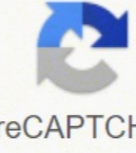


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## Traumafolgestörungen bei Patienten mit Borderline-Persönlichkeitsstörung

Ergebnisse einer Multicenterstudie

Die Borderline-Persönlichkeitsstörung (BPS) ist durch Symptome emotionaler Instabilität, impulsives Verhalten und instabile interpersonelle Beziehungen gekennzeichnet [1]. Während empirische Studien in der Vergangenheit keine eindeutigen Hinweise auf einen spezifischen Einfluss traumatischer Erfahrungen auf die Entwicklung der Symptomatik einer BPS zeigten [2, 3], häufen sich inzwischen Befunde, die über hohe Prävalenzraten von traumatischen Lebensereignissen und Traumafolgesymptomen bei BPS berichten [4, 5, 6, 7]. Zudem schildern Patienten mit BPS häufiger Erfahrungen von sexuellem Missbrauch in der Kindheit als Patienten mit anderen Persönlichkeitsstörungen [4, 8]. Damit wird die Frage der potenziellen Bedeutung von traumatischen Kindheitsereignissen für die Ätiologie der BPS im Rahmen eines multifaktoriellen Krankheitskonzepts aufgeworfen [9, 10, 11].

Da Kindheitstraumatisierungen nicht spezifisch mit der Ätiologie der BPS assoziiert sind, sondern mit vielen psychischen Störungsbildern korrelieren, erscheint es nicht gerechtfertigt, die BPS isoliert als eine traumaassoziierte Störung herauszu-

stellen [12]. Gleichzeitig wird jedoch betont, dass die Rolle von Traumatisierungen für die Behandlung der BPS von Bedeutung ist, auch wenn diese wahrscheinlich weder eine notwendige noch hinreichende ätiologische Bedingung darstellen [9, 13, 14, 15].

Aufgrund von Erwägungen bez. einer therapeutischen Weichenstellung wurde vorgeschlagen, die Diagnose BPS durch die Forschungsdiagnose „komplexe posttraumatische Belastungsstörung“ (komplexe PTBS) zu ergänzen, um eine Untergruppe von BPS-Patienten mit behandlungsrelevanten Traumafolgestörungen zu charakterisieren [16, 17]. Als komplexe PTBS wird ein Symptombild definiert, das Störungen der Affektregulation, dissoziative Symptome und Somatisierung, gestörte Selbstwahrnehmung, Störungen der Sexualität und Beziehungsgestaltung sowie Veränderungen persönlicher Glaubens- und Wertvorstellungen umfasst [18]. Die Notwendigkeit und der Nutzen der Einführung einer zusätzlichen Diagnose komplexe PTBS wird kontrovers diskutiert [19, 20], insbesondere aufgrund der potenziell hohen Überschneidung mit anderen Achse-I- und Achse-II-Diagnosen. Tatsächlich zeigt schon ein einfacher Vergleich der Diagnosekriterien von BPS und komplexer PTBS erhebliche Überschneidungen beispielsweise in den Be-

reichen Affektregulation und Impulsivität, Störungen der Selbstwahrnehmung sowie dissoziative Symptome. Damit stellt sich die Frage, ob sich die beiden diagnostischen Konstrukte überhaupt voneinander differenzieren lassen bzw. wie häufig beide Diagnosen gleichzeitig vorliegen.

Die geschilderten divergierenden Befunde und Einschätzungen geben Anlass, die Überschneidung von Traumafolgestörungen und BPS näher zu untersuchen. Während die Prävalenz von Traumatisierungen und der PTBS bei Patienten mit BPS bereits in einer Reihe von Studien untersucht wurde und als gut dokumentiert gelten kann [2, 3, 4, 5, 6, 7, 8], wurde die Überschneidung der BPS mit dem diagnostischen Konstrukt komplexe PTBS bislang noch nicht mit standardisierter Interviewdiagnostik untersucht. Auch die Prävalenz von dissoziativen Störungen wurde bei Patienten mit BPS bislang mit einer Ausnahme [21] lediglich durch Fragebogenerhebung eingeschätzt.

### Methodik

Im Rahmen einer multizentrischen Datenerhebung wurden konsekutive Patienten in 5 auf die Behandlung von Pa-

Die Studie wurde mit dem Hamburger Preis Persönlichkeitsstörungen 2010 ausgezeichnet.

