Health Education England

MRCPsych General Adult Module

Personality Disorders

Developing people
for health and
healthcare

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GA Module: Personality Disorders

Aims and Objectives

- Aims
  - To give an overview of personality disorders

- Objectives:
  - By the end of the sessions, trainees should have:

    An understanding of personality disorders (aetiology, epidemiology, diagnostic criteria, classification, psychopathology, clinical presentation, assessment, course and prognosis) and their management (pharmacological, psychological, social).

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GA Module: Personality Disorders

To achieve this

- Case Presentation
- Journal Club
- 555 Presentation
- Expert-Led Session
- MCQs

- Please sign the register and complete the feedback

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GA Module: Personality Disorders

Expert Led Session

Personality Disorders: an overview

Contents

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What is ‘personality’?

What is 'personality'?

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*From the Latin word **'persona'**, relating to a theatrical mask worn by performers to either project different roles or disguise their identities*

'That which permits a prediction of what a person will do in a given situation…'

–Raymond B Cattell, 1950

'The distinctive patterns of behaviour (thoughts, feelings, emotions, actions) that characterise each individual enduringly.'

– Walter Mischel, 1999

'A pattern of relatively permanent traits and unique characteristics that give both consistency and individuality to a person's behaviour.'

– Feist and Feist 2009

'The ingrained patterns of thought, feeling and behaviour characterizing an individual's unique lifestyle and mode of adaptation, and resulting from constitutional factors, development and social experience.'

– World Health Organisation Lexicon of Psychiatric and Mental Health Terms

Models of Personality

Health Education England

- Various different models to explain personality have been developed:

Categorical

Eg ICD-10/DSM-V categories

Disorders in personality are seen as discrete categories

Experimental Approach

Looks for general laws and causal relationships between personality variables

Correlational Approach

Assumes the structure of personality is common to all but varies in combinations of traits

Psychoanalytic Approach

Eg Sigmund Freud

Assesses personality using the psychological principles of the superego, id, ego and defence mechanisms

Dimensional Models

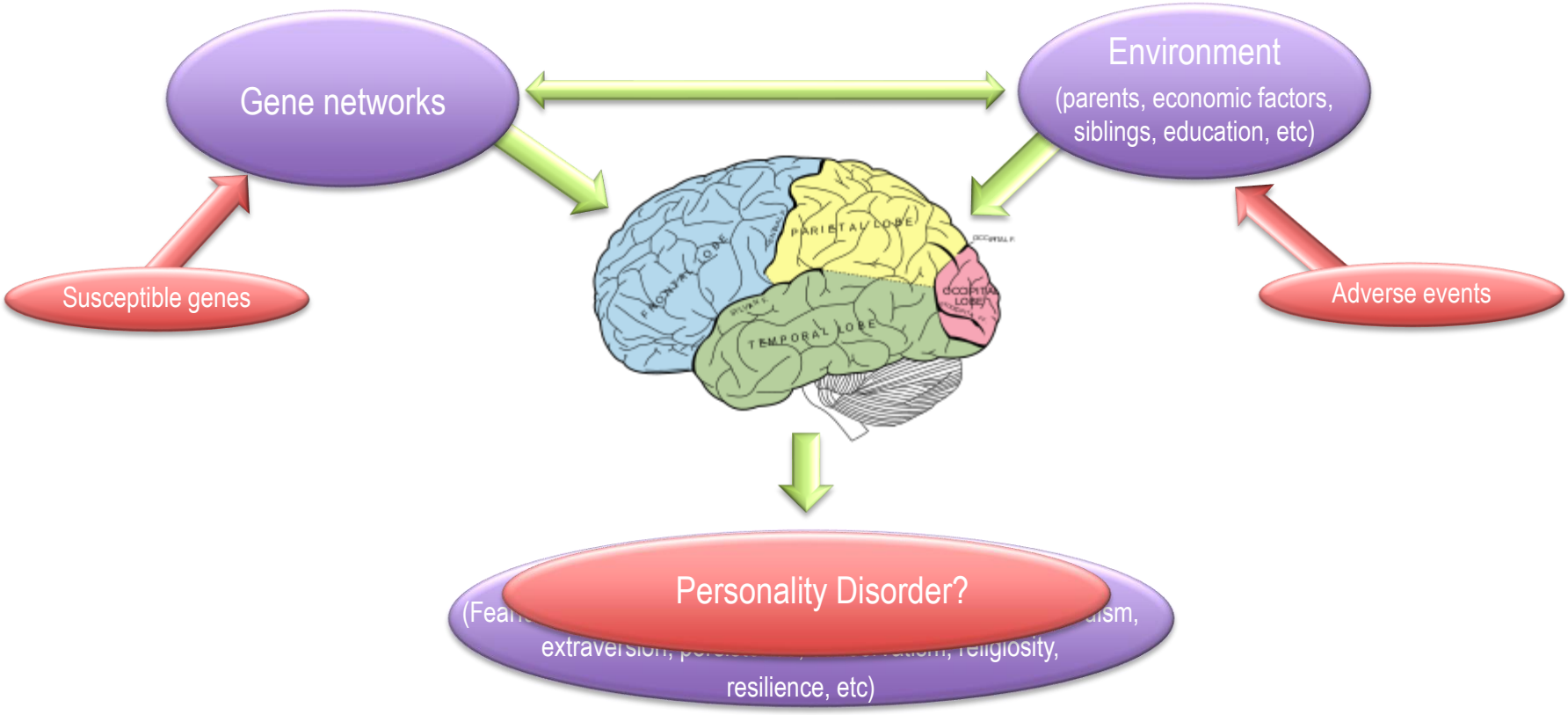
Eg Eysenck's theory, OCEAN

Traits are distributed within dimensions, enabling classification of people by their personality type

Genes, the Environment and Personality

Health Education England

- Hamer (2002) argued for a complex interaction between genes and environment to produce personality traits:



Hamer, D. (2002) Rethinking Behaviour Genetics. Science; 298(5591):71-2

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What is ‘personality disorder’?

