WEAVE SPRINT . PAPER II

Personality disorders

The personality disorders in one document: the general criteria that gate every diagnosis, the ICD-11 dimensional model of severity and trait domains set against the DSM-5 categorical clusters and their ten types, the disorders by cluster from paranoid to anankastic with borderline at the centre, the borderline-versus-bipolar-II differential, and the treatment block led by structured psychotherapy (dialectical behaviour therapy, schema therapy, mentalisation-based and transference-focused work) with symptom-targeted medication only, anchored on the NICE, Indian and WFSBP guidance.

CONTENTS

- Framework and classification
- The personality disorders by cluster
- Aetiology, assessment and treatment
- Apply and consolidate

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PAPER II

Personality disorders: framework, types and treatment

Three sections . one complete notes document

This material gathers the personality disorders into one document, first the framework and the classification, then the disorders themselves, then how they are assessed and treated. The first band is **the framework and classification**: the definition and the general diagnostic criteria that must hold before any type is named, the ICD-11 dimensional model that abolished the categorical types for a severity gradient and a set of trait domains, the DSM-5 categorical clusters and their ten types with the alternative hybrid model alongside, and the comparison of the two approaches. The second band is **the personality disorders by cluster**: the cluster A odd and eccentric disorders, borderline personality disorder as the highest-yield type with its features, course and complications, antisocial personality disorder and its forensic significance, the histrionic and narcissistic disorders, the cluster C anxious and fearful disorders, and the borderline-versus-bipolar-II differential that examiners return to. The third band is **aetiology, assessment and treatment**: the genetic, neurobiological and developmental aetiology and the Linehan biosocial model, the assessment instruments and structured interviews, and the treatment block, dialectical behaviour therapy, schema therapy, mentalisation-based and transference-focused psychotherapy, the symptom-targeted pharmacotherapy, and the integrated borderline plan. The examinable skill is the safe, guideline-anchored diagnosis and treatment of each disorder: which criteria gate a personality-disorder diagnosis, how the classification shifted and why exams still test the categorical names, which disorder behind which presentation, the borderline-versus-bipolar-II boundary, which structured psychotherapy for which patient, and the rule that a drug is not the first-line treatment for borderline personality disorder.

HOW TO USE THESE NOTES

Read the three bands as one continuous account of how the personality disorders are classified, recognised and treated. The **framework and classification** band builds the frame: the general criteria that gate every diagnosis, the headline nosology shift where ICD-11 replaced the categorical types with a dimensional model of severity and trait domains, the DSM-5 categorical clusters and their ten types cross-mapped, and why exams still test both. The **personality disorders by cluster** band teaches the disorders themselves, cluster A, borderline personality disorder in full, antisocial personality disorder and its forensic frame, the histrionic and narcissistic disorders, cluster C, and the borderline-versus-bipolar-II differential. The **aetiology, assessment and treatment** band teaches the aetiology and the Linehan biosocial model, the assessment instruments, and the treatment block, where structured psychological therapy is primary and dialectical behaviour therapy, schema therapy, mentalisation-based and transference-focused psychotherapy are owned and fully taught here. Every management recommendation is guideline-anchored, led by NICE with the Indian Psychiatric Society and WFSBP positions stated, on the where-to-treat, target-by-phase, modes-of-treatment spine; every named disorder ends with a **Good to remember** box giving the defining criterion, the discriminator and the first step, and every named therapy ends with one giving the mechanism, the indication and the signature caution. Figures declare one axis and code it in colour: **petrol** marks structure and the neutral case, **coral** marks the trap or the danger, and **marigold** highlights the number to hold. Several boundaries are stated up front and cross-referenced by chapter name: the deep pharmacology of the mood stabilisers, low-dose antipsychotics and serotonin reuptake inhibitors used in symptom-targeted treatment is taught in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes; the bipolar-II side of the differential in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; the forensic frame of antisocial personality disorder in the Mental health legislation and forensic psychiatry notes; the complex-PTSD boundary in the Anxiety, OCD and trauma-related disorders notes; the schizotypal-versus-schizophrenia boundary in the Schizophrenia: aetiology, phenomenology, classification and course notes; and the wider psychotherapy models in the Psychotherapies, clinical assessment, MSE and nosology notes. This is doctor-facing revision, so the full technical vocabulary is used, brand names lead with the Indian brand, and every criterion, trait domain, cluster mapping, severity anchor, dose and guideline rule is verified against a source or omitted and flagged.

Framework and classification

1 . Definition, concept and general diagnostic criteria

Why this leads the chapter. Every personality-disorder question turns on one gate that most candidates skip. Before any of the ten named types can be diagnosed, a set of **general diagnostic criteria** must ALL hold: an **enduring pattern** of inner experience and behaviour that is **pervasive and inflexible**, deviates markedly from the person's culture, begins by adolescence, is stable over time, is not better explained by another disorder or a substance, and causes clinically significant impairment or distress. A personality disorder is not diagnosed by pattern-matching a vignette to a type; it is diagnosed by first clearing this general threshold and only then asking

which type fits. Get the gate right and the whole family, however you later classify it, becomes a disciplined exercise; get it wrong and you will pin a lifelong label on a situational mood state.

This fragment sets the **definition of personality disorder**, walks the six-part general threshold criterion by criterion, and isolates the four features an examiner rewards: the **ego-syntonic** quality, the trait-versus-state caution, the cultural reading, and the rule that no type is named until the general criteria are met. The accompanying figure lays the same content out as a general-criteria decision map to be carried as one image. The forward split into the ICD-11 dimensional model and the DSM-5-TR categorical clusters is developed in the topics that follow; the borderline-versus-bipolar-II boundary is cross-referenced to the Mood disorders: classification, depressive & bipolar syndromes, neurobiology notes, the forensic weight of antisocial personality disorder to the Mental health legislation & forensic psychiatry notes, the complex-PTSD boundary to the Anxiety, OCD & trauma-related disorders notes, and the wider technique of the psychological therapies to the Psychotherapies, clinical assessment, MSE & nosology notes.

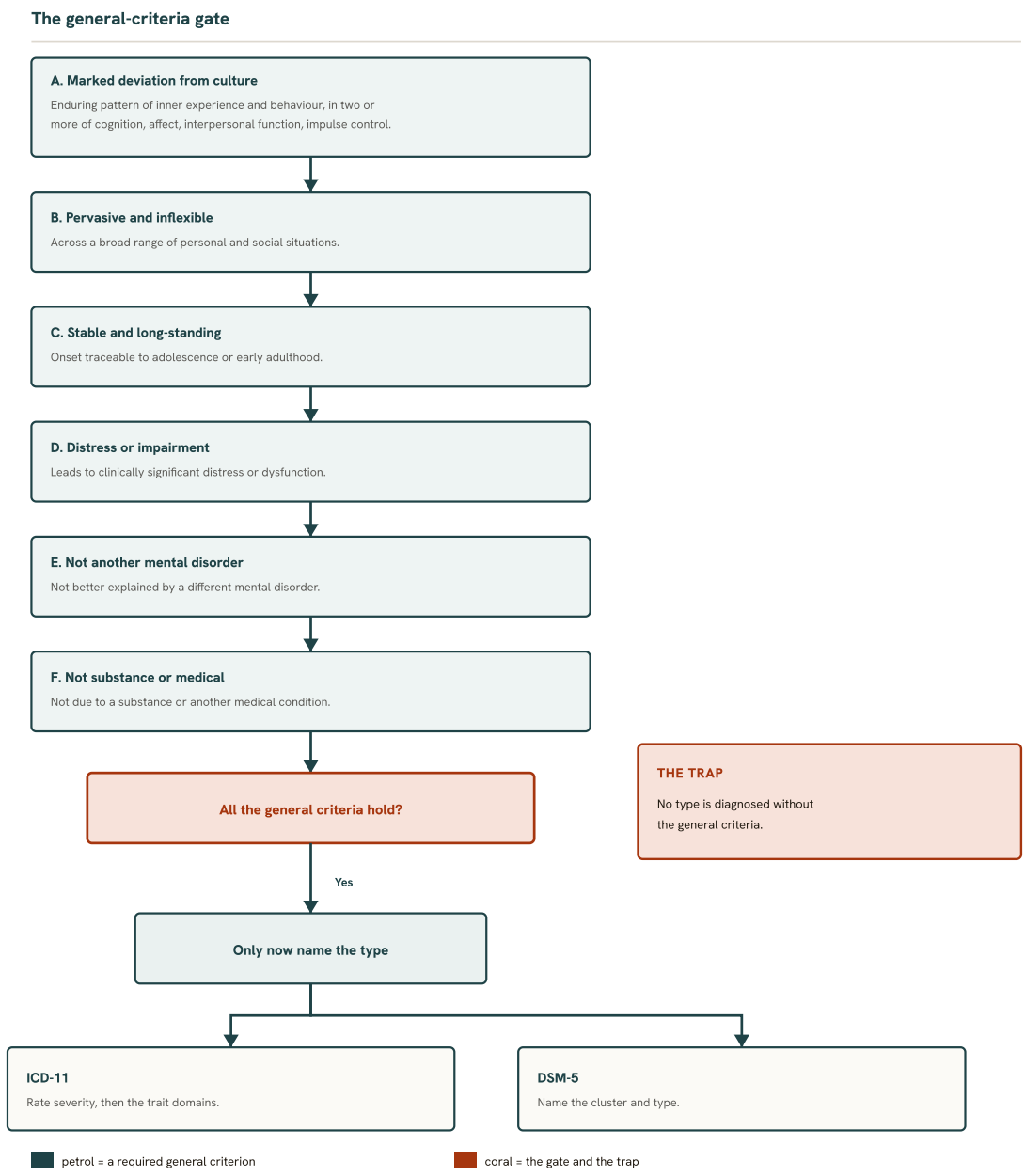


Fig 16.1 The general criteria for a personality disorder are a gate: the pattern must be enduring, pervasive and inflexible, deviate from cultural expectation, begin by adolescence or early adulthood, cause distress or impairment, and not be better explained by another disorder or a substance before any specific type is named.

1.1 Personality, trait, and what makes a disorder

A disorder is the maladaptive extreme of a normal continuum. Personality is the characteristic, deeply ingrained pattern of perceiving, relating to and thinking about oneself and the environment (DSM-5-TR). *Personality traits* are the normal, prominent aspects of that pattern; they become a disorder only when they are inflexible and maladaptive and cause significant functional impairment or subjective distress (DSM-5-TR). That single hinge, from normal-but-prominent to inflexible-and-impairing, is the working **definition of personality disorder**. The concept has a long descriptive spine: Kurt Schneider defined the abnormal (psychopathic) personalities as those who suffer from their abnormality or make society suffer, dissolving the older moral reading into a clinical one. ICD-11 phrases the modern definition as a

marked disturbance in personality functioning, with the central manifestations being impairments in aspects of the *self* (identity, self-worth, capacity for self-direction) and in *interpersonal* functioning (forming and keeping close relationships, understanding others, managing conflict). Hold both halves, self and other, because the dimensional model that follows is built on exactly this pair.