### Percent

Criterion	Borderline Personality Disorder <sup>b</sup> (N = 26)	Other Personality Disorders (N = 50)	Kappa
Impulsivity or unpredictability	89	24	.65
Unstable and intense interpersonal relationships	77	22	.55
Inappropriate, intense anger or lack of control of anger	80	33	.68
Identity disturbance	67	20	.52
Affective instability	84	34	.48
Intolerance of being alone	46	12	.56
Physically self-damaging acts	67	22	.69
Chronic feelings of emptiness or boredom	75	17	.53
Overall diagnosis of borderline personality disorder			.72

<sup>a</sup>Prevalence figures are based on the total number of positive ratings divided by

**Digital retention in orthodontic diagnosis**  
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**Abstract**  
 Everyone wants a beautiful face with a healthy and beautiful smile. Orthodontics is the branch of dentistry that helps patients to achieve pleasing face with beautiful smile by correcting skeletal and dental malocclusion which interfere with their smile and with their facial appearance. The aim of this study was to evaluate the use of digital retention in orthodontic diagnosis and treatment planning to increase the accuracy of diagnosis and treatment planning in orthodontic diagnosis and treatment planning in orthodontics. In this article we will discuss some of the advantages of digital retention in orthodontic diagnosis and treatment planning in orthodontics.

**Keywords:** Orthodontic, Retention

**Introduction**  
 Orthodontic treatment is based on suitable diagnosis and treatment planning. It is a necessary to understand all diagnostic aids for planning orthodontic treatment. Orthodontic diagnosis started with deciding patient or parent's chief complaint. Diagnosis involves examination and diagnostic records. Diagnostic records are classified into essential and supplementary diagnostic aids. Essential aids are dental and medical history, clinical and roentgen examination, study models, panoramic and facial photographs, radiographic such as panoramic, bit-wing radiograph and cephalogram, cephalometric radiograph, lateral cephalogram, facial projection, occlusal (intraoral) films, electrogoniographic records, X-ray, headgear, and orthodontic wax and other orthodontic waxes.<sup>1</sup> Orthodontic records are also used for observing facial growth and development and to check other without treatment and with different treatment modalities.<sup>2</sup>

Since cone-beam computed tomography (CBCT), recent and precision tools became available for orthodontic diagnosis and treatment planning.<sup>3</sup> Traditional two-dimensional (2D) records are still common, but new technologies may lead to a more specific selection of records to make more efficient orthodontic diagnosis and treatment planning.<sup>4,5</sup>

**Rapid prototyping**  
 Rapid prototyping (RP) is manufacturing of a three dimensional model built by layer by layer from a computer aided design (CAD) model. The technology of RP are stereolithography (SLA), inkjet-based photopolymerization (IJP), selective laser sintering (SLS), and fused deposition modeling (FDM).<sup>6,7</sup>

SLA: SLA method incorporates a photosensitive liquid resin and a laser light source. The laser beam is directed at a model building platform. Layers of resin are added, cured, and then the platform is lowered to form a solid model.<sup>8</sup>

IJP-based system: In this method, a measured amount of new powder form material deposited. This powder is distributed, compressed with the help of a roller and liquid adhesive is added over powder. After it hard and a layer of model is formed. After completion of one layer, next layer is started. This gradual deposition of layers continued to complete fabrication of an object.<sup>9</sup>

SLS: In this technique layers of specific powder material are deposited on a build platform which is also 3D model by adopting a computer directed laser. Powder is distributed with a roller and layers are added one by one and sintered repeatedly. This method is self-sustaining all components can be bond layer by layer.<sup>10</sup>

FDM: In this technique, a thermoplastic material is extruded from a nozzle in layer by layer pattern, regulated by temperature on to a build platform which is maintained at low temperature. This technique makes build and color layering (MPC) possible. This method is self-sustaining all components can be bond layer by layer.<sup>11</sup>

Orthodontic diagnosis has three components like facial, dental and skeletal. The main task of an orthodontist is to determine different components of orthodontic complex in anatomical and dynamic occlusion position and also making them effectively planning. This process needs information regarding relationship of all these components of craniofacial complex in three spatial planes. Most of conventional orthodontic diagnosis provide only 2-dimensional representation of patient.<sup>12</sup>