What is personality disorder

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- When personality develops in such a way as to be harmful or distressing to themselves and/or others and interferes with daily functioning

ICD10 Description

Deeply engrained and **enduring behavior patterns**, manifesting as **inflexible responses** to a broad range of **personal** and **social situations**.

They represent **extreme** or **significant deviations** from the way in which the average individual in a given culture **perceives**, **thinks**, **feels** and, particularly, **relates to others**.

Such behavior patterns tend to be stable and to **encompass multiple domains** of **behavior** and **psychological** functioning.

They are frequently, but not always associated with various degrees of **subjective distress** and **problems of social performance**.

They usually manifest since childhood or adolescence and continue throughout adulthood.

DSM-V Description

The essential features are impairments in personality (**self** and **interpersonal**) functioning and the presence of **pathological personality traits**.

Significant impairments in **self** (identity or self-direction) and **interpersonal** (empathy or intimacy) functioning and one or more pathological personality trait domains or trait facets.

The impairments in personality functioning and the individual's trait expression are **relatively stable** across **time** and consistent across **situations**.

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5TH ed.) Washington, DC.
World Health Organisation (1992) International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO

Personality Disorder Classification

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There are differences in diagnoses between ICD and DSM:

ICD-10	DSM-V
F60.0 Paranoid	Paranoid
F60.1 Schizoid	Schizoid
	Schizotypal
F60.2 Dissocial	Antisocial
F60.3 Emotionally Unstable	Borderline
F60.4 Histrionic	Histrionic
	Narcissistic
F60.5 Anankastic	Obsessive-Compulsive
F60.6 Anxious (avoidant)	Avoidant
F60.7 Dependent	Dependent
F60.8 Other (inc. narcissistic)	

DSM-V

Retains current diagnostic classification but also includes a radical shift in the appendix for further research into a hybrid methodology retaining six personality types but addressing degree of impairment in functioning.

ICD-11

Is mooted to follow a similar pattern using 6 domain traits with an additional specifier for severity of disorder

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5TH ed.) Washington, DC.
World Health Organisation (1992) International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO

Personality Disorder Clusters

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DSM-III grouped personality disorders into clusters:

Cluster A	Cluster B	Cluster C
Odd or Eccentric	*Dramatic or Erratic*	*Anxious*
Paranoid	Histrionic	Avoidant
Schizoid	Narcissistic	Dependant
Schizotypal	Borderline	Obsessive-Compulsive
	Antisocial	

American Psychiatric Association (1980) Diagnostic and Statistical Manual of Mental Disorders (3rd ed.) Washington, DC.

Features of Cluster A PD

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- Characterised by odd, eccentric beliefs and behaviours
- Have an unwillingness and inability to form and maintain close relationships
- Unusual perceptions are distinguishable from psychotic illness

Paranoid PD
Irrational suspicion
Mistrustful
Jealous
Sensitive
Resentful
Bears grudges
Self-importance
Interpret motives as malevolent

Schizoid PD
Emotionally detached
Apathy
Aloof
Lack of desire for close friendships
Preoccupation with fantasy
Introspective

Schizotypal PD (DSM-V)
Extreme discomfort in interactions
Paranoid thoughts
Perceptual abnormalities
Strange beliefs or magical thinking
Inappropriate or constricted affect
Odd, eccentric, peculiar behaviour

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5TH ed.) Washington, DC.
World Health Organisation (1992) International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO

Features of Cluster B PD

Health Education England

- Characterised by dramatic, overly emotional or unpredictable behaviour
- Extreme difficulty in relating to others

Dissocial PD
Callous disregard for others
Transient relationships
Irresponsible
Impulsive and irritable
Lack of guilt and remorse
Fail to accept responsibility
Criminal and antisocial behvaiour

Histrionic PD
Self-dramatization
Shallow, labile affect
Seeks attention and excitement
Suggestibility
Inappropriately seductive
Exaggerated expression of emotions
Self-indulgence

Narcissistic PD (DSM-V)
Grandiose sense of self-importance
Fantasises about unlimited success
Believes self to be special
Requires excessive admiration
Sense of entitlement from others
Exploits others for own benefit
Lack of empathy
Envious of others

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5TH ed.) Washington, DC.
World Health Organisation (1992) International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO

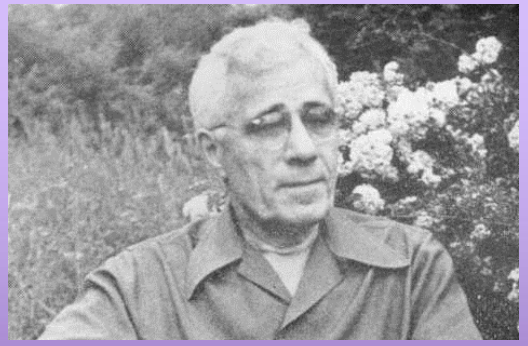
Features of Cluster B PD

Health Education England

- Emotionally Unstable Personality Disorder is characterised by emotional lability, impulsivity and disturbance in interpersonal relationships

EUPD Impulsive Type
Emotional lability
Explosive outbursts of emotion
Lack of impulse control
Liability to anger and violence
Quarrelsome
Difficulty maintaining course of action
Unstable, capricious mood