PEARL

The two manuals fight over how to sub-type personality pathology but barely differ on what it *is*: DSM-5-TR and the ICD systems give very similar GENERAL definitions of personality disorder, each locating the core pathology in cognition about self and others, emotional experience and regulation, interpersonal relating and behavioural control (Companion). Learn the general definition once; it survives every classification change.

1.2 The general diagnostic criteria: the six-part gate

All six must hold before any type. The DSM-5-TR general personality disorder criteria are the cleanest checklist to memorise, and the ICD equivalents map onto them almost one to one. They run: an enduring pattern deviating markedly from cultural expectation, shown in at least two areas of functioning (Criterion A); the pattern is inflexible and pervasive across situations (B); it causes clinically significant distress or impairment (C); it is stable and long-standing with onset traceable to adolescence or early adulthood (D); it is not better explained by another mental disorder (E); and it is not due to a substance or another medical condition (F). Reproduce the block as one table; this is the highest-yield single object in the chapter.

CRITERION	WHAT IT REQUIRES
A - Pattern and areas	**An enduring pattern of inner experience and behaviour deviating markedly from the person's culture, shown in two or more of four areas: cognition, affectivity, interpersonal functioning, impulse control**
B - Pervasiveness	The pattern is inflexible and pervasive across a broad range of personal and social situations
C - Impairment	It leads to clinically significant distress or impairment in social, occupational or other important functioning
D - Onset and stability	The pattern is stable and of long duration, with onset traceable back at least to adolescence or early adulthood
E - Not another disorder	Not better explained as a manifestation or consequence of another mental disorder
F - Not organic or substance	Not attributable to the physiological effects of a substance or another medical condition (for example head trauma)

The DSM-5-TR general criteria for a personality disorder (A to F); the ICD-11 essential features map closely onto the same requirements.

RULE **Clear the gate, then name the type.** No specific personality disorder is diagnosed unless every general criterion (enduring, pervasive and inflexible, culturally deviant, onset by adolescence, impairing, and not better explained) is first satisfied. The type is a sub-question that only opens once the gate is passed.

1.3 The four channels of deviation (Criterion A)

Two or more of four must be involved. Criterion A is not satisfied by trouble in one domain of life; the enduring pattern must show up in **two or more of the four** channels below. Learning these four is what lets you defend a diagnosis, because they force you to demonstrate that the disturbance is broad rather than a single symptom.

Cognition

Ways of perceiving and interpreting self, other people and events (for example pervasive suspiciousness, or a chronically fragile self-image).

Affectivity

The range, intensity, lability and appropriateness of emotional response (for example constricted flat affect, or rapidly reactive mood).

Interpersonal functioning

The characteristic pattern of relating (for example detachment and avoidance, or intense and unstable relationships).

Impulse control

The regulation of urges and behaviour (for example recurrent recklessness, aggression or self-damaging impulsivity).

1.4 Enduring, pervasive and inflexible, with onset by adolescence (Criteria B and D)

Trait-like breadth and lifelong reach are what separate a disorder from an episode. The words are load-bearing. *Enduring* and *stable* mean the pattern has run for years, not weeks; ICD-11 asks for a disturbance persisting over an extended period, typically two years or more. *Pervasive and inflexible* mean it holds across a broad range of personal and social situations rather than being triggered by one relationship or setting, and that the person cannot flex out of it when circumstances change. *Onset by adolescence* or early adulthood means the roots are developmental: an **enduring pattern** that first appears in mid or late adult life is a red flag for a personality change due to another medical condition or an unrecognised substance use disorder, not a primary personality disorder (DSM-5-TR). A pattern that is genuinely pervasive and inflexible with onset by adolescence is the developmental signature you are hunting for.

1.5 Deviation from cultural expectation (the cultural criterion)

The yardstick is the person's own culture, not the clinician's. Criterion A demands **deviation from cultural expectation**: the pattern must depart markedly from what the individual's *own* culture expects in cognition, affect, relating and impulse control. DSM-5-TR is explicit that personality disorder must not be confused with problems of acculturation after migration, or with habits, customs, and religious or political values rooted in the person's background; behaviour that looks rigid or dysfunctional may in fact be an adaptive response to real cultural

constraints. This is not a soft caveat but part of the criterion itself, and it is where cross-cultural over-diagnosis happens.

TRAP **Reading personality through one culture's norms.** Scoring deference, family-embeddedness, religiously framed experience or protest that risks the person's own safety as pathological dependence, oddness or callousness, when it is normative in their community, converts a cultural difference into a false diagnosis. Judge deviation against the patient's culture, with an informant if needed.

1.6 Impairment or distress, and the two exclusions (Criteria C, E and F)

Deviance alone is not a disorder. A culturally deviant, enduring, pervasive pattern still is not a personality disorder unless Criterion C is met: it must cause clinically significant **impairment or distress** in social, occupational or other important functioning. Many people have marked, inflexible traits and function well; without the impairment or distress they carry a personality *style*, and ICD-11 formalises this as personality difficulty (QE50.7), a factor influencing health status rather than a mental disorder. The final two criteria are exclusions that protect against mislabelling: the pattern must not be better explained by another mental disorder (E), and must not be attributable to a substance or medical condition such as head trauma (F).

COMMON TRAP

The mirror error to over-diagnosis: reading the enduring interpersonal and cognitive changes of a chronic Axis I illness (long-standing depression, an anxiety disorder, early psychosis, a frontal lesion or ongoing substance use) as a personality disorder. Criteria E and F exist precisely to catch this. If a supposedly lifelong pattern in fact tracks the course of another disorder or a drug, the personality label is wrong.

1.7 The ego-syntonic quality, and trait versus state

The patient rarely complains of the very thing you are diagnosing. Classically the abnormal personality traits are **ego-syntonic**: they are experienced as part of the self and are not felt as problematic, in sharp contrast to the ego-dystonic symptoms of the neurotic disorders, which distress the patient and drive help-seeking. Two consequences follow. First, people with a personality disorder often do not present for the personality disorder itself, but for a comorbid depression, anxiety or crisis, so the diagnosis is easy to miss and easy to make only from collateral history. Second, and the single commonest error, the traits must be distinguished from *states*: features that emerge in response to a specific situational stressor or a transient mental state (a mood episode, an anxiety disorder, or substance intoxication) are not personality (DSM-5-TR). Because the pattern is developmental, in a person under eighteen the features must have been present for at least one year before a personality disorder is diagnosed, and antisocial personality disorder is never diagnosed before eighteen (DSM-5-TR), a rule with direct medico-legal force.

TRAP **Calling a state a trait.** The affective lability, impulsivity and stormy relationships of an acute mood episode, an intoxication or a fresh crisis are not a personality disorder unless the same pattern is enduring, pervasive and predates the current state. Diagnose personality when the patient is at baseline, not mid-storm.

INDIA

Personality disorders are substantially under-recognised in Indian practice, and the ego-syntonic quality is a large part of why: patients present for the comorbid depression, self-harm or family conflict, not for the personality pattern, so it is recorded only when it is actively looked for. Two further Indian angles are genuine. The cultural criterion bites hardest here: deference, joint-family interdependence and religiously framed experience are normative and must not be read as dependent, avoidant or odd pathology. And the disorder-specific psychotherapies are arriving but unevenly available: dialectical behaviour therapy and schema therapy are being delivered and culturally adapted at Indian tertiary and private centres rather than being widely accessible, which shapes what a realistic management plan can offer. The forensic reading of antisocial personality disorder in the Indian court context is carried in the Mental health legislation & forensic psychiatry notes.

1.8 The rule that governs the whole chapter, and the forward map

General criteria first; classification second. With the gate cleared, the chapter splits into two ways of describing what lies beyond it, both cross-mapped in the topics that follow. DSM-5-TR keeps the familiar *categorical* system: the ten types grouped into three clusters (A odd or eccentric, B dramatic or erratic, C anxious or fearful), plus a Section III alternative hybrid model. ICD-11 takes the opposite route, abolishing the categorical types for a *dimensional* model that rates a severity level first and then adds trait-domain qualifiers and an optional borderline pattern. Whichever framework an examiner uses, it is downstream of the same general criteria you have just cleared. The ten categorical types are worth carrying as a single skeleton from the outset.

CLUSTER	TYPE	DESCRIPTOR
A	Paranoid	Odd or eccentric
A	Schizoid	Odd or eccentric
A	**Schizotypal**	Odd or eccentric (schizophrenia-spectrum edge)
B	Antisocial	Dramatic, emotional or erratic
B	**Borderline**	Dramatic, emotional or erratic
B	Histrionic	Dramatic, emotional or erratic
B	Narcissistic	Dramatic, emotional or erratic
C	Avoidant	Anxious or fearful
C	Dependent	Anxious or fearful
C	Anankastic (obsessive-compulsive)	Anxious or fearful

The three DSM-5-TR clusters and ten categorical types; ICD-11 abolishes these types for a dimensional model, developed in the topics that follow.

WORKED EXAMPLE

A woman in her twenties is referred after an overdose following a break-up, described as having "borderline personality disorder". You do not accept the label yet; you run the gate. Is the pattern of stormy relationships, identity instability and impulsivity *enduring* and traceable to adolescence, or does it date from a recent depressive episode (Criterion D, and E)? Is it *pervasive* across settings, or confined to one relationship (B)? Does it cause impairment at baseline, not only in crisis (C)? Only when every general criterion holds do you move to the type-specific criteria. If the pattern proves to be a first depressive episode with situational distress, you have prevented a lifelong misdiagnosis.

GOOD TO REMEMBER

- **Personality disorder (general):** defining requirement is an enduring pattern of inner experience and behaviour, pervasive and inflexible, deviating markedly from cultural expectation in two or more of cognition, affectivity, interpersonal functioning and impulse control, with onset by adolescence, causing impairment or distress, and not better explained by another disorder, a substance or a medical condition. Discriminator from a personality *style*: the impairment or distress (Criterion C); ICD-11 codes the style short of this as personality difficulty. First diagnostic step: clear all the general criteria before naming any type.

1.9 The master hook for the whole chapter

One scaffold to reassemble the day. The chapter has four countable skeletons: the clusters and types, the ICD-11 trait domains, the borderline criterion count, and the core skills therapy. Carry them as one mnemonic now and every later topic hangs off it; the pieces are paid off in full at consolidation.