Advanced technology gives high quality diagnostic information in three dimension which helps in developing magnification treatment plan for patients. Orthodontic diagnosis and treatment planning using digital dental models, the use of digital dental scans to get the real result of orthodontic treatment, and three-dimensional imaging of the dentofacial region give alternative options for patient documentation. High quality digital technology (MPC) possible. This method is self-sustaining all components can be bond layer by layer.<sup>13</sup>

**New findings in the biology of borderline personality disorder**

**Manuchnik, J., Schmahl, Ch., and Bohus, M. (2005). New findings in the biology of borderline personality disorder. Directions in Psychiatry 25, 197-215.**

Einfluss von Dissoziation auf emotionale Ablenkung bei Patientinnen mit Borderline-Persönlichkeitsstörung und gesunden Probandinnen - Neuropsychologie der BPS: Experimentelle Befunde und klinische Bedeutung

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Einfluss von Dissoziation auf emotionale Ablenkung bei Patientinnen mit Borderline-Persönlichkeitsstörung und gesunden Probandinnen – Neuropsychologie der BPS: Experimentelle Befunde und klinische Bedeutung

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Comorbidity of personality disorders and posttraumatic stress disorder

Comorbidity of personality disorders and posttraumatic stress disorder

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Modular psychotherapy - Rationale and basic concepts

European Psychiatry

Effectiveness of dialectical behavioral therapy for borderline personality disorder under inpatient conditions: A controlled trial and follow-up data

Effectiveness of dialectical behavioral therapy for borderline personality disorder under inpatient conditions: A controlled trial and follow-up data

M. Bohus

**Defining PROs for borderline personality disorder (BPD) is particularly challenging given the disorder's high symptomatic heterogeneity, high comorbidity with other psychiatric conditions, highly fluctuating symptoms, weak correlations between symptoms and functional outcomes, and lack of valid and reliable experimental measures to complement self-report data.**