EUPD PD Borderline Type
Disturbances in self-image
Chronic feelings of emptiness
Intense and unstable relationships
Tendency to self-destructive behaviour
Fear of abandonment



*'It is well known that a large group of patients fit frankly neither into the psychotic not into the psychoneurotic group, and that this **borderline** group of patients is extremely difficult to handle effectively by any psychotherapeutic method'*

--Adolph Stern, 1938

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5TH ed.) Washington, DC.
World Health Organisation (1992) International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO

Features of Cluster C PD

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- Characterised by high levels of anxiety and fear
- Often have a significant desire for relationships but struggle to manage them appropriately

Anankastic PD
Inhibited by perfectionism
Excessive conscientiousness
Preoccupation with details
Stubbornness and rigidity
Expects others to conform to their view
Unwelcome thoughts
Feelings of doubt

Anxious (Avoidant) PD
Feelings of tension and apprehension
Feel insecure and inferior
Yearning to be accepted
Hypersensitivity to rejection/criticism
Restricted personal attachment
Excessively fearful of potential danger
Avoids social activity due to fear

Dependent PD
Passive reliance on others
Fear of abandonment
Feel helpless and incompetent
Passive compliance with others wishes
Transfer responsibility to others
Relies on others for decision-making
Unwilling to make reasonable demands

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5TH ed.) Washington, DC.
World Health Organisation (1992) International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Geneva: WHO

Aetiology

Health Education England

- Cluster A Personality Disorders:

Biological
Modestly heritable (21-28%)
Schizotypal displays the **most genetic influence**
Familial association between schizotypal and schizophrenia
Reduced cortical **dopamine** → poor conceptual organisation → suspiciousness and distorted perception

Environmental
Environmental factors more important
Deficits in early developmental stages lead to **mistrust** and **lack of confidence**
Poor protective care and **affective support** leads to paranoid features

Kendler, K.S., et al (2006) Dimensional representations of DSM-IV Cluster A personality disorders in a population-based sample of Norwegian twins: a multivariate study. Psychological Medicine; 36(11): 1583-91

Aetiology

Health Education England

- EUPD:

Biological
Familial factors: parents have high incidence of mood disorders; family history of ASPD/alcoholism
HPA axis dysfunction – leading to increased sensitivity of the amygdala
Abnormal limbic emotional reactivity (insufficient regulation from cingulate and prefrontal areas)
Reduced serotonin metabolite (5-hydroxyindole-acetic acid) in CSF, **blunted prolactin response** to serotonin agonists – thought to be associated with **impulsive aggression**

Environmental
Childhood trauma may play crucial role (up to 45% have history of CSA)
Attachment difficulties in early life → Deficiencies in **self identity**
Poor regulation and modelling of behaviour from others leads to use of **maladaptive coping strategies**
Maladaptive traits evoke **negative response** from environment and **disrupt healthy social development**

Winsper, C. (2018) The aetiology of borderline personality disorder (BPD): contemporary theories and putative mechanisms. Current opinion in psychiatry. 21: 105-10

Aetiology

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- Dissocial PD:

Biological
Genetic factors strongly contribute
Reduced serotinergic activity in the brain thought to lead to **aggression**
Impulsive ADHD is a strong predictor for development of dissocial PD in later life
25% of girls and **40% of boys** with **conduct disorder** will develop dissocial PD

Environmental
Parental deprivation, inconsistent maternal care, family violence, severe childhood physical abuse – **strong predictors**
Social disintegration and chronic criminality reflect a **normal adaptation** to **abnormal social environment**

Strorebo, O.J., & Simonsen, E. (2016) the association between ADHD and antisocial personality disorder (ASPD): a review. Journal of attention disorders. 20(10): 815-24

Aetiology

Health Education England

- Cluster C Personality Disorders:

Biological
Biological mechanisms of anxiety disorders/social phobias have a role in **avoidant PD**
Hypersensitivity of brain areas involved in **separation anxie**ty response
Overactivity of serotinergic **limbic** neuronal circuits

Environmental
Criticism / rejection / relentless control by parents → reduced social esteem → social avoidance *(Avoidant PD)*
Control from parents and restriction of autonomy → belief one is helpless → dependency on others *(Dependent PD)*
Parental over-control and strong discipline → guilt if fails to achieve perfection → OCD behaviours *(Anankastic PD)*

Millon, T., & Davis, R. (2000) Personality Disorders in modern life. New York: John Wiley & Sons

Epidemiology

NHS
Health Education England

- Personality disorders are common

4.4%
Prevalence in UK households

~50%
Prevalence in secondary care mental health services

60-80%
Prevalence in prison population

M > F
For all disorders except schizotypal in household survey

17-18 years
Shorter life span for those with PD, not explained by lifestyle/suicide