MNEMONIC

MAD BAD SAD, FIVE DOMAINS, NINE-FOR-FIVE, FOUR TO COPE

MAD BAD SAD are the three clusters holding the ten types: *mad* = Cluster A odd or eccentric (Paranoid, Schizoid, Schizotypal); *bad* = Cluster B dramatic or erratic (Antisocial, Borderline, Histrionic, Narcissistic); *sad* = Cluster C anxious or fearful (Avoidant, Dependent, Anankastic). **FIVE DOMAINS** are the ICD-11 trait qualifiers, hooked as *New Dogs Do Dig Antiques*: Negative affectivity, Detachment, Dissociality, Disinhibition, Anankastia (plus the optional borderline pattern). **NINE-FOR-FIVE** is borderline personality disorder, defined by **five or more of the nine** criteria. **FOUR TO COPE** is dialectical behaviour therapy and its four skills modules (mindfulness, interpersonal effectiveness, emotion regulation, distress tolerance). Four numbers, and the chapter rebuilds from one line.

3	10	5	4
DSM-5-TR CLUSTERS	CATEGORICAL PERSONALITY TYPES	ICD-11 TRAIT DOMAINS	DBT SKILLS MODULES

HOLD THIS

The general diagnostic criteria are a gate, not a description: an enduring, pervasive and inflexible pattern, deviating from cultural expectation, with onset by adolescence, causing impairment or distress, and not better explained otherwise, must all hold before any specific personality-disorder type is diagnosed.

2 · ICD-11 dimensional classification: severity and trait domains

Why this matters. This is the single highest-yield nosology point of the personality-disorders chapter, and the examiner knows it. The **ICD-11 dimensional** system did something no previous classification dared: it **abolished the categorical personality-disorder types altogether**. There is no ICD-11 code for paranoid, schizoid, dissocial, histrionic, anankastic, avoidant or dependent personality disorder. In their place stands a model that first rates **severity** and then, optionally, describes style. Get the architecture of that model straight, the severity gradient that leads and the five trait domain qualifiers that follow, and you can answer almost any framework stem the paper sets.

The governing idea is a reversal of habit. The old question was "which type is this?"; the ICD-11 question is "how severe is the personality dysfunction, and what is its flavour?". Severity is rated **first and leads** because the degree of disturbance in self and interpersonal functioning predicts outcome, service need and risk far better than any type label ever did (ICD-11 CDDR; New Oxford Textbook of Psychiatry). The alternative model of personality disorders in DSM-5-TR Section III (the hybrid AMPD) and the retained DSM-5-TR categorical clusters are cross-mapped here so the two systems can be held side by side, and a legacy ICD-10 box records exactly what was removed and why the categorical names still get tested. The accompanying figure lays the whole model out as one object: the severity gradient down one axis and the trait-domain qualifiers across the other, with the borderline pattern qualifier hung off to the side.

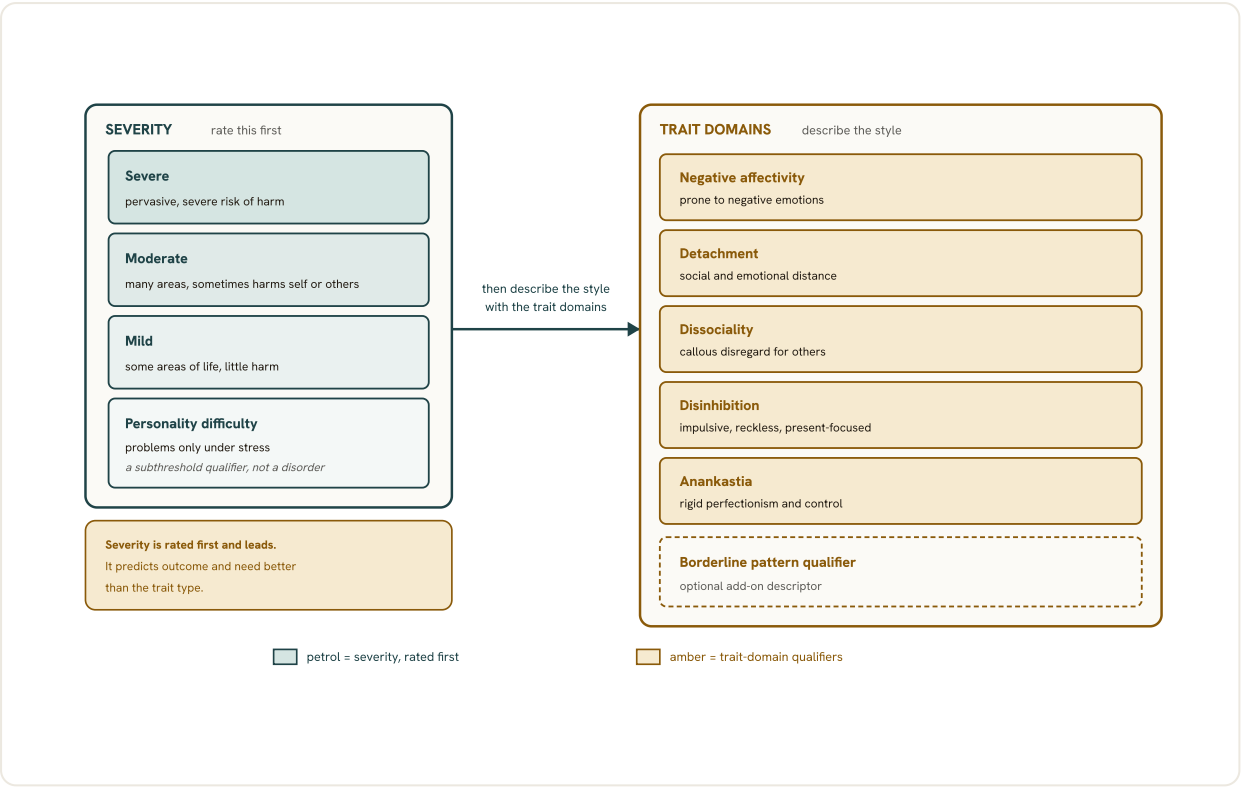


Fig 16.2 The ICD-11 model abolished the categorical types: rate severity first (personality difficulty, then mild, moderate or severe on a harm gradient), then describe the style with the five trait-domain qualifiers, negative affectivity, detachment, dissociality, disinhibition and anankastia, plus the optional borderline pattern qualifier.

2.1 The headline shift: types out, a dimensional model in

The ICD-11 dimensional model replaces the entire list of named types with a single diagnostic pathway (ICD-11 CDDR, grouping 6D10 to 6D11). You confirm the general criteria of a personality disorder (an enduring, pervasive, inflexible pattern of the self and of relationships, deviating from cultural expectation, with onset by adolescence or early adulthood and causing distress or impairment, all taught in the general-framework topic alongside), and then you make three moves in order. **First, rate severity** on a graded scale. **Second, add any of the five trait-domain qualifiers** that best describe the style of the disturbance. **Third, add the borderline pattern qualifier** if that specific picture is present. The type has vanished; the diagnosis is now a severity level plus a set of descriptive qualifiers. This is why the model is called dimensional rather than categorical: personality pathology is placed on continua of severity and trait, not sorted into boxes.

RULE **Severity is rated first and leads.** In the ICD-11 personality classification the degree of self-and-interpersonal dysfunction, not the type, is the primary axis, because severity predicts outcome and need better than any category.

2.2 How severity is defined, and why it carries the weight

Severity is judged on two linked capacities and one consequence. The capacities are **self functioning** (the stability and accuracy of identity, self-worth, self-direction and self-view) and **interpersonal functioning** (the desire and ability to form and sustain relationships, to grasp others' perspectives, and to manage conflict). The consequence is the associated **risk of harm** to self or others together with the breadth of functional impairment (ICD-11 CDDR). The rater asks

how pervasively these are disturbed, across how many domains of life, and with what danger attached. That single graded judgement then does the work the ten separate type-diagnoses used to do. The empirical case, built by Tyrer and the ICD-11 working group, is that the old categories overlapped so heavily that "type" was unreliable, whereas a simple severity rating tracks concurrent and prospective impairment robustly (New Oxford Textbook of Psychiatry).

PEARL

The reason severity leads is not administrative tidiness but prediction. Across longitudinal data the *severity* of personality dysfunction, more than its stylistic type, forecasts self-harm, suicide risk, service use, relationship breakdown and occupational failure. Rate severity well and you have already said the most prognostically useful thing about the patient.

2.3 The severity gradient: personality difficulty, then mild, moderate and severe

The gradient has a subthreshold rung and three disorder rungs. Personality difficulty (coded QE50.7, and deliberately placed not among the mental disorders but in the chapter on factors influencing health status) is **not a diagnosis of disorder**: it flags pronounced personality features that colour presentation or treatment without reaching the threshold. Above it sit mild personality disorder (6D10.0), moderate personality disorder (6D10.1) and severe personality disorder (6D10.2), separated by how many areas of functioning are affected and how much harm attaches. The table is the object to memorise; the highlighted cell in each row is the feature that fixes that level against its neighbours.

LEVEL (ICD-11 CODE)	SELF AND INTERPERSONAL FUNCTIONING	HARM AND IMPAIRMENT
Personality difficulty (QE50.7)	Pronounced features below the disorder threshold; some relevance to health or treatment	**Not a mental disorder; a health-status qualifier, not a diagnosis**
Mild personality disorder (6D10.0)	**Some areas of functioning affected, others spared; many relationships and expected roles still maintained**	Usually not associated with substantial harm to self or others
Moderate personality disorder (6D10.1)	**Marked problems in most relationships and most expected role functions; most areas of functioning affected**	May be associated with harm to self or others
Severe personality disorder (6D10.2)	**Severe disturbance of the sense of self (identity unstable or incoherent) and of nearly all relationships**	High risk of harm to self or others; severe functional impairment

The ICD-11 severity gradient: the subthreshold rung plus three disorder levels, read by degree of self-and-interpersonal dysfunction and attached risk of harm.

2.4 The five trait-domain qualifiers: describing the style once severity is set

Once severity is rated, one or more **trait-domain qualifiers** (postcoordinated codes 6D11.0 to 6D11.4) describe the prominent style of the disturbance. Each trait domain is a broad dimension,

not a type; a patient may carry several. The five, verbatim in construct, are set out below. Note the mnemonic order and hold them as a closed set: a sixth invented domain, or a missing one, is the classic slip.

Negative affectivity (6D11.0)

A tendency to experience a broad range of negative emotions (anxiety, anger, self-loathing, emotional lability, mistrust).