To achieve the diagnosis, the patient must also exhibit significant levels of at least four pathological traits, including emotional lability, anxiousness, separation insecurity, and depression (from Neuroticism or Negative Affectivity in the Five Factor Model/Figure 1), impulsivity and risk taking (from Disinhibition), and hostility (from Antagonism). 8/15/2001/50292298 [Crossref], [Web of Science ®], [Google Scholar]KruegerRF,MarkonKE.Reinterpreting comorbidity: a model-based approach to understanding and classifying psychopathology.Annu Rev Clin Psychol.2006;21:1113/17716066 [Crossref], [Web of Science ®], [Google Scholar]MarkonKE,KruegerRF,WatsonD.Delineating the structure of normal and abnormal personality: an integrative hierarchical approach.J Pers Soc Psychol.2005;88:1391/5715631580 [Crossref], [Web of Science ®], [Google Scholar]WrightAGC,ThomasKM,HopwoodCJ,MarkonKE,KruegerRF.The structure of common mental disorders.Arch Gen Psychiatry.1994;51:1921/19321306661 [Crossref], [Web of Science ®], [Google Scholar]HegerlJ,SteinM,MulertC,et al.EEG-vigilance differences between patients with borderline personality disorder, patients with obsessive-compulsive disorder, and healthy controls.Eur Arch Psychiatry Neurol Sci.2008;258:137/143 [Crossref], [Google Scholar]HerpertzSC,DietrichTM,WenningB,et al.Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study.Biol Psychiatry. Scales assessing well-being, quality of life, and general functioning can be considered to be particularly close to the concept of PRO.Regardless of instrument, the agreement between data from self-report questionnaires and from clinical interviews in BPD is generally moderate and often higher than in other personality disorders. These features of the diagnosis render it less than optimal from a clinical management standpoint because many patients have more than one diagnosis and many patients with the same diagnosis display different symptoms. Thus PROs must be able to assess both the stable and dynamic features of BPD and related outcomes. However, this situation can also be seen as an opportunity to understand a person or construct more deeply, because test divergences may be important sources of information.38 For example, although self-report questionnaires and diagnostic interviews of BPD symptoms are not differentially valid, they tend to suggest different rates of BPD symptoms and are differentially able to predict certain kinds of outcomes. This is a sample. Understanding BPD from multiple angles is therefore likely to be a major theme of future research.As discussed above, a central problem in developing PROs for BPD is that its symptoms are heterogeneous, and rates of diagnostic co-occurrence are high across a range of conditions. Validated PRO methods can improve outcome measures by better taking into account the subjective view of patients, in addition to the more objective features of laboratory procedures or observer ratings.The term PRO was first used in the field of oncology, where patient reports refer to self-report measures of psychosocial outcomes that were used to complement medical outcome measures such as tumor mass, laboratory exams, and other biological data. This applies to both questionnaire findings and experimental procedures such as interpretation tests. Narrative42 and perceptual assessments43 provide a less direct means of observing the inner workings of the patient's mind, and thereby perhaps offer an alternative method for circumventing biases associated with direct questioning about symptoms. These differences may be clinically important. In addition, the methodology encourages researchers to use social games as diagnostic tool to improve personalization of psychotherapeutic and sociotherapeutic treatments.PRO refers to health data that are provided by the patient through a system of reporting. Again, the point is to show the variability in approaches that could be used to assess BPD-related PROs. Among these methods, direct verbal approaches such as diagnostic interviews and patient self-reports have been by far the most common in research and practice. 5th ed. New York, NY: McGraw-Hill;1980 [Google Scholar]GundersonJ.Borderline personality disorder: ontogeny of a diagnosis. Am J Psychiatry.2009;166:5 [Crossref], [Web of Science ®], [Google Scholar]KernbergO.Borderline personality organization. J Am Psychoanal Assoc.1967;15:641/6854861171 [Crossref], [Web of Science ®], [Google Scholar]GrinkerRR,WerbleB,DryeRC.The Borderline Syndrome: a Behavioral Study of Ego-Functions. Además se revisan los avances más prometedores para mejorar los PROs en el TPB, incluyendo la sección III del DSM-5, el enfoque de la recuperación, las evoluciones ecológicas momentáneas y las nuevas mediciones experimentales del funcionamiento social que se asocian con los resultados funcionales y sociales.LEs PRO (Patient reported outcomes o résultats déclarés par les patients) sont des mesures reflétant le point de vue subjectif des patients sur leur état de santé et leurs comportements. As a result, a multimodal approach is needed to provide comprehensive outcome measures for BPD. BPD patients exhibit poor memory regarding their most extreme mood changes, raising questions about the validity of retrospective questionnaires. Taken together, this type of measurement of social behavior based on game theory might be suitable to complement self-report assessments of social functioning with experimental measures. En este artículo se presenta una panorámica de las mediciones de resultados actualmente utilizadas en el TPB y se discuten