24-28%
Primary Care attendees

Cluster B + psychotic, affective, anxiety disorders
Strong associations

Cluster C + affective disorders, anxiety disorders
Strong associations

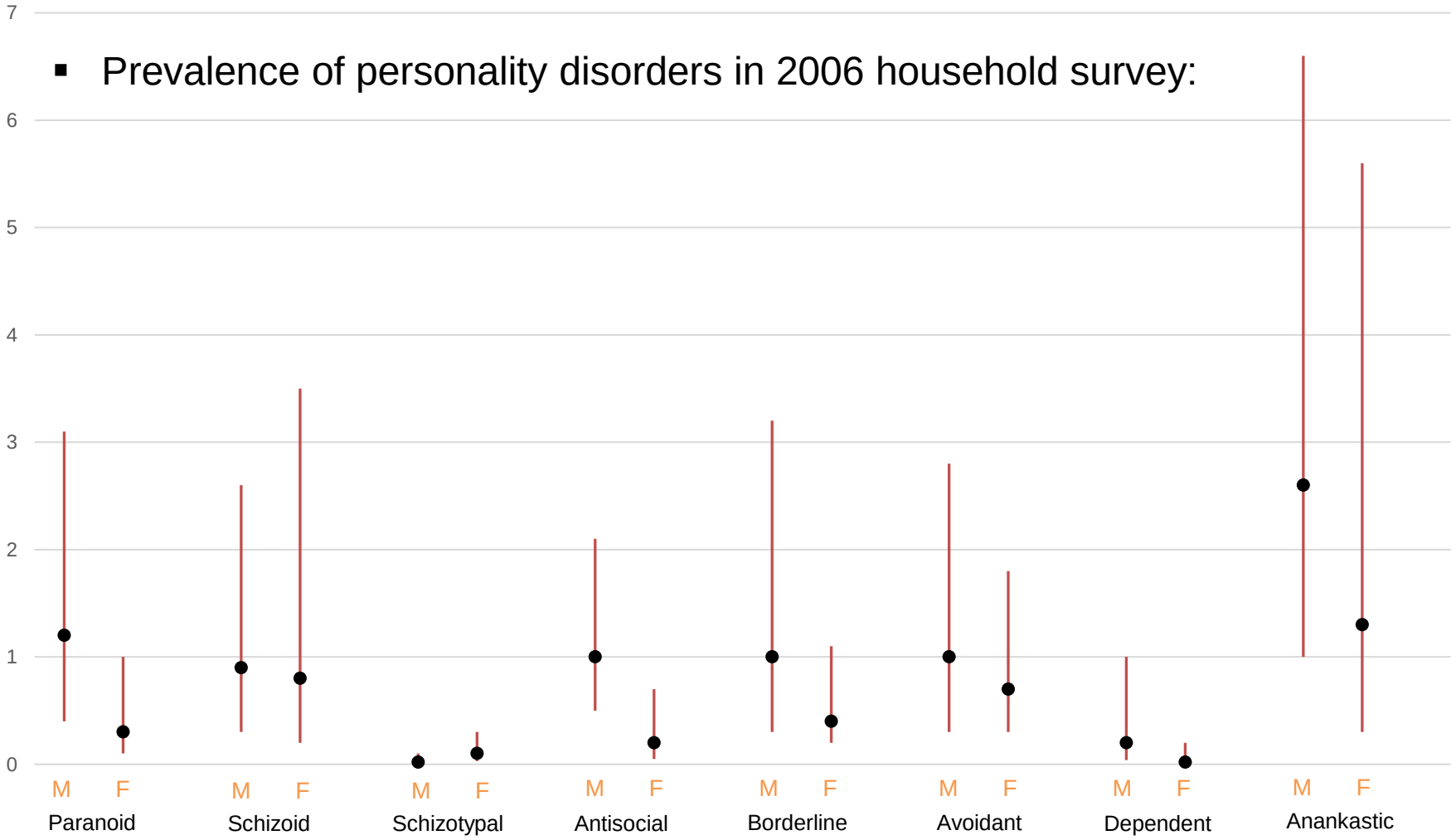
Separated, unemployed, low social class, living in urban areas
Increased prevalence

Coid, J., et al (2006) Prevalence and correlates of personality disorder in Great Britain. British Journal of Psychiatry; 188: 423-31
Zimmerman, M., Chelminski, I., Young, D. (2008) The frequency of personality disorders in psychiatric patients. The Psychiatric Clinics of North America. 31(3): 405-20
Fazel, S., Danesh, J. (2002) Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. Lancet; 359(9306): 545-50
Moran, P., et al (2001) The prevalence of personality disorder among UK primary care attenders. Acta Psychiatrica Scandinavica. 102 (1)
Fok, M.L.Y., et al (2012) Life expectancy at birth and all-cause mortality among people with personality disorder. Journal of psychosomatic research. 73(2): 104-7

Epidemiology

Health Education England

- Prevalence of personality disorders in 2006 household survey:



Coid, J., et al (2006) Prevalence and correlates of personality disorder in Great Britain. British Journal of Psychiatry; 188: 423-31

Epidemiology

Health Education England

- Suicide and self-harm are highly prevalent in PD populations
- In EUPD:

50-80%
Engage in deliberate self-harm

41%
Have >50 acts of deliberate self-harm

5-10%
Will die by suicide

- Risks are significantly increased by comorbid MH diagnosis
- In patients who present with DSH to A+E:

45.9%
Diagnosed with personality disorder

44.1%
Diagnosed with personality disorder and MH comorbidity

Oumaya, M., et al (2008) Borderline personality disorder, self-mutilation and suicide: literature review. Encephale. 34(5): 452-8
Stone, M.H. (2016). Long-term course of borderline personality disorder. Psychodynamic psychiatry. 44(3): 449-74
Haw, C., et al (2001) Psychiatric and personality disorders in deliberate self-harm patients. British Journal of Psychiatry. 178(1): 48-54

Course & Prognosis

Health Education England

- Personality disorders have been considered as life-long conditions
- However, evidence is emerging that their outcome is more positive
- Remission over a ten year period is common
- EUPD patients lag behind other PDs in terms of remission and recovery