Detachment (6D11.1)

A tendency to maintain interpersonal and emotional distance: social withdrawal, aloofness, limited emotional expression and experience of pleasure.

Dissociality (6D11.2)

Disregard for the rights and feelings of others; self-centredness and lack of empathy, with grandiosity or callousness.

Disinhibition (6D11.3)

Acting rashly and impulsively on immediate stimuli, without consideration of consequences; recklessness and poor planning.

Anankastia (6D11.4)

A rigid focus on one's own and others' standards, commonly shown as perfectionism and emotional and behavioural constraint.

MNEMONIC

"N, then D-D-D, then A"

The five ICD-11 trait domains in order: **N**egative affectivity, then the three D's, **D**etachment, **D**issociality, **D**isinhibition, and finally **A**nankastia. The three D's are easy to muddle, so anchor them: detachment is *distance*, dissociality is *disregard for others*, disinhibition is *daring impulsivity*. The borderline pattern is a sixth token that sits apart, an optional add-on qualifier, not one of the five domains.

2.5 The borderline pattern qualifier: the one pattern that survived

The single named picture the ICD-11 kept is the borderline pattern qualifier (6D11.5), added for clinical utility and continuity with a large treatment literature (ICD-11 CDDR). It is an **additional qualifier**, not a type and not a trait domain, and it typically overlaps the domains (especially negative affectivity and disinhibition). It marks a pervasive pattern of instability of interpersonal relationships, self-image and affect together with marked impulsivity, defined by **five or more of the nine** features: frantic efforts to avoid abandonment; unstable, intense relationships that swing between idealisation and devaluation; identity disturbance; impulsivity that is potentially self-damaging; recurrent self-harm or suicidal behaviour; affective instability; chronic emptiness; inappropriate intense anger; and transient stress-related paranoid ideation or dissociation (Kaplan & Sadock CTP 2024). The threshold and the nine features are the same set the DSM-5-TR uses for borderline personality disorder, which is why the borderline construct crosses cleanly between the systems while the other types do not. The boundary with complex post-traumatic

stress disorder, a distinction ICD-11 sharpened by introducing both, is drawn in the Anxiety, OCD and trauma-related disorders notes.

GOOD TO REMEMBER

- **ICD-11 personality classification:** no types; rate severity first (personality difficulty, then mild, moderate, severe by self-and-interpersonal dysfunction and risk of harm), then add trait qualifiers.
- **The five trait domains:** negative affectivity, detachment, dissociality, disinhibition, anankastia; they describe style, not severity, and several may co-occur.
- **Borderline pattern qualifier (6D11.5):** the one retained pattern; an add-on qualifier defined by five or more of the nine borderline features; overlaps the domains, not a type.

2.6 Assembling a diagnosis: how the pieces combine in practice

A finished ICD-11 personality diagnosis is a severity level with any qualifiers appended, coded by postcoordination. You never stop at a trait: a qualifier without a rated severity is an incomplete diagnosis. The clinical value is that the same language scales from a screening judgement to a detailed formulation, and that severity, the part that drives the management plan and the risk assessment, is stated up front rather than buried inside a type label. The bipolar-II differential that so often shadows an affectively unstable presentation is worked in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; the forensic reading of a prominent dissociality trait belongs to the Mental health legislation and forensic psychiatry notes.

WORKED EXAMPLE

A woman in her twenties has an incoherent sense of who she is, stormy relationships that collapse repeatedly, recurrent self-cutting after perceived abandonment, chronic emptiness and stress-related dissociation. Work the model in order. General criteria met. Severity: the self is severely disturbed and almost all relationships are affected with a high risk of self-harm, so this is severe personality disorder (6D10.2). Trait qualifiers: prominent negative affectivity and disinhibition. Pattern: the picture meets five or more of the nine borderline features, so add the borderline pattern qualifier (6D11.5). The diagnosis is "severe personality disorder with negative affectivity, disinhibition and a borderline pattern", not "borderline personality disorder" as a type.

2.7 Cross-map to DSM-5-TR: the categorical clusters and the AMPD hybrid

DSM-5-TR did not follow the ICD-11 all the way. Its main text **retains the categorical system**: three clusters (A the odd or eccentric, B the dramatic or erratic, C the anxious or fearful) holding ten types. In parallel, Section III offers the **alternative model of personality disorders**, a hybrid that mirrors the ICD-11 logic: Criterion A rates self and interpersonal functioning on the Level of Personality Functioning Scale (self as identity and self-direction; interpersonal as empathy and intimacy), and Criterion B specifies five pathological trait domains with 25 facets (Kaplan & Sadock CTP 2024). The two dimensional systems are close cousins but their trait sets are not identical, and the mismatch is examinable. The grid below is the discriminator to hold.

ICD-11 TRAIT DOMAIN	DSM-5-TR AMPD COUNTERPART	NOTE
Negative affectivity	Negative affectivity	Shared construct
Detachment	Detachment	Shared construct
Dissociality	Antagonism	**Same construct, different name**
Disinhibition	Disinhibition	Shared construct
Anankastia	(no AMPD domain)	**ICD-11 only; a constraint pole absent from the AMPD**
(no ICD-11 domain)	Psychoticism	**DSM only; ICD-11 places schizotypal with the psychoses, so it has no psychoticism domain**

The two dimensional trait sets: four align, but ICD-11 carries anankastia and the AMPD carries psychoticism; the highlighted rows are where they part.

TRAP **Do not equate the ICD-11 five with the DSM-5 AMPD five.** Anankastia is ICD-11-only and psychoticism is DSM-only; the schizotypal-versus-schizophrenia placement is set out in the Schizophrenia: aetiology, phenomenology, classification and course notes.

2.8 The legacy ICD-10 box: what changed and why the old names still get tested

The break from ICD-10 is total, which is exactly why the categorical vocabulary refuses to die. Knowing what was removed is itself the exam point.

ICD-10 TO ICD-11: WHAT CHANGED

ICD-10 (F60) **kept the categorical specific types**: paranoid, schizoid, dissocial, emotionally unstable (impulsive and borderline subtypes), histrionic, anankastic, anxious or avoidant, and dependent personality disorder, with schizotypal sitting separately under the schizophrenia grouping. ICD-11 **removed all of these named types** and rebuilt the diagnosis as a severity level plus trait-domain qualifiers, keeping only the borderline pattern as an optional qualifier. Exams still test the categorical names because DSM-5-TR retains them in its main text and clinicians still speak in them, so you must read fluently in both the dimensional and the categorical languages.

COMMON TRAP

Rating a trait qualifier while skipping severity, or naming "borderline personality disorder" as an ICD-11 type. In ICD-11 borderline is a *pattern qualifier* appended to a rated severity, never a standalone type; and no trait domain is a diagnosis on its own.

2.9 India and the cultural frame

Two India-specific cautions attach to this model. The first is **under-recognition**: personality disorders are diagnosed far less often in Indian clinical practice than Western prevalence would predict, an under-detection documented in Indian samples (Gupta & Mattoo, on personality-disorder prevalence and demography). A severity-led system that begins with a graded judgement of self-and-interpersonal dysfunction, rather than demanding a full type match, is well suited to

catching the milder end that Indian services routinely miss. The second is the **cultural expression of pathology**: the general criteria require deviation from what the person's own culture expects, so a self that is deeply embedded in family and community, or a deference and interdependence that would look like dependence through a Western lens, must not be read as disorder. The medico-legal weight of a prominent dissociality trait, which surfaces most sharply in offender assessment, is handled in the Mental health legislation and forensic psychiatry notes.

INDIA

Access to the structured psychotherapies that this severity framing points toward is uneven. Dialectical behaviour therapy and schema therapy are available and being culturally adapted in Indian metros and academic centres but remain scarce elsewhere, so a severe rating that mandates intensive structured therapy can outrun what a given service can deliver. Rate honestly, then match the plan to what is actually accessible, and never read collectivist family-embeddedness as a personality disorder.

5	3	5+	3 / 10
ICD-11 TRAIT DOMAINS	SEVERITY LEVELS (MILD, MODERATE, SEVERE)	OF NINE BORDERLINE-PATTERN FEATURES	DSM-5-TR CLUSTERS / TYPES (RETAINED)

HOLD THIS

ICD-11 has no personality-disorder types: rate severity first (personality difficulty, then mild, moderate, severe by self-and-interpersonal dysfunction and risk of harm), then add any of the five trait domains, negative affectivity, detachment, dissociality, disinhibition, anankastia, and the borderline pattern qualifier.

3 · DSM-5 categorical clusters and the alternative model

Two classifications of personality live side by side inside one manual. **dsm-5-tr** keeps, in its official Section II, the familiar **categorical clusters** and the **ten types** inherited almost unchanged from DSM-IV; and it offers, in its research Section III, an **alternative model**, a dimensional-categorical **hybrid model** (the **ampd**) that scores how badly the personality functions and profiles the traits that colour it. Knowing both, and being able to cross-map them onto the ICD-11 dimensional system, is the single highest-yield task on the personality-disorders paper.

Why it matters, and what this note owns. This note owns the DSM-5-TR side of the nosology: the three **categorical clusters** and their ten types with each type under its correct cluster, and the Section III **alternative model** in full, its Criterion A **level of personality functioning** scale and its Criterion B **pathological trait domains**. The ICD-11 dimensional model (the severity gradient and the five trait qualifiers) is taught forward in its own sibling note and only cross-mapped here; the deeper per-disorder phenomenology of each type lives in the cluster notes, and the general diagnostic criteria that gate any personality-disorder diagnosis are stated here only as the framing rule. The accompanying figure maps the ten types under the three clusters; a second figure alongside it lays the DSM-5 alternative model against the ICD-11 domains.