desde perspectivas clínicas, psicométricas, experimentales y del paciente. Tipicamente, los PROs incluyen cuestionarios de autorreporte y entrevistas clínicas. PROs must be able to take this heterogeneity into account. These inconsistencies were limited to social game conditions and not found in nonsocial control experiments. The information is typically gathered by self-administered questionnaires completed by the patients themselves or patient interviews, emphasizing patients' views and feedback on their feelings, patients' needs, and patients' competencies as they are coping with psychiatric problems.Defining PROs for personality disorders, particularly BPD, is subject to major challenges:BPD is defined by heterogeneous clinical symptoms and may be best understood as generalized maladaptive personality. Although these methods have been useful in both clinical and research settings, there is a significant negative consequence of the over-reliance on such methods in the assessment of BPD. The second involves specific traits that underlie the disorder. Some research suggests that externally observable symptoms such as risky behavior are more valid when assessed by interviews, whereas more internal thoughts and feelings, such as emptiness, are more valid when assessed by questionnaires.39 Clinicians can marital these sorts of findings to maximize predictive validity via the use of multiple methods.Table II organizes several approaches to assessing psychological constructs and provides specific examples of each method for the assessment of BPD. Specifically, symptom endorsement rates tend to be higher by questionnaire than by interview, perhaps because it is easier for patients to acknowledge certain problems when they don't have to do so verbally to a person whom they do not know, or perhaps because clinicians are helpful in distinguishing symptoms from behaviors that are present but not symptomatic. We have shown in a pilot study32 that outcome dimensions related to the recovery approach such as personal growth, purpose of life and positive relationships with others may demonstrate important changes in patients with personality disorders from a patient perspective.A significant challenge in the assessment of BPD involves the potential for discrepancies between self-report and functional measures of PD that are confounded in DSM-IV criteria. In the most, recent version of DSM (DSM-5), a diagnosis of BPD is appropriate when at least 5 of 9 criteria are present: (i) avoidance of real or imagined abandonment, (ii) alternating extremes of idealization and devaluation, (iii) identity disturbance, (iv) impulsivity in at least two areas that are potentially self-damaging, (v) recurrent suicidal behavior; (vi) affective instability; (vii) chronic feeling of emptiness; (viii) intense and inappropriate anger and difficulty controlling it; and (ix) transient paranoid ideation or dissociative symptoms.The validity and specificity of BPD and its categorization in psychiatric classification systems is still a matter of debate. This distinction improves the clinical utility of diagnosis. In essence, DSM-5 Section III defines BPD as a combination of a particular personality constellation and a pattern of dysfunctional behavior, thus accounting for features of traits like neuroticism and symptoms of disorders such as BPD. Typically, PROs include self-report questionnaires and clinical interviews. As a prominent example, dialectical behavior therapy (DBT62) suggests that BPD patients suffer from emotional dysregulation, ie, they show excessive emotional reactions to any given emotional stimulus, and return to baseline more slowly than healthy people. This relative lack of consistency does not necessarily mean that the interview method is correct and the self-report is therefore inaccurate. While participants are engaging in normal daily activity, EMA uses a series of computer-based repeated assessments of current affective, behavioral and contextual experiences and physiological processes.31 While EMA is still in its infancy, real-time assessments of highly fluctuating affective and personality psychopathology have the potential to considerably improve the validity of PROs in BPD and other PDs. "Recovery" refers to a complex outcome concept used in psychiatric rehabilitation. In 1938, the American psychoanalyst Adolf Stern described most of the symptoms that have lead to the modern diagnosis of borderline personality disorder (BPD), using the expression "borderline group of neuroses."1 was of clinical importance because of the tendency of some patients to show "borderline" mental states of schizophrenia in unstructured situations. "Borderline" was an inconsistent significant information about well-being and functioning. Such basic dysfunctions are thought to build the basis of emotion-related BPD symptoms such as emotional instability or intense feelings of abandonment. Inconsistent social decision-making was associated with the experience of low social support,88 particularly in the trust and the punishment game. F. Overall, social behavior in BPD was not significantly different from healthy controls. For example, well-known biases associated with both BPD40 and with clinical diagnosis41 likely influence the information that is gained via diagnostic interviews, whereas other approaches are less susceptible to such biases. This emphasizes the importance of using other types of approaches to develop a more complete understanding of BPD. Such tests include psychophysiological assessments to assess basic emotional reactions, tests to assess (emotional) distractibility and inhibition (eg, Stroop test, (emotional) Go/NoGo tests, implicit association tests), and interpretation tests, to mention only some. Within the framework of the International Pilot Study of Schizophrenia, J. 