Remission
No longer meet diagnostic criteria

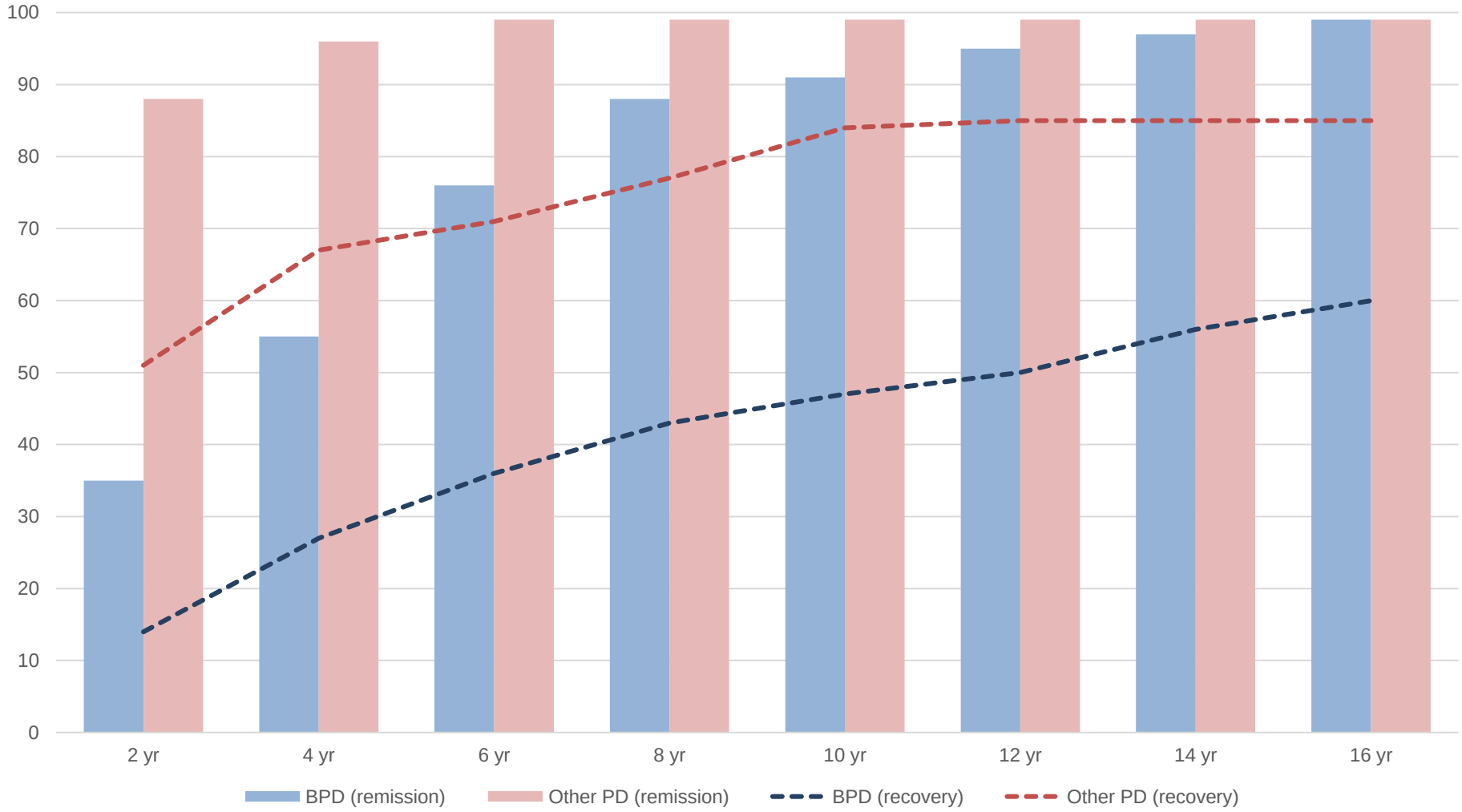
Recovery
Symptomatic, vocational and social wellness

- Once a patient has met criteria for remission, a substantial and sustained recurrence of symptoms is rare
- In EUPD patients, some symptoms are more chronic, and improve in order:

Zanarini, M.C., et al (2003) The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. Am J Psychiatry. 160(2): 274-83

Course & Prognosis

Health Education England



Zanarini, M.C., et al (2012) Attainment and stability of sustained symptomatic remission and recovery among borderline patients and axis II comparison subjects: a 16-year prospective follow-up study. Am J Psychiatry. 169(5): 476-483

Assessment of personality disorder

Health Education England

- Thorough history including developmental history, social history, personal history and thorough risk assessment are vital

- In order to diagnose PD it is important to gather premorbid personality history
- Comorbid mental disorder may cloud the overall picture
- Collateral history from someone who knew the patient well is vital

- It is important to identify comorbid mental illness
- It is important to consider to what extent personality difficulties have impacted patient's sense of self, relationships with others, daily functioning

Assessment Tools

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- A variety of structured assessment tools are available for PD diagnosis:

Personality Assessment Schedule (PAS)

Semi-structured interview with informant

ICD-10 + DSM-IV criteria

24 questions

International Personality Disorder Examination (IPDE)

Semi-structured interview with patients

ICD-10 + DSM-IV criteria

537 questions

Structured Clinical Interview for PD (SCID-II)

Semi-structured interview with patients

DSM-IV criteria

303 questions

Zanarini Rating Scale for Borderline PD

Semi-structured interview with patients

DSM-IV criteria

9 questions

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Management of EUPD

Psychological Treatment

*Covered in detain in psychotherapy module

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There is evidence that various modalities of psychological therapy help core and associated general psychopathology:

- Dialectical Behaviour Therapy
- Mentalization Based Therapy
- Transference Focussed Therapy
- Schema Focussed Therapy
- Systems Training for Emotional Predictability
- Problem Solving for Borderline Personality Disorder (STEPPS)

There is little robust evidence supporting one therapy over another

NICE CG78:

Do not use **brief psychological interventions** (of less than 3 months' duration).

