD leads to dramatically different (and often less effective) treatment pathways. The integrative framework — particularly SSCT thematic coding provides the diagnostic precision needed to pierce through male externalizing defenses and accurately characterize underlying personality organization.

4.5 Treatment Implications

The integrative findings directly inform a personalized, phase-sensitive treatment approach:
Mentalization-Based Therapy (MBT): primary modality to target epistemic mistrust, psychic equivalence, and identity diffusion. Authority resentment in O.P. is not best understood behaviorally but as a projection-based mentalization failure amenable to MBT intervention.
Dialectical Behavior Therapy (DBT): structured containment for affective dysregulation, impulsivity, suicidal urges, and self-harm behaviors via validated skills-based protocols (Linehan et al., 1993).
Transference-Focused Psychotherapy (TFP): systematic exploration of splitting and projection within the therapeutic relationship, directly addressing primitive object relations (Levy et al., 2015).
Stepped-Care Approach: integration of family psychoeducation and targeted pharmacotherapy where warranted, particularly for affective instability and impulsivity (Malogiannis et al., 2025).

5. Limitations and Future Directions

5.1 Limitations

Several limitations constrain the generalizability of the present findings and must be explicitly acknowledged:

Single-case design: While the case functions as a clinical prototype, findings cannot be generalized without replication across larger, heterogeneous samples. Idiographic depth is traded for nomothetic breadth.

Cultural specificity: O.P.'s identity as an Indian, urban, upper-middle-class male postgraduate student introduces cultural specificity that may not generalize across socioeconomic, regional, or cultural contexts. The ICD-11 dimensional model's greater cultural flexibility should be further exploited in cross-cultural replications.

Projective validity debates: The SSCT, as a projective instrument, remains subject to ongoing methodological critique. The triangulation strategy employed here — cross-validating SSCT findings with structured diagnostic criteria and achieving $\kappa = 0.85$ interrater reliability — substantially mitigates but does not fully resolve these concerns.

Cross-sectional design: The assessment represents a single time-point; predictive validity of thematic patterns for treatment response or longitudinal course remains unexplored.

IPDE criterion generation: IPDE criteria were originally validated against DSM-IV and ICD-10 rather than DSM-5-TR and ICD-11. The cross-validation employed here provides reasonable construct continuity but requires formal validation in updated criterion sets.

5.2 Future Directions

The following research directions would substantially extend the clinical and scientific value of the integrative model:

Larger gender-comparative samples: Application to diverse male, female, and non-binary BPD populations to test diagnostic invariance and identify gender-specific symptom profiles with sufficient power.

Cross-cultural replication: Testing the integrative coding model in non-Western, lower-income, and rural populations to examine ICD-11 dimensional trait stability and SSCT thematic universality.

Therapeutic tracking: Pre- and post-MBT/DBT SSCT administration to examine shifts in defense operation frequency and mentalization capacity, providing projective indices of treatment outcome.

Machine-assisted coding: Integration of NVivo analytics with machine learning algorithms for automated thematic coding of larger SSCT response sets, enhancing reproducibility and scalability.

Validity studies: Formal psychometric studies examining the convergent and discriminant validity of SSCT thematic clusters against established personality disorder measures, mentalization indices, and defense mechanism scales.

6. Conclusion

This study demonstrates that a multi-framework integrative diagnostic strategy — combining DSM-5-TR and ICD-11 categorical criteria, psychodynamic defense analysis, mentalization profiling, and SSCT projective narrative coding constructs a substantially richer and more clinically actionable understanding of male BPD than any single framework can achieve in isolation.

Whereas structured categorical diagnostics identify and enumerate symptoms, projective thematic coding exposes the subjective narratives of parental rejection, relational mistrust, identity emptiness, authority conflict, and affective numbing that sustain pathology at a structural level. Defense mechanism analysis explains the psychological operations maintaining these patterns, while mentalization profiling identifies the reflective deficits that render them treatment-resistant without

targeted intervention.

Beyond its clinical value, the multi-step thematic coding process developed and validated here provides a replicable, transparent assessment methodology suitable for gender-diverse clinical research. It harmonizes categorical, dimensional, projective, and dynamic approaches in a protocol explicitly sensitive to the ways in which male socialization and gender-specific defense styles mask the core vulnerability of borderline personality organization.

As BPD research increasingly prioritizes precision assessment and personalized treatment planning (Leichsenring, 2024; StatPearls, 2024), integrative frameworks of this kind — capable of translating diagnostic depth into treatment specificity — represent a necessary and productive direction for the field. The present study offers a validated clinical prototype for this approach, applicable across assessment, training, supervision, and research contexts in personality disorder and psychopathology.

Declarations

Conflict of Interest: The authors declare no potential conflict of interest.

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