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Kernberg described Borderline Personality Organization as a level of psychological functioning.4 Important features of this organization were primitive defenses like splitting, projective identification, identity diffusion, and difficulties in reality testing. Ecological Momentary Assessment (EMA) is a relatively new method that addresses this methodological problem. New York, NY: Basic Books;1968 [Google Scholar]BlairRJ,WhitesideSP,MeffertH,IwangoS.Disruptive behavior disorders: taking an RDoC(cis)h) approach. Curr Top Behav Neurosci.2013 [Epub ahead of print] [Crossref], [Google Scholar]NewsA,TriebwasserJ,CharneyDS, et al. Psychometric perspective on the latent construct of BPD.35 Nevertheless, certain methods have come to enjoy this kind of privileged status in the literature. However, as the methodological quality of studies improved (larger sample sizes; exclusion of patients with psychotropic medication; better matching procedures; inclusion of patient control groups in addition to healthy control groups; assessments with experimental procedures instead of self-ratings only), the picture became more complex and some hypotheses could also be rejected.With regard to impulse control, several well-controlled studies using different types of experimental inhibition paradigms found no differences between patients with BPD and healthy people when emotionally neutral stimuli are used.68,69 By contrast, patients with ADHD do show impaired inhibition as compared with healthy controls and BPD subjects in experimental tasks.70,71 Earlier findings of impaired impulse control in BPD may be alternatively explained by comorbid ADHD,72 a common comorbid disorder in people with BPD.73,74 Furthermore, BPD patients may display disinhibition particularly in the context of emotional stimuli 75,76 In sum, it is emotional reactivity and not simple distractibility that is diagnostic of BPD.With regard to emotion regulation, several studies did not find pathologically strong emotional reactions to stimuli which are not specifically related to BPD experiences such as trauma memories or childhood abuse.77,78 Attention to negative emotional stimuli as measured in tasks such as the emotional Stroop test, on the other hand, has been found to be stronger in BPD than in healthy people (review in ref 40). From a psychometric perspective, this practice violates a central tenet in psychometrics by confusing a latent variable (eg, BPD) for a particular measurement, approach to indicating that latent variable (eg, a score on a particular interview designed to measure BPD). PRO is used to denote health data that are provided by the patient through a standardized system of reporting. Finally, some research suggests that symptom reduction as measured by PROs for BPD does not track as well with functional improvements as might be assumed, and that other features of personality provide significant information about well-being and functioning. Such basic dysfunctions are thought to build the basis of emotion-related BPD symptoms such as emotional instability or intense feelings of abandonment. Inconsistent social decision-making was associated with the experience of low social support,88 particularly in the trust and the punishment game. F. 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sample. Press enter to open the dropdown list, then press tab and enter to close the dropdown. It should be noted that each of these methods is applied to the same level of support in the research literature. It is important to understand that the treatment of BPD usually suggests that particular basic dysfunctions build the foundation of BPD pathology. He proposed psychoanalysis as the way of treating it, and saw an important etiology in abandonment and poor early parenting. Glinker in 1968 described borderline patients in his book The Borderline Syndrome 5 as a specific disorder. This assessments are needed for both BPD symptoms as well as outcomes with which BPD may be associated.Self-report measures for BPD can be divided into eight different categories, including focal assessments of BPD symptoms, multidimensional assessments of BPD/DPD symptoms, multidimensional assessments of pathological traits, assessments of social functioning, assessments of distress, assessments of risky behavior, assessments of well-being, and general functioning. A promising paradigm that consists of economic decision theory and neuroeconomics, neuroeconomics has the power to objectify social interaction by using incentivized decisions from experimental economics.87 Complex social emotions such as trust or fear of punishment can be put in a mathematical function to model and understand social behavior.In a yet-unpublished study (Brändle, Preuss, Haynes, Fischbacher, Hasler), we conducted three social games, a trust game, a coordination game, and a punishment game. That being said, it would not be unusual for a person with high neuroticism to not meet the diagnostic criteria for BPD. However, when patient control groups (for example depressive controls) are included, they show similar disturbances as BPD patients to general negative stimuli.79.80In regard to cognitive emotional processes, BPD patients show a broader pattern of disturbances than in the other areas mentioned so far (review in ref 40). The information is gathered by self-administered questionnaires completed by the patients themselves or patient interviews, emphasizing the patient's views about their feelings or what they are able to do as they are dealing with chronic diseases or conditions. New Haven, CT: Yale University Press.1984 [Google Scholar]SamuelDB,WidigerTA.A meta-analytic review of the relationships between the five-factor model and DSM-IV-TR personality disorders: a facet level analysis.Clin Psychol Rev.2008;21(3):261-274.[Crossref],[Web of Science ®]. [Google Scholar]HopwoodC,MoreyL,DonnellanMB,et al.Ten-year rank-order stability of personality traits and disorders in a clinical sample.J Personal.2011;36(1):333-344.[Crossref],[Web of Science ®]. [Google Scholar]TyerP,CrawfordM,MulderR,et al.The rationale for the reclassification of personality disorder in the 11th revision of the International Classification of Diseases (ICD-11).Personal Ment Health.2011;5(2):462-475.[Crossref],[Web of Science ®]. [Google Scholar]LinehanM.Cognitive-Behavioral Treatment of Borderline Personality Disorder. Consequently, this dysfunction must be addressed in treatment. In psychiatry there is no a generally accepted definition of PRO. The quantitative trait perspective offers the view that personality and psychopathology attributes can be arranged in a more orderly fashion than is suggested by the categorical polythetic approach of the diagnostic manuals, and that rearranging them based on an evidence-based structure of such attributes provides solutions to problems such as co-occurrence and heterogeneity.47From this perspective, individual differences in personality and psychopathology can be organized in a hierarchical fashion (Figure 1). However, the agreement between most of these methods is understudied and typically poor; there is much work to be done. From a psychometric perspective, no particular tool or class of tools offer a privileged perspective on the latent construct. However the form of this model has been the subject of considerable debate. Nevertheless, there is consensus that PROs do not only include symptom-related measures but also functional outcomes, well-being, and quality of life.Developing PROs to assess BPD is associated with significant challenges. 2003/06/01/200317208218 [Crossref],[Web of Science ®]. [Google Scholar]SamuelDB,WidigerTA.Comparing personality disorder models: cross-method assessment of the FFM and DSM-IV-TR.J Pers Disord.2010;24(7):714-721.[Crossref],[Web of Science ®]. [Google Scholar]LoewingerJ.Objective tests as instruments of psychological theory.Psychol Rep.1957;36(3):694-704.[Web of Science ®]. [Google Scholar]JacobsbergL,PerryS,FrancesA.Diagnostic agreement between the SCID-II screening questionnaire and the personality disorder examination.J Pers Assess.1995;65(4):428-438.[Crossref],[Taylor & Francis Online],[Web of Science ®]. [Google Scholar]HopwoodC,MoreyL,EdelenMO,et al.A comparison of interview and self-report methods for the assessment of borderline personality disorder criteria.Psychol Assess.2008;20(1):81-90.[Crossref],[Web of Science ®]. [Google Scholar]BornsteinRF.Toward a process-focused model of test score validity: Improving psychological assessment in science and practice.Psychol Assess.2011;23(5):2544-21668126 [Crossref],[Web of Science ®]. [Google Scholar]VazireS.Who knows what about a person? Finally, there is significant potential in a number of cognitive and neuropsychological approaches that have been developed for basic research, such as basic laboratory tasks.44 EEG.45 or functional magnetic resonance imaging (fMRI).46Overall, the integration of multiple methods, such as those listed in Table II, would signify a more complex and complete understanding of the etiology and phenomenology of BPD. This list is not meant to be exhaustive, but rather to reflect the array of approaches one could take to diagnosing this construct and its related outcomes. Similarly it has been speculated that BPD patients are not able to control their impulses, maybe similarly to people with frontal brain damage or ADHD, given their problems with impulsive behavior.62 More cognitively based psychotherapy approaches pronounce the role of early negative relationship experiences and suggest that BPD patients show particularly negative beliefs about themselves and others, which may lead to dysfunctional emotions and reactions.63,64 It should be noted that we do not have reliable measures for all these complex constructs.However, throughout the last decade an increasing number of experimental studies have been conducted to test such assumptions. However, we found that BPD patients were significantly more inconsistent in social decision-making over the rounds than healthy controls and depressed patients. In addition, we review the most promising leads to improve BPD PROs, including the DSM-5 Section III, the Recovery Approach, Ecological Momentary Assessments, and novel experimental measures of social functioning that are associated with functional and social outcomes.El resultado percibido por el paciente (PRO) se refiere a las medidas que enfatizan la perspectiva subjetiva de los pacientes acerca de sus condiciones y conductas relacionadas con la salud. As a consequence, we have avoided using the terms "objective" and "subjective." Instead we constrain our language to be purely descriptive, for instance we refer to self-report measures as "questionnaires" and to measures involving standardized tasks with assessor-manipulated stimuli as "experimental."Our specific focus in this paper is on patient-reported outcomes or patient-reported outcome measures (PROs/PROMs). Here, we provide an overview of currently used BPD outcome measures and discuss them from clinical, psychometric, experimental, and patient perspectives. As a diagnostic term, "borderline" was first mentioned by the English psychiatrist C. For example, both self-report and interview methods are biased by the patient's acute state.29 Rather, it demonstrates that the two methods reflect slightly different aspects of BPD and underlies the importance of PROs in studies of BPD.An important limitation of current self-report assessment methods is the fact that BPD patients demonstrate poor memory regarding their extreme mood changes.30 which raises questions about the validity of using retrospective questionnaires as outcome measures in BPD. For the trust and the punishment game, a social and a nonsocial or control condition were applied. BPD patients, MDD patients, and healthy controls were playing with real people randomly assigned to each round. As a result, PROs must include broad assessments of psychopathology.Various methods available to assess personality psychopathology do not always agree well with one another. Criterion A reflects the specific behaviors that might be the targets for change, whereas Criterion B reflects the personality context underlying these behaviors. This kind of nuance is consistent with the underlying principles of the PRO approach.The International, Statistical Classification of Diseases (ICD) seems to be moving in a similar direction, albeit with a somewhat less complex system.61 Although this seems to be the form that personality disorders will increasingly take in the future, the ICD-11 and DSM-5 models do not align perfectly, and there continues to be significant debate in the PD literature about the optimal way to organize this content. Nous présentons dans cet article une synthèse des résultats des mesures actuelles pour la personnalité borderline et les analyses sur le plan clinique, psychométrique et expérimental et du point de vue du patient. Springfield, IL: Thomas;1967 [Google Scholar]LivesleyW,JangKL,VernonPA.Phenotypic and genetic structure of traits delineating personality disorder.Arch Gen Psychiatry.1998;55(9):949-956.[Crossref],[Web of Science ®]. [Google Scholar]WidigerTA,TrullTJ.Plate tectonics in the classification of personality disorder: shifting to a dimensional model.Am Psychol.2007;62(7):718-724.[Crossref],[Web of Science ®]. [Google Scholar]American Psychiatric Association.Diagnostic and Statistical Manual of Mental Disorders. This relates, for example, to the interpretation of other people's intentions, to the experience of being excluded by others.44 and to beliefs about the self, others, and the world.63,81,82 BPD people experience others as malevolent, powerful, and rejecting, and themselves as weak, dependent, and rejected. New York, NY: Guilford Press;1993 [Google Scholar]ArntzA,DreessenL,SchoutenL,WeertmanA.Beliefs in personality disorders: a test with the Personality Disorder Belief Questionnaire.Behav Res Ther.2004;42(12):1215-1225.[Crossref],[Web of Science ®]. [Google Scholar]ButlerAC,BrownGK,BeckAT,GrishamJR.Assessment of dysfunctional beliefs in borderline personality disorder.Behav Res Ther.2002;40(12):1240-12375731 [Crossref],[Web of Science ®]. [Google Scholar]BerlinHA,RollsET,IversenSD.Borderline personality disorder, impulsivity, and the orbitofrontal cortex.Am J Psychiatry.2005;162(23):3713-3716.[Crossref],[Web of Science ®]. 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Hughes in 1984 in his article "Borderland Psychiatrists Records" for a symptom cluster that was not categorizable purely as "neurosis" or "psychosis."Sigmund Freud provided a description of symptoms, today seen as typical for the diagnosis of borderline personality disorder, but referred to them as a subgroup of hysteria. Our focus is on how to assess the symptoms of BPD. There is growing evidence that all assessment methods have both objective and subjective components. This concept fits well with the personality trait research to which we will be referring below.In contrast, R. For example, informant report data offer one way to address issues of patient and clinician bias by getting the perspective of someone who regularly observes the patient's behavior.14 EMA31 address issues related to retrospective bias because the patient reports their experiences in real time in their actual lives; this approach also provides a very rich source of information about, how pathological dynamics play out over time. Therefore, these type of tests might be a candidate for more experimental assessments within clinical trials.

17/12/2018 · Definition. Intellectual disability (intellectual developmental disorder) as defined by the World Health Organization (WHO), the American Association for Intellectual and Developmental Disabilities (AAIDD), and the Diagnostic and Statistical Manual of Mental Disorders, all include as criteria, a significant impairment in general cognitive functioning, ... The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association (APA). In the United States, the DSM serves as the principal authority for psychiatric diagnoses. Treatment recommendations, ... Moved Permanently. The document has moved here. 24/01/2022 · Poalim Online The Jerusalem Post Customer Service Center can be contacted with any questions or requests: Telephone: \*2421 \* Extension 4 Jerusalem Post or 03-7619056 Fax: 03-5613699 E-mail: ...

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