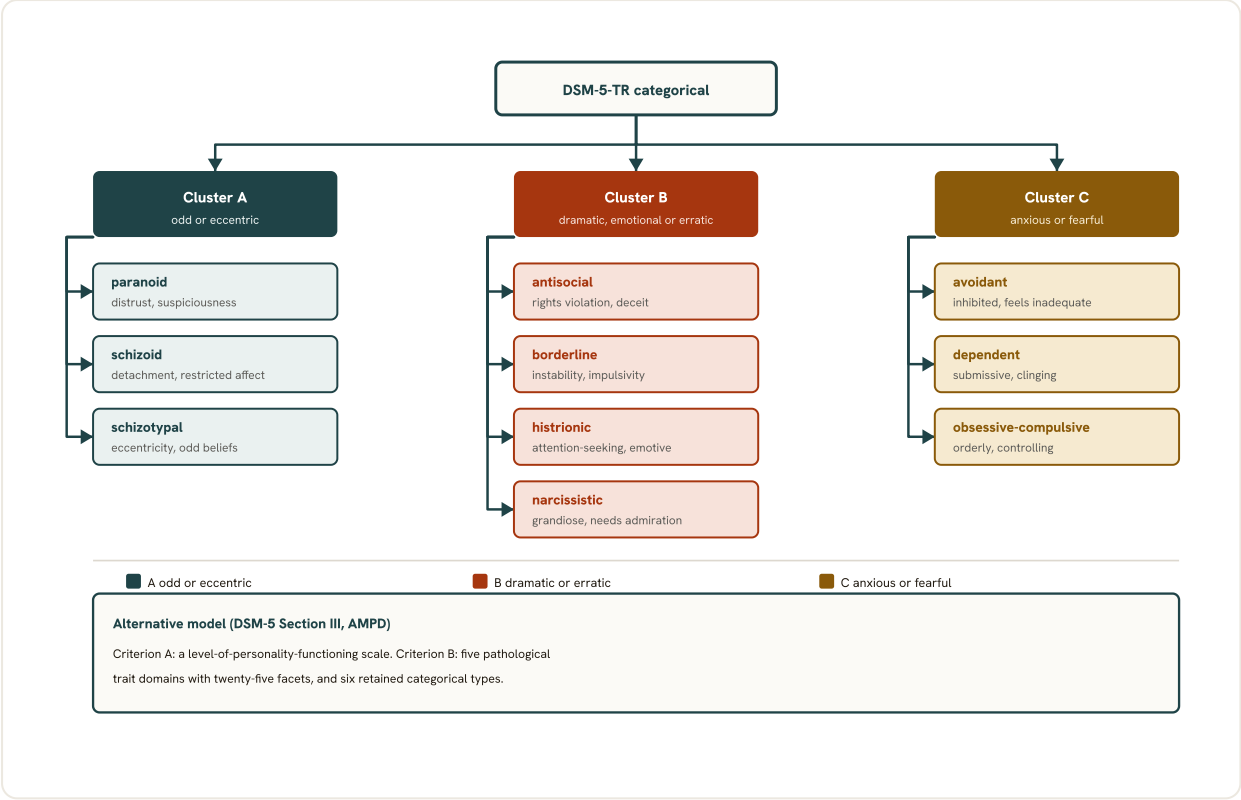


Fig 16.3 The DSM-5-TR keeps the ten categorical types in three clusters, A odd or eccentric, B dramatic or erratic, C anxious or fearful, with the Section III alternative model (a functioning scale plus pathological trait domains) alongside; ICD-10 kept these categories, which is why exams still test them.

3.1 Two systems in one manual: Section II categorical, Section III alternative

The structural fact to state first. dsm-5-tr carries *both* a categorical and a dimensional account of personality disorder. Section II, the official classification for routine clinical use, retains the ten categorical types grouped into three **categorical clusters**, virtually unchanged from DSM-IV-TR (DSM-5-TR 2022). Section III, "Emerging Measures and Models", houses the alternative model (also called the **hybrid model** or **ampd**, the Alternative **dsm-5** Model for Personality Disorders), placed there for further study rather than official use. The APA Board of Trustees kept both deliberately: the categorical set to preserve continuity with clinical practice, and the hybrid model to answer the categorical system's well-known failings (excessive comorbidity between types, and "other specified" being the commonest and least informative diagnosis).

Why the split is examinable. The examiner wants you to be fluent in the official categorical vocabulary (paranoid, borderline, and the rest) *and* able to explain the model that is expected to replace it. That is the through-line of the whole chapter: teach the dimensional direction of travel (ICD-11 has already abolished the categorical types entirely), but master the categorical names because Section II, everyday communication and most examinations still run on them.

GOOD TO REMEMBER

- **DSM-5-TR dual structure:** Section II retains the official categorical system, three clusters and ten types unchanged from DSM-IV-TR; Section III offers the alternative (hybrid AMPD) model for further study; both are printed in the same manual by deliberate APA decision, the categorical for continuity, the dimensional to fix comorbidity and the uninformative "unspecified" default.

3.2 The gate before any label: the general criteria for a personality disorder

The pattern precedes the type. No cluster and no type may be assigned until the general criteria for a personality disorder are met: an enduring, pervasive, inflexible pattern of inner experience and behaviour that *deviates markedly from the expectations of the individual's culture*, is stable over time, traceable to **adolescence or early adulthood**, and leads to distress or impairment, and is not better explained by another mental disorder, a substance, or a medical condition (DSM-5-TR 2022). The same seven general criteria (A to G) sit at the head of the Section III model, where Criterion A is reframed as moderate or greater impairment in personality functioning and Criterion B as one or more pathological traits, but the enduring, pervasive, culturally-deviant, early-onset spine is identical.

Deviation is judged against the person's own culture. The cultural clause is not decorative; the pattern must deviate from the norms of the individual's *own* cultural, ethnic and social reference group, and manifest across cognition, affectivity, interpersonal functioning and impulse control. Reading a migrant's habits, a subculture's mores, or a life-stage's turbulence as personality pathology is the classic misdiagnosis this criterion exists to block.

RULE **The enduring pattern before the label.** Establish the general personality-disorder criteria first, an inflexible, pervasive, culturally-deviant pattern stable since adolescence or early adulthood with distress or impairment, and only then place the cluster and the type; the cluster or the AMPD trait profile is meaningless without that gate.

TRAP **State mistaken for trait.** Do not label situational or episodic features a personality disorder: calling a passing affective lability "borderline" without the enduring identity disturbance and abandonment features, or reading a cultural or developmental norm as pathology, breaks the general criteria and is the commonest error on this topic.

3.3 Cluster A, the odd or eccentric cluster

The cluster and its three types. **cluster a** groups the personality disorders whose sufferers "often appear odd or eccentric" (DSM-5-TR 2022): paranoid personality disorder (a pervasive distrust and suspiciousness, reading others' motives as malevolent), schizoid personality disorder (detachment from social relationships with a restricted, flattened emotional range, the person is a genuine loner who does not want closeness), and schizotypal personality disorder (acute social discomfort with cognitive and perceptual distortions and eccentricities, ideas of reference, odd beliefs and magical thinking, unusual perceptions). The cluster's phenomenology shades toward the schizophrenia spectrum.

The boundary that is tested. Schizotypal is the one to place carefully: its cognitive-perceptual eccentricities are attenuated, not frank psychosis, so it stays a personality disorder in DSM-5-TR (though it is cross-listed with the schizophrenia spectrum), and mislabelling it as schizophrenia is a standard error, developed in the Schizophrenia: aetiology, phenomenology, classification and course notes.

GOOD TO REMEMBER

- **Cluster A (odd or eccentric):** paranoid (pervasive distrust and suspiciousness), schizoid (detachment with restricted emotion, a contented loner), schizotypal (social discomfort plus cognitive-perceptual distortions, ideas of reference, magical thinking); the discriminator from the schizophrenia spectrum is that the distortions are attenuated, not frankly psychotic.

3.4 Cluster B, the dramatic, emotional or erratic cluster

The cluster and its four types. **cluster b** groups those who "often appear dramatic, emotional, or erratic" (DSM-5-TR 2022): antisocial personality disorder (a pervasive disregard for and violation of the rights of others, deceit, impulsivity, aggression and lack of remorse, requiring evidence of conduct disorder before the age of fifteen years), borderline personality disorder (instability of relationships, self-image and affect with marked impulsivity), histrionic personality disorder (pervasive excessive emotionality and attention seeking), and narcissistic personality disorder (grandiosity, need for admiration and lack of empathy). This is the cluster that dominates the clinic and the examination, borderline above all.

Two exam anchors. Antisocial personality disorder is the one type DSM-5-TR will not diagnose before the age of eighteen years and only with a documented childhood conduct disorder, and it carries the forensic weight of the chapter (offender assessment, court reports), developed in the Mental health legislation and forensic psychiatry notes. Borderline is the flagship carried in detail below and across the day.

GOOD TO REMEMBER

- **Cluster B (dramatic, emotional or erratic):** antisocial (disregard for and violation of others' rights; needs conduct disorder before age fifteen and diagnosis only from age eighteen), borderline (instability of relationships, self-image and affect with impulsivity), histrionic (excessive emotionality and attention seeking), narcissistic (grandiosity, need for admiration, lack of empathy); it is the highest-yield cluster.

3.5 Cluster C, the anxious or fearful cluster, and the full ten-type map

The cluster and its three types. **cluster c** groups those who "often appear anxious or fearful" (DSM-5-TR 2022): avoidant personality disorder (social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation, the person wants closeness but is too afraid of rejection to risk it), dependent personality disorder (a pervasive, excessive need to be taken care of, submissive and clinging behaviour, fear of separation), and obsessive-compulsive personality disorder (a preoccupation with orderliness, perfectionism and control at the expense of flexibility and efficiency). Avoidant is separated from social anxiety disorder by its pervasive, trait-level character, and obsessive-compulsive personality disorder is separated from OCD by the absence of true obsessions and compulsions, the confusion of the anankastic character with the anxiety disorder being a stock trap.

The ten under the three. The mapping to reproduce cold, three **categorical clusters** holding **ten types**, is set out in the table and the accompanying figure. DSM-5-TR itself warns that the clustering, though useful for teaching and research, "has serious limitations and has not been

consistently validated": types from different clusters co-occur freely, which is exactly the comorbidity problem the alternative model was built to solve.

CLUSTER	CHARACTER	TYPE	ONE-LINE SIGNATURE
Cluster A	**Odd or eccentric**	Paranoid	Pervasive distrust and suspiciousness; reads motives as malevolent
Cluster A	Odd or eccentric	Schizoid	Detachment from relationships; restricted emotion; a contented loner
Cluster A	Odd or eccentric	Schizotypal	**Social discomfort plus cognitive-perceptual distortions and eccentricity**
Cluster B	**Dramatic, emotional or erratic**	Antisocial	Disregard for and violation of others' rights; deceit, impulsivity, no remorse
Cluster B	Dramatic, emotional or erratic	Borderline	**Instability of relationships, self-image and affect; marked impulsivity**
Cluster B	Dramatic, emotional or erratic	Histrionic	Excessive emotionality and attention seeking
Cluster B	Dramatic, emotional or erratic	Narcissistic	Grandiosity, need for admiration, lack of empathy
Cluster C	**Anxious or fearful**	Avoidant	Social inhibition, feelings of inadequacy, fear of negative evaluation
Cluster C	Anxious or fearful	Dependent	Excessive need to be cared for; submissive, clinging; fear of separation
Cluster C	Anxious or fearful	Obsessive-compulsive	**Preoccupation with order, perfectionism and control; not OCD**

The DSM-5-TR Section II categorical system: three clusters holding ten types; the discriminator cells flag the boundaries most often tested (schizotypal versus schizophrenia, borderline as the flagship, obsessive-compulsive personality versus OCD) (DSM-5-TR 2022).