For **women**… for whom **reducing recurrent self-harm** is a priority, consider a comprehensive **dialectical behavior therapy** programme.

NICE Guideline: Borderline Personality Disorder: recognition and management clinical guideline (CG78). January 2009
Stoffers-Winterling, J.M., et al (2012) Psychological therapies for people with borderline personality disorder. Cochrane database of Systematic Reviews, 8.

Psychological Treatment

*Covered in detain in psychotherapy module

Health Education England

- Psychosocial treatment is recommended as the primary treatment for personality disorders including EUPD.
- NICE suggest a mixture of group and individual therapies integrated with other services (social care, employment support, substance misuse services).

NICE Guideline: Borderline Personality Disorder: recognition and management clinical guideline (CG78). January 2009

Bateman, A.W., Gunderson, J., Mulder, R. (2015) Treatment of personality disorder. The Lancet, 385(9969): 735-43

Psychological Treatment

*Covered in detain in psychotherapy module

Health Education England

There are five common characteristics of evidence-based psychological treatments for EUPD:

- **Structured approaches** to prototypic EUPD problems
- Patients encouraged to **assume control** themselves (sense of agency)
- Therapists help connections of **feelings** to **events** and **actions**
- Therapists are **active**, **responsive** and **validating**
- Therapists **discuss** cases and **personal reactions** with others

Bateman, A.W., Gunderson, J., Mulder, R. (2015) Treatment of personality disorder. The Lancet, 385(9969): 735-43

Pharmacological Treatment

Health Education England

- NICE does not recommend any specific drug intervention for treatment of EUPD
- Sedatives (eg antihistamine) may be used in crisis
- Prescriptions should be short-term time-limited
- Medication should be used to treat comorbidities only

However…

NICE CG78:

Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behavior associated with the disorder.

Antipsychotic drugs should not be used for the medium- and long-term treatment of borderline PD.

Drug treatment may be considered in the overall treatment of comorbid conditions.

Short term sedative medication may be considered in a crisis

NICE Guideline: Borderline Personality Disorder: recognition and management clinical guideline (CG78). January 2009

Pharmacological Treatment

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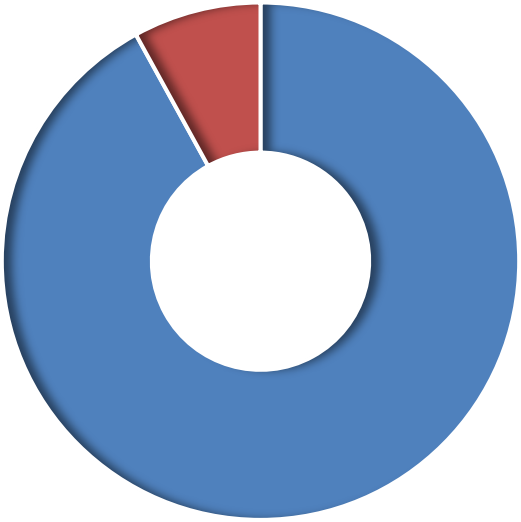
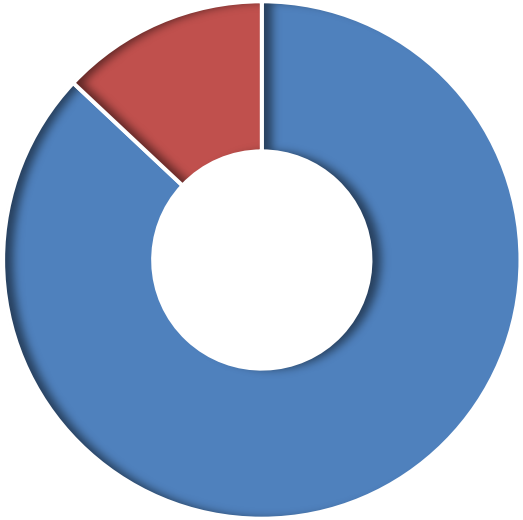


92% of EUPD patients are prescribed psychotropics



87% of people with a <u>sole</u> diagnosis of EUPD are prescribed psychotropics

Where EUPD is the sole diagnosis:

13% - no medication

21% - 1 medication

28% - 2 medications

23% - 3 medications

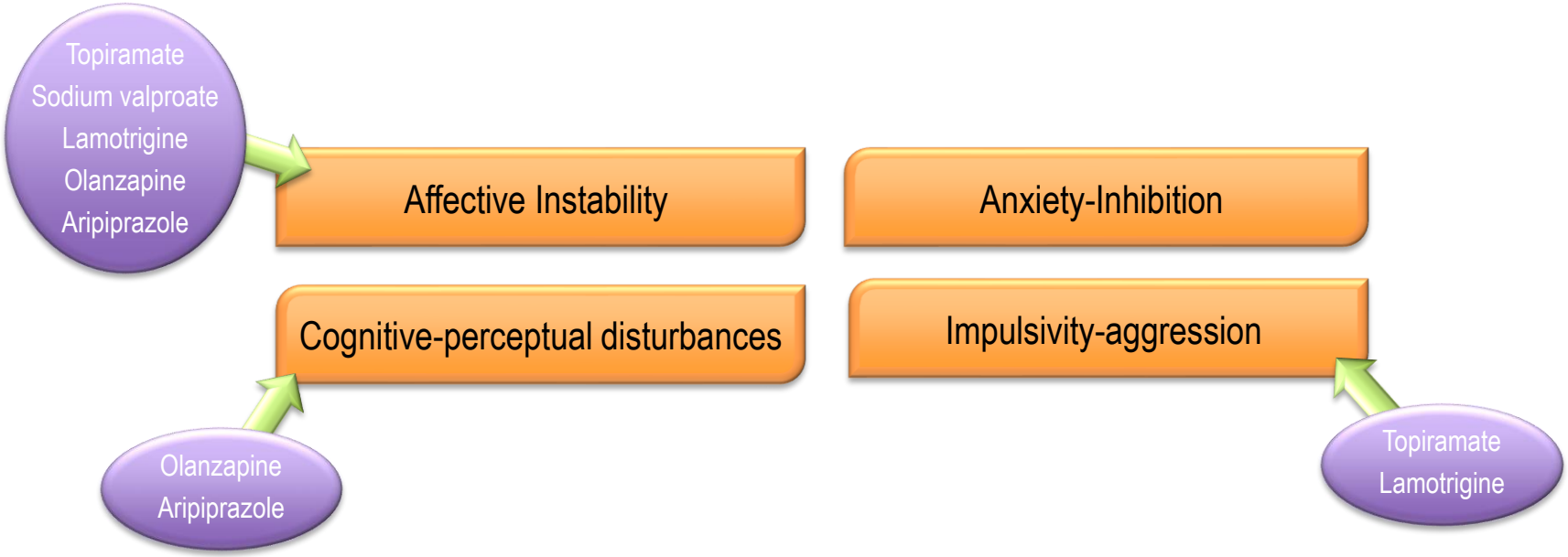
16% - 4 medications

Paton, C., et al (2015) The use of psychotropic medication in patients with emotionally unstable personality disorder under the care of UK mental health services. The Journal of Clinical Psychiatry. 76(4): 512-8

Pharmacological Treatment

Health Education England

- Some researchers argue for treatment of individual behaviour dimensions common to all personality disorders rather than treat the disorder itself:



- A 2010 Cochrane review supported treatment of specific dimensions
- There is no evidence for drug treatment of chronic emptiness, feelings of abandonment or identity disturbance
- There is no evidence that SSRIs are beneficial in treatment of EUPD

Bateman, A.W., Gunderson, J., Mulder, R. (2015) Treatment of personality disorder. The Lancet, 385(9969): 735-43
Soloff, P.H. (2000). Psychopharmacology of borderline personality disorder. Psychiatric Clinics of North America. 23(1): 169-92
Siever, L.J., David, K.L. (1991) A psychobiological perspective on the personality disorders. American Journal of Psychiatry. 148(12): 1647-58
Lieb, K., et al (2010) Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomized trials. British Journal of Psychiatry. 196: 4-12

Structured Clinical Management

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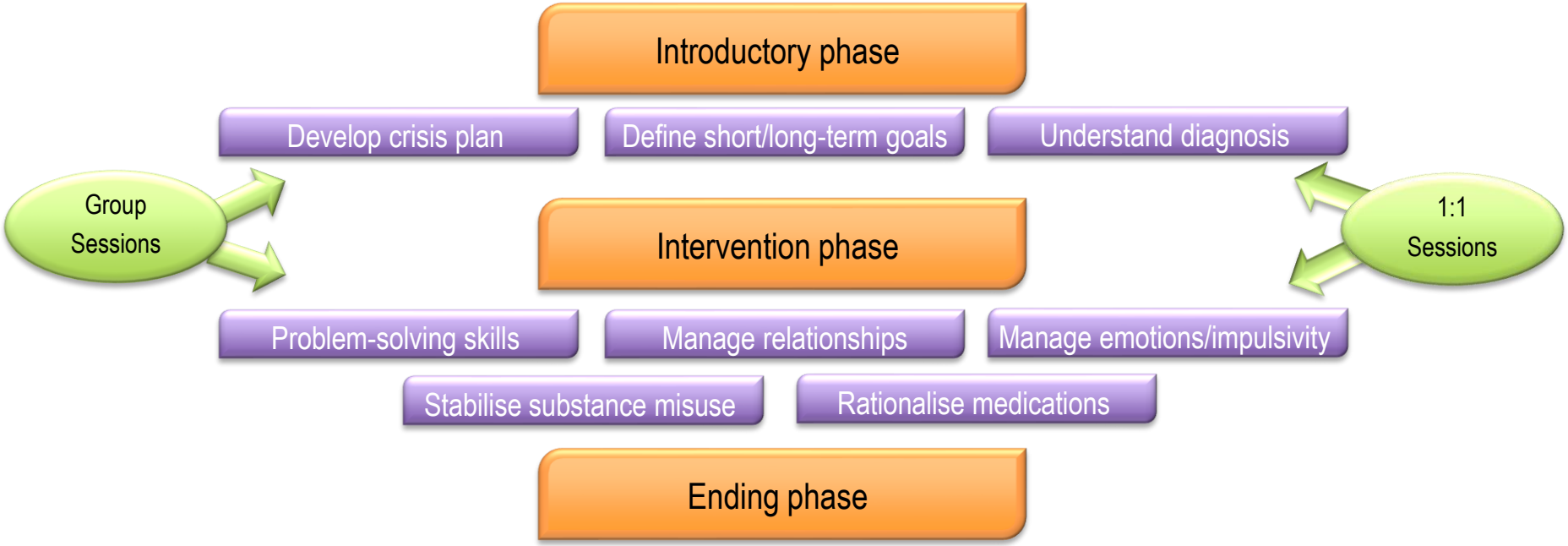
- Originally devised as a control for psychotherapy interventions for PD studies
- Essentially, the core elements of 'good psychiatric care' have positive impact in patients with EUPD



Bateman, A.W., Krawitz, R. (2013) Borderline Personality Disorder: An evidence-based guide for generalist mental health professionals. Oxford University Press

Treatment of Dissocial PD

Health Education England

- There is insufficient evidence for psychological interventions
- MBT, DBT and Democratic Therapeutic Community can be offered
- Major improvements only related to substance misuse outcomes
- No studies have demonstrated improvements in antisocial behaviour
- There is insufficient evidence of pharmacological interventions

Democratic Therapeutic Community

- DBT has been offered to those with Dissocial PD and EUPD
- Integrates a range of psychological approaches
- Enables members to re-experience and re-enact relationship difficulties
- Data is conflicting and comes from meta-analyses of poor-quality studies
- However, DCT continues to be offered in many different forms in the UK
- It is not specifically recommended by NICE

Gibbon, S., et al (2010) Psychological interventions for antisocial personality disorder. Cochrane database systematic review. 6.
Capone, G., et al (2016) Outcomes of therapeutic community treatment for personality disorder. Research paper submitted for Therapeutic Communities, 2016.
NHS Centre for reviews and dissemination. (1999) Therapeutic community effectiveness: a systematic international review of therapeutic community treatment for people with personality disorders and mentally disordered offenders. Database of Abstracts of Reviews of Effects: Quality Assessed Reviews

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GA Module: Personality Disorders

Any Questions?

Thank you

References & Further Reading

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Diagnosis and epidemiology:

- American Psychiatric Association (2013) **Diagnostic and Statistical Manual of Mental Disorders (5TH ed.**) Washington, DC.
- World Health Organisation (1992) **International Statistical Classification of Diseases and Related Health Problems, 10th Revision** (ICD-10). Geneva: WHO
- Zanarini, M.C., et al (2012) **Attainment and stability of sustained symptomatic remission and recovery among borderline patients and axis II comparison subjects: a 16-year prospective follow-up study.** Am J Psychiatry. 169(5): 476-483
- Coid, J., et al (2006) **Prevalence and correlates of personality disorder in Great Britain.** British Journal of Psychiatry; 188: 423-31
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- Fazel, S., Danesh, J. (2002) **Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys.** Lancet; 359(9306): 545-50
- Moran, P., et al (2001) **The prevalence of personality disorder among UK primary care attenders.** Acta Psychiatrica Scandinavica. 102 (1)
- Fok, M.L.Y., et al (2012) **Life expectancy at birth and all-cause mortality among people with personality disorder.** Journal of psychosomatic research. 73(2): 104-7

References & Further Reading

Health Education England

Aetiology:

- Hamer, D. (2002) **Rethinking Behaviour Genetics**. Science; 298(5591):71-2
- Kendler, K.S., et al (2006) **Dimensional representations of DSM-IV Cluster A personality disorders in a population-based sample of Norwegian twins: a multivariate study**. Psychological Medicine; 36(11): 1583-91
- Winsper, C. (2018) **The aetiology of borderline personality disorder (BPD): contemporary theories and putative mechanisms**. Current opinion in psychiatry. 21: 105-10
- Strorebo, O.J., & Simonsen, E. (2016) **The association between ADHD and antisocial personality disorder (ASPD): a review**. Journal of attention disorders. 20(10): 815-24
- Millon, T., & Davis, R. (2000) **Personality Disorders in modern life**. New York: John Wiley & Sons

Treatment:

- **NICE Guideline: Borderline Personality Disorder: recognition and management clinical guideline** (CG78). January 2009
- Stoffers-Winterling, J.M., et al (2012) **Psychological therapies for people with borderline personality disorder**. Cochrane database of Systematic Reviews, 8.
- Bateman, A.W., Gunderson, J., Mulder, R. (2015) **Treatment of personality disorder**. The Lancet, 385(9969): 735-43
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- Soloff, P.H. (2000). **Psychopharmacology of borderline personality disorder**. Psychiatric Clinics of North America. 23(1): 169-92
- Siever, L.J., David, K.L. (1991) **A psychobiological perspective on the personality disorders**. American Journal of Psychiatry. 148(12): 1647-58
- Lieb, K., et al (2010**) Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomized trials**. British Journal of Psychiatry. 196: 4-12
- Bateman, A.W., Krawitz, R. (2013) **Borderline Personality Disorder: An evidence-based guide for generalist mental health professionals**. Oxford University Press

MCQ

1. Which of the following is NOT a personality disorder in ICD-10?

A. Schizoid personality

B. Paranoid personality

C. Emotionally unstable personality

D. Schizotypal personality

E. Anankastic personality

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GA Module: Personality Disorders

MCQ

2. What is the estimated prevalence of personality disorders in the prison population?

A. 5-20%

B. 20-40%

C. 40-60%

D. 60-80%

E. 80-95%

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GA Module: Personality Disorders

MCQ

3. A 36 year old man is visited at home by his GP. There is very little furniture, no television, no ornaments or pictures on the wall. He is indifferent to these observations, stating he has no need of those things. He has limited contact with his family and does not have any friends. He is clear he does not feel lonely or depressed. Which of the following personality disorders could he have?

A. Histrionic
B. Antisocial
C. Paranoid
D. Schizotypal
E. Schizoid

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4. Which of the following is recommended in the management of emotionally unstable personality disorder?

A. Selective Serotonin Reuptake Inhibitors
B. Minimum inpatient stay of one month
C. Eye movement desensitisation and reprogramming
D. Structured clinical management
E. Polypharmacy

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Any Questions?

Thank you.