MNEMONIC

Weird, Wild, Worried

The three clusters by feel. **Cluster A** is **Weird** (odd or eccentric: Paranoid, Schizoid, Schizotypal, the three "P-S-S" types). **Cluster B** is **Wild** (dramatic, emotional or erratic: Antisocial, Borderline, Histrionic, Narcissistic). **Cluster C** is **Worried** (anxious or fearful: Avoidant, Dependent, Obsessive-compulsive). Three, four, three, adding to the ten types.

GOOD TO REMEMBER

- **Cluster C (anxious or fearful):** avoidant (social inhibition and fear of negative evaluation; wants but fears closeness), dependent (excessive need to be cared for, clinging, fear of separation), obsessive-compulsive personality (orderliness, perfectionism and control without true obsessions or compulsions); the whole set is three clusters and ten types, a clustering DSM-5-TR itself flags as weakly validated.

ICD-10 LEGACY: WHAT CHANGED

The old ICD-10 KEPT a categorical list of personality disorders largely paralleling the DSM types (paranoid, schizoid, dissocial for antisocial, emotionally unstable with an impulsive and a borderline type, histrionic, anankastic for obsessive-compulsive, anxious for avoidant, and dependent), with two familiar divergences: narcissistic sat only under "other specific personality disorder", and schizotypal was placed in the schizophrenia and delusional-disorders grouping, not among the personality disorders. ICD-11 then made the sharpest break of all: it *abolished* every one of these discrete categorical types, replacing them with a single personality-disorder diagnosis rated by severity (personality difficulty, then mild, moderate or severe) plus five trait qualifiers and a borderline pattern qualifier. Examinations still test the categorical names because DSM-5-TR Section II retains them, decades of literature and clinical communication use them, and the dimensional transition is recent, so the vocabulary of clusters and types remains the shared currency even where the official classification has moved on.

3.6 Borderline personality disorder: the flagship type and the five-of-nine threshold

The criterion to state cold. borderline personality disorder is "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood", diagnosed when **five or more of the nine** criteria are present (DSM-5-TR 2022). The nine are: frantic efforts to avoid abandonment; a pattern of unstable, intense relationships alternating between idealisation and devaluation; identity disturbance; impulsivity in at least two potentially self-damaging areas; recurrent suicidal or self-mutilating behaviour; affective instability due to marked reactivity of mood; chronic feelings of emptiness; inappropriate, intense anger; and transient, stress-related paranoid ideation or severe dissociative symptoms.

Why the threshold is worth memorising. The **five or more of the nine** rule is the count most likely to be asked, and it is the reason a polythetic categorical system produces so many symptom combinations: two people can each carry the borderline label while sharing only one of the nine features. That combinatorial sprawl is the empirical case for the dimensional models. The borderline-versus-bipolar-II discrimination (do not start a mood stabiliser for personality-based

instability) and the biosocial and psychotherapeutic detail are developed elsewhere in the day and in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

GOOD TO REMEMBER

- **Borderline personality disorder:** a pervasive pattern of instability of relationships, self-image and affect with marked impulsivity from early adulthood; diagnosed on five or more of the nine criteria (abandonment fears, idealisation-devaluation, identity disturbance, impulsivity, recurrent self-harm or suicidality, affective instability, chronic emptiness, intense anger, transient paranoia or dissociation); the first diagnostic step is the enduring pattern, and the five-of-nine polythetic threshold is why the same label covers very different presentations.

3.7 The alternative model (AMPD): a dimensional-categorical hybrid

What the hybrid does. The Section III alternative model for personality disorders redefines a personality disorder as the combination of two things: *impairment in personality functioning* (Criterion A) and one or more *pathological personality traits* (Criterion B) (DSM-5-TR 2022). It is a **hybrid model** because it fuses a dimensional severity axis (how impaired the personality is) with a dimensional trait profile (which traits are elevated), then still allows six named categorical diagnoses to be reconstructed from those dimensions. The general criteria C to G (inflexible and pervasive, stable since adolescence or early adulthood, not better explained by another disorder, a substance or a developmental or cultural norm) carry over unchanged.

The two determinations. Diagnosing under the **ampd** requires two assessments in order: first rate the level of impairment in personality functioning (Criterion A) on the Level of Personality Functioning Scale, then evaluate the pathological personality traits (Criterion B) across the trait domains. A *moderate* or greater impairment in personality functioning is the entry threshold; below it, no personality disorder is diagnosed however the traits fall.

GOOD TO REMEMBER

- **Alternative model (AMPD):** the DSM-5 Section III dimensional-categorical hybrid; a personality disorder is impairment in personality functioning (Criterion A) plus one or more pathological personality traits (Criterion B), retaining general criteria C to G; diagnosis runs A then B, with moderate or greater functional impairment the required entry threshold; it exists to cure the categorical system's comorbidity and its uninformative "unspecified" default.

3.8 Criterion A: the Level of Personality Functioning scale (self and interpersonal)

The self and interpersonal axes. Criterion A grades disturbance in *self* and *interpersonal* functioning on the Level of Personality Functioning Scale (DSM-5-TR 2022). Self functioning has two elements, identity and self-direction; interpersonal functioning has two, empathy and intimacy. The scale differentiates five levels of impairment, from little or no impairment (healthy) through some, moderate and severe to extreme; moderate impairment is the threshold that a personality disorder must reach. The severity of impairment also predicts whether the person has more than one personality disorder or one of the more severe types, which is why the **level of personality functioning** is rated first and leads.

Identity (self)

A stable, bounded sense of self; regulated self-esteem and accurate self-appraisal; capacity to experience and modulate a range of emotion.

Self-direction (self)
Pursuit of coherent short-term and life goals; constructive, prosocial internal standards; the ability to self-reflect productively.

Empathy (interpersonal)
Comprehension of others' experiences and motives; tolerance of differing perspectives; awareness of one's effect on others.

Intimacy (interpersonal)
Depth and duration of connection; the desire and capacity for closeness; mutuality of regard in relationships.

The four elements of personality functioning that anchor Criterion A of the alternative model; two are self elements, two interpersonal, graded across five severity levels with moderate impairment the diagnostic threshold (DSM-5-TR 2022).

GOOD TO REMEMBER

- **Criterion A (Level of Personality Functioning):** the AMPD severity axis, self functioning (identity, self-direction) and interpersonal functioning (empathy, intimacy) across five levels from little-or-no to extreme; moderate or greater impairment is required to diagnose any personality disorder, and severity predicts multiplicity and the more severe types, so it is rated first.

3.9 Criterion B: the five pathological trait domains, and the ICD-11 cross-map

The five domains and their facets. Criterion B profiles the personality across five broad pathological trait domains: **negative affectivity**, **detachment**, **antagonism**, **disinhibition** and **psychoticism**, which subdivide into twenty-five specific trait facets (DSM-5-TR 2022). Each named disorder's B criterion is a defined subset of those facets, for example antisocial personality disorder draws on Antagonism and Disinhibition, avoidant on Negative Affectivity and Detachment. The five domains are the maladaptive-range extensions of the Big Five personality dimensions.

The cross-map to ICD-11, the point examiners love. The ICD-11 dimensional model, taught forward in its own note, uses its own five trait qualifiers, and four broadly correspond to the DSM-5 **pathological trait domains**: negative affectivity, detachment, dissociality (aligning with DSM-5 Antagonism) and disinhibition are shared. The fifth is where they part: DSM-5 has **psychoticism** (which ICD-11 has no equivalent domain for), while ICD-11 has **anankastia** (which DSM-5 folds into low Disinhibition rather than naming). ICD-11 then adds a borderline pattern qualifier on top of its domains, a feature the DSM-5 trait set does not carry.

DSM-5 ALTERNATIVE-MODEL DOMAIN	ICD-11 TRAIT QUALIFIER	WHAT IT CAPTURES
Negative affectivity	Negative affectivity	Frequent, intense negative emotions (anxiety, insecurity, emotional lability)
Detachment	Detachment	Social and emotional withdrawal, avoidance of intimacy, restricted emotion
Antagonism	**Dissociality**	Disregard for others; grandiosity, deceit, callousness, manipulation
Disinhibition	Disinhibition	Impulsivity, irresponsibility, recklessness, distractibility
Psychoticism (no ICD-11 domain)	**Anankastia (no DSM-5 domain)**	DSM-5: odd beliefs, unusual perceptions, eccentricity. ICD-11: rigidity, perfectionism, constraint

Cross-mapping the two dimensional trait systems: four domains broadly correspond, but the fifth differs, DSM-5 names Psychoticism where ICD-11 names Anankastia, and ICD-11 adds a borderline pattern qualifier the DSM-5 set lacks (DSM-5-TR 2022; ICD-11 CDDR).

COMMON TRAP

Do not treat the two dimensional systems as identical five-domain sets. Four domains align (negative affectivity, detachment, antagonism as ICD-11 dissociality, disinhibition), but the fifth is different in each: the DSM-5 alternative model has *psychoticism* and no anankastia domain, whereas ICD-11 has *anankastia* and no psychoticism domain. Naming psychoticism as an ICD-11 domain, or anankastia as a DSM-5 domain, is a straight error.

GOOD TO REMEMBER

- **Criterion B (pathological trait domains):** five domains, negative affectivity, detachment, antagonism, disinhibition and psychoticism, with twenty-five facets, each disorder's B criterion a defined subset; four align with the ICD-11 qualifiers (antagonism maps to dissociality), but DSM-5's fifth is psychoticism while ICD-11's is anankastia, and only ICD-11 adds a borderline pattern qualifier.

3.10 The six retained types and the trait-specified diagnosis

Ten collapse to six, plus a residual. Where the categorical system names ten types, the **alternative model** retains only six that can be diagnosed by their own criteria sets: antisocial, avoidant, borderline, narcissistic, obsessive-compulsive and schizotypal personality disorders (DSM-5-TR 2022). Each is defined by a characteristic Criterion A functioning impairment plus a specified Criterion B trait subset. The four categorical types dropped from the named list (paranoid, schizoid, histrionic, dependent) are not lost: when a personality disorder is present but no specific set is met, it is diagnosed as *personality disorder, trait specified* (PD-TS), recording the impairment level and the elevated trait domains directly.

How a diagnosis is built. To diagnose, say, avoidant personality disorder under the hybrid model, the clinician confirms moderate or greater impairment across the relevant functioning elements (Criterion A) and the specified maladaptive traits, here in Negative Affectivity and Detachment (Criterion B), then checks the general criteria C to G. The system's promise is that the profile itself, the severity level and the domain scores, carries the clinical information even when no tidy category fits, which is precisely the case in most real patients.

GOOD TO REMEMBER

- **The six AMPD types and PD-TS:** the alternative model diagnoses six specific types, antisocial, avoidant, borderline, narcissistic, obsessive-compulsive and schizotypal, each an A-functioning impairment plus a B-trait subset; the other cases (including the dropped paranoid, schizoid, histrionic and dependent) become personality disorder, trait specified, recorded by severity level and trait domains.

3.11 The India lens: under-recognition, cultural expression and the medico-legal frame

An under-recognised group read through the wrong culture. Personality disorders are markedly under-recognised in routine Indian practice: they present through their comorbidities (a mood or anxiety disorder, a substance problem, repeated self-harm) rather than as a personality diagnosis, they are under-coded, and the personality label is often avoided for fear of stigma. The cultural clause in the general criteria matters acutely here, deviation must be judged against the patient's own cultural, familial and social norms, so that collectivist family embeddedness is not misread as dependent personality, culturally sanctioned religious or ritual practice is not misread as schizotypal eccentricity, and gendered social scripts are not misread as histrionic or avoidant traits. The cultural expression of personality pathology is genuine and must be weighed before any type is fixed.

Where the label carries force. Antisocial personality disorder is the type with the sharpest medico-legal edge in Indian practice, surfacing in offender assessment, fitness and court reports, where a careful, non-pejorative formulation matters, and it is developed in the Mental health legislation and forensic psychiatry notes. On the treatment side, the structured psychotherapies that the borderline diagnosis calls for, dialectical behaviour therapy and schema therapy, are available only patchily outside the metros and are being culturally adapted for Indian settings; that availability gap, not the classification, is usually what limits care once the diagnosis is correctly made.

INDIA

Personality disorders are under-recognised in Indian practice, surfacing through comorbid mood, anxiety, substance or self-harm presentations and often left uncoded for fear of stigma. The general criteria's cultural clause is the safeguard: judge deviation against the patient's own cultural and social norms, so family embeddedness is not scored as dependency, religious practice not as schizotypal eccentricity, and social scripts not as histrionic or avoidant pathology. Antisocial personality disorder carries the medico-legal weight (offender and court work, cross-referenced to the forensic notes), and the structured psychotherapies borderline needs, dialectical behaviour therapy and schema therapy, are unevenly available and still being culturally adapted for India.

3	10	5	five
CATEGORICAL CLUSTERS (A ODD, B DRAMATIC, C ANXIOUS)	CATEGORICAL PERSONALITY-DISORDER TYPES ACROSS THE CLUSTERS	PATHOLOGICAL TRAIT DOMAINS IN THE DSM-5 ALTERNATIVE MODEL	OF THE NINE CRITERIA NEEDED TO DIAGNOSE BORDERLINE PERSONALITY DISORDER

HOLD THIS

DSM-5-TR keeps the categorical clusters in Section II (Cluster A odd or eccentric: paranoid, schizoid, schizotypal; Cluster B dramatic, emotional or erratic: antisocial, borderline, histrionic, narcissistic; Cluster C anxious or fearful: avoidant, dependent, obsessive-compulsive, ten types in all) and offers, in Section III, the alternative hybrid model (AMPD): Criterion A the Level of Personality Functioning scale (self: identity, self-direction; interpersonal: empathy, intimacy) plus Criterion B the five pathological trait domains (negative affectivity, detachment, antagonism, disinhibition, psychoticism), diagnosing six specific types; ICD-11 has abolished the categorical types for a severity-led dimensional model whose fifth domain is anankastia, not psychoticism, yet the categorical names remain the examinable vocabulary.

4 · Categorical versus dimensional approaches

Why this matters. This is the conceptual hinge of the whole personality-disorders chapter, and it is the stem an examiner reaches for when a single question has to test understanding rather than recall. The sibling notes teach the two live classifications in full, the DSM-5-TR categorical clusters and the ICD-11 dimensional model; this note owns the argument *between* them. The **categorical versus dimensional** debate asks a prior question: is a personality disorder a distinct kind of thing that you either have or do not, or a position on a set of continua that shade imperceptibly into ordinary personality? Answer that, and you can explain every failing of the old system and every design choice of the new one.

Held tightly, the **comparison of approaches** is a small object: two definitions, a short list of **strengths and weaknesses** on each side, and the reason the evidence tilted one way. The categorical approach trades validity for familiarity; the dimensional approach trades familiarity for validity and coverage; and the modern manuals split the difference, ICD-11 committing fully to dimensions while DSM-5-TR keeps the categories in front and files the dimensional model behind them for study. The accompanying figure lays the two approaches out as one grid, discrete boxes on one side against graded continua on the other, and it is the single image to carry for this

topic. The detailed severity gradient, the trait domains and the cluster map are developed in the sibling framework notes and only invoked here as evidence.

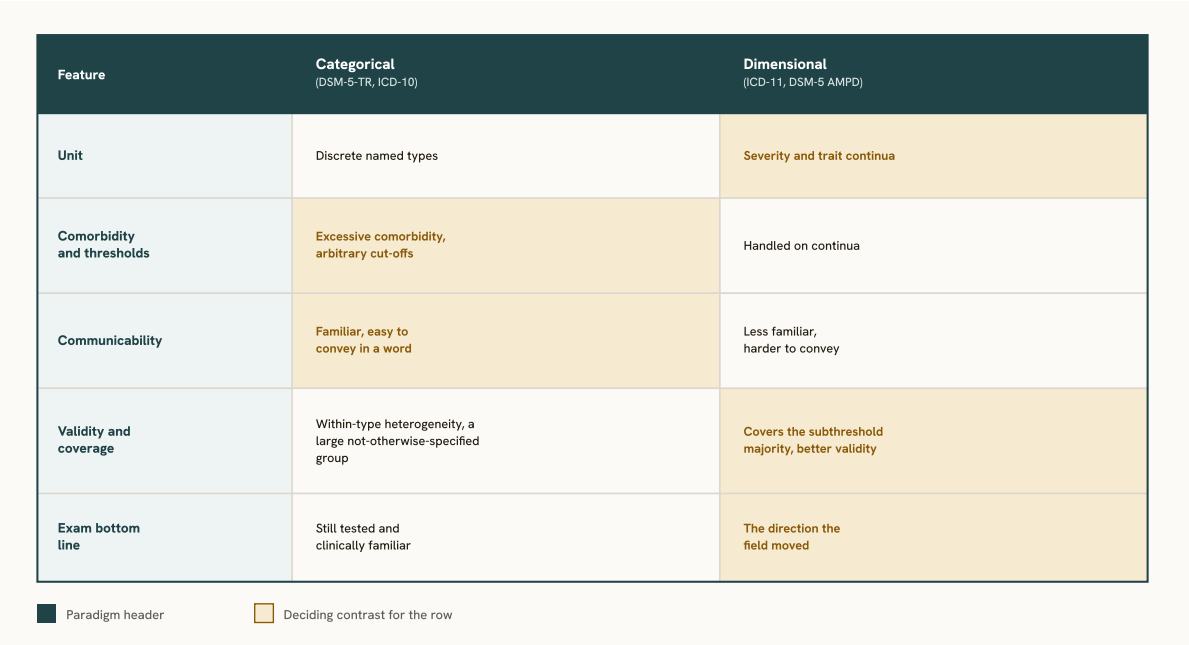


Fig 16.4 Categorical classification names discrete types (familiar, but with excessive comorbidity, arbitrary thresholds and a large residual group), while dimensional classification grades severity and traits on continua (better validity and coverage of the subthreshold majority); the field moved dimensional, though the categories are still examined.

4.1 Two ways to carve personality: kinds versus degrees

The distinction to state first. The categorical approach holds that personality disorders are *qualitatively distinct clinical syndromes*, discrete kinds that a person either meets or does not, sorted into named types (DSM-5-TR 2022). The dimensional approach holds the opposite: that personality pathology represents *maladaptive variants of personality traits that merge imperceptibly into normality and into one another*, so that difference from health is one of degree, not of kind (DSM-5-TR 2022). One view draws boundaries and puts patients in boxes; the other places them on continua of severity and trait and reads their position. Everything else in the debate follows from this single fork, kinds against degrees.

Why the fork is not merely philosophical. The choice determines what the diagnosis can say. A category returns a name; a dimension returns a profile. Where a categorical system must decide a threshold above which a person "has" the disorder, a dimensional system can describe exactly how far along each continuum the person sits, and can keep describing the many people who fall below any categorical cut-off. The five-factor model of normal personality supplies the trait scaffolding the dimensional side builds on, its maladaptive poles becoming the pathological trait domains of the modern models (New Oxford Textbook of Psychiatry).

RULE **Kinds versus degrees is the whole debate.** The categorical approach treats a personality disorder as a discrete type you have or lack; the dimensional approach treats it as a position on continua of severity and trait that grade smoothly into normal personality. Every strength and weakness on either side is a consequence of this one choice.

4.2 The categorical approach: where it is strong

Familiarity and communicability are its real assets. The categorical approach is the default of clinical medicine: a diagnosis is a name, and a name is fast to assign, easy to record, and instantly communicable to another clinician in a single phrase (Tasman Psychiatry). Saying "borderline personality disorder" transmits a rich prototype in two words; there is a century of description, a large treatment literature and an examination vocabulary all built on the named types. The explicit operational criteria introduced from DSM-III onward gave the categories a further, genuine payoff: they let the field *document* substantial community and clinical prevalence, high rates of social and occupational impairment, and a more chronic course for co-occurring disorders (New Oxford Textbook of Psychiatry). These are not trivial gains, and they are why the categories have survived every attempt to retire them.

The prototype is the mechanism. Clinicians reason by pattern-matching a patient to a remembered exemplar, and the categorical types are ready-made prototypes. That cognitive fit, not evidence of natural boundaries, is the categorical system's durable strength: it maps onto how doctors actually think and talk.

PEARL

The categorical system persists because of its *communicative* value, not its scientific validity. The single most defensible thing to say for it is that a type name carries a whole clinical picture in one phrase, which is exactly what a busy clinic and a shared record need. Hold that as its strength, and its weaknesses become easier to name honestly.

4.3 The categorical approach: where it fails

Four failings, and they are examinable as a set. The problems are the mirror image of the discrete-kinds assumption, and the New Oxford Textbook lists them cleanly: *extensive co-occurrence of personality disorders* (excessive comorbidity, patients routinely meeting several type criteria at once), *considerable heterogeneity within categories* (two people can share a diagnosis while sharing almost none of its features), *arbitrary diagnostic thresholds without empirical bases* (the cut-off between disorder and no-disorder is a convention, not a natural join), and *incomplete coverage of the full range of personality pathology* (the many patients whose difficulty is real but does not match any single type). Temporal instability of the categories and their limited validity and clinical utility round out the indictment (New Oxford Textbook of Psychiatry).

Borderline is the worked case of heterogeneity. Because borderline personality disorder is polythetic, diagnosed on **five or more of the nine** criteria, two patients can each carry the label while overlapping on only one feature. That combinatorial sprawl is the categorical system's within-category heterogeneity made concrete, and it is the empirical case the dimensional models

were built to answer. The unstable, affectively reactive presentation also blurs into bipolar-II, a boundary drawn in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

The residual category tells the story. The clearest sign of incomplete coverage is that the residual not-otherwise-specified diagnosis (personality disorder not otherwise specified in DSM-IV, and the "other specified" and "unspecified" categories in DSM-5-TR) has been among the most frequently assigned of all the personality-disorder diagnoses, and is also the least informative one (DSM-5-TR 2022; New Oxford Textbook of Psychiatry). A system whose commonest verdict is "a personality disorder, but none of the ones we named" is telling you its named types do not cover the territory.

TRAP **Reading the types as non-overlapping natural kinds.** The categorical model implies the types are distinct and separable, but they co-occur freely and blur at every edge; treating a tidy single-type label as the natural truth of a patient, rather than a convenient summary, is the error the dimensional case exists to correct.

COMMON TRAP

Mistaking the frequency of the not-otherwise-specified diagnosis for clinician laziness. It is a structural signal, not a shortcut: the residual category is common *because* most real personality pathology is subthreshold or mixed and falls between the named types. That is the coverage problem, not a documentation problem.

4.4 The dimensional approach: its strengths

It fixes what the categories broke. By placing severity and traits on continua, the dimensional approach retains the information a category discards: a profile records how impaired the personality is and which traits are elevated, so two patients who would share one categorical label are told apart, and a patient who matches no type is still fully described (Tasman Psychiatry). This is why the empirical structure favours it: a meta-analytic review of many latent-structure studies found little persuasive evidence for discrete taxa underlying the personality disorders, with schizotypal the only possible partial exception (New Oxford Textbook of Psychiatry). If the underlying reality is continuous, a continuous model has better *validity* and, crucially, covers the subthreshold majority that the categorical cut-offs leave out.

Severity leads because severity predicts. The single most useful dimension is overall severity of personality dysfunction, which forecasts self-harm, service use, relationship breakdown and occupational failure better than any type label; rating it first is the design principle both modern dimensional systems adopt. The schizotypal exception, the one construct with some categorical support, sits at the schizophrenia-spectrum edge and is developed in the Schizophrenia: aetiology, phenomenology, classification and course notes.

4.5 The dimensional approach: its price

Validity is bought with unfamiliarity. The dimensional model's weaknesses are the reciprocal of its strengths. It is *less familiar* and harder to communicate: a severity level plus a set of trait

qualifiers does not compress into a single memorable phrase the way "narcissistic personality disorder" does, and clinicians trained on the types find the profiles unintuitive at first (New Oxford Textbook of Psychiatry). There has also been decades of *controversy over the best dimensional representation*, how many domains, which ones, how to set the severity anchors, though considerable consensus has now settled on a small set of core trait domains. Notably, once clinicians use the dimensional models they tend to find them *more* clinically useful than the categories, so the unfamiliarity is a transitional cost rather than a permanent defect (New Oxford Textbook of Psychiatry).

GOOD TO REMEMBER

- **Categorical approach:** personality disorders as qualitatively distinct kinds sorted into named types; strengths are clinical familiarity and one-phrase communicability plus documented prevalence, impairment and course; weaknesses are excessive comorbidity, within-category heterogeneity, arbitrary thresholds, temporal instability, limited validity, and incomplete coverage of the subthreshold majority (a large not-otherwise-specified group).
- **Dimensional approach:** personality pathology as maladaptive variants of traits on continua of severity and trait that merge into normality; strengths are better validity, retention of individual profile information and coverage of the subthreshold majority; weaknesses are unfamiliarity, harder single-phrase communication, and past controversy over the best representation.
- **The discriminator to state:** kinds versus degrees; every strength and weakness on each side follows from that one assumption.

4.6 The comparison of approaches, side by side

The object to reproduce cold. The **comparison of approaches** is best held as a two-column ledger of matched trade-offs; the highlighted cells are the points most often tested. Read across each row and the reciprocal structure is obvious: what one approach gains, the other loses.

DIMENSION OF COMPARISON	CATEGORICAL APPROACH	DIMENSIONAL APPROACH
Core claim	Distinct kinds; a disorder you have or lack	**Degrees; maladaptive variants merging into normality**
Diagnosis returns	A type name	A severity level plus a trait profile
Communicability	**High; one phrase carries a prototype**	Lower; a profile is harder to state briefly
Clinical familiarity	**High; the default of medicine, a century of use**	Low; newer and initially unintuitive
Comorbidity	**Excessive; types co-occur freely**	Dissolved; overlap is expected on shared traits
Within-category variation	Large; polythetic criteria yield heterogeneous cases	**Captured; the profile separates similar-looking patients**
Thresholds	Arbitrary, without empirical basis	Graded; the cut is a chosen point on a continuum
Coverage of subthreshold pathology	Poor; a large not-otherwise-specified residual	**Good; the subthreshold majority is still described**

DIMENSION OF COMPARISON	CATEGORICAL APPROACH	DIMENSIONAL APPROACH
Empirical validity	Limited; little evidence for discrete taxa	**Better; matches the continuous latent structure**

The categorical and dimensional approaches as matched trade-offs; the highlighted cells mark each side's decisive advantage, and every row is a consequence of the kinds-versus-degrees choice.

MNEMONIC

Categories COMMUNICATE, dimensions VALIDATE

The one-line split. The **categorical** approach wins on **C**ommunicability and **C**linical familiarity but is **C**omorbidity-ridden and **C**rudely-thresholded. The **dimensional** approach wins on **V**alidity, **V**ariation captured and coverage, but is unfamiliar and hard to state in a phrase. Communicate versus validate is the trade-off, and the field has decided validity should lead.

4.7 Why the field moved to dimensional

The evidence tilted, then the manuals followed. The reason for the shift is not fashion but data. Latent-structure research found little support for discrete personality-disorder taxa, and by a 2007 survey a large majority of personality-disorder experts, some **eighty-seven per cent**, judged that personality pathology was dimensional in nature (New Oxford Textbook of Psychiatry). The verdict in the literature is that the classification of personality pathology has been "slowly but inexorably moving from a categorical to a dimensional model", because a dimensional model better reflects the continuous phenomena and better describes both the distance from normal personality and the degree of severity. That, in a phrase, is **why the field moved to dimensional**: the discrete kinds the categories assume do not appear to exist, and continua describe the reality and predict the outcomes better.

Two manuals, two speeds of change. ICD-11 made the full commitment: it abolished the categorical types outright and rebuilt the diagnosis as a severity rating (personality difficulty, then mild, moderate or severe) followed by the trait-domain qualifiers and an optional borderline pattern, the model taught forward in the ICD-11 dimensional-classification note. DSM-5-TR was more cautious, and its caution is itself the examinable compromise: it kept the familiar categorical clusters and ten types in Section II for everyday use, and placed the alternative model of personality disorders (the AMPD, a dimensional-categorical hybrid built on the Level of Personality Functioning Scale plus five trait domains) in Section III for further study, developed in the DSM-5 categorical-clusters note. The hybrid is the evidence-driven middle path: it scores personality functioning and traits dimensionally, yet still lets a handful of named types be reconstructed, so the field can move toward dimensions without discarding a century of clinical vocabulary at once.

ICD-10 TO ICD-11: WHAT CHANGED

ICD-10 (F60) **kept the categorical types**, paranoid, schizoid, dissocial, emotionally unstable, histrionic, anankastic, anxious and dependent, in step with the DSM tradition. ICD-11 **removed every one of them** and replaced the list with a severity-led dimensional diagnosis plus trait qualifiers and a borderline pattern qualifier. This is the field moving to dimensional in its purest form. Examinations still test the categorical names because DSM-5-TR Section II retains them, because decades of literature and clinical communication run on them, and because the transition is recent, so a candidate must read fluently in both the categorical and the dimensional languages.

WORKED EXAMPLE

Take the same patient through both approaches. A man in his thirties has rigid perfectionism and interpersonal coldness, plus marked suspiciousness, but does not fully meet any single type. The *categorical approach* stalls: he has features of obsessive-compulsive, paranoid and schizoid personality disorder, meets none cleanly, and is filed as a personality disorder, unspecified, a label that says almost nothing. The *dimensional approach* succeeds: rate moderate personality dysfunction and note prominent anankastia and detachment with some negative affectivity, and the profile describes him precisely and guides the plan. The contrast is the whole argument in one case: the category returns a shrug, the dimensions return a description.

4.8 The India lens and the cultural frame

Under-recognition meets a severity-led model. Personality disorders are markedly under-recognised in routine Indian practice: they surface through comorbid mood, anxiety, substance or self-harm presentations rather than as a personality diagnosis, and the personality label is often avoided for fear of stigma (Gupta and Mattoo, on Indian personality-disorder prevalence and demography). A severity-led dimensional system, which begins with a graded judgement of self-and-interpersonal dysfunction rather than demanding a full type match, is well suited to catching the milder and mixed presentations that categorical thresholds cause Indian services to miss. The categorical versus dimensional choice is therefore not only academic here; the dimensional route may materially improve detection.

The cultural expression of pathology cuts across both. Whichever approach is used, the general criteria require deviation from what the person's *own* culture expects, so a self deeply embedded in family and community, or a deference and interdependence that would read as dependence through a Western lens, must not be scored as disorder; personality pathology must not be read through a single culture's norms. On the treatment side, the structured psychotherapies a dimensional severity rating points toward, dialectical behaviour therapy and schema therapy, are available and being culturally adapted in Indian metros and academic centres but remain scarce elsewhere, so a severe rating can outrun what a service can deliver. Antisocial personality disorder carries the sharpest medico-legal edge in Indian practice, and its offender and court framing is handled in the Mental health legislation and forensic psychiatry notes; the wider technique of the psychological therapies belongs to the Psychotherapies, clinical assessment, MSE and nosology notes.

INDIA

Personality disorders are under-recognised in Indian practice, presenting through their comorbidities and often left uncoded for fear of stigma; a dimensional, severity-first reading is better at catching the subthreshold and mixed cases that categorical cut-offs miss. Judge deviation against the patient's own cultural and social norms, so collectivist family-embeddedness is not scored as dependency and religiously framed experience not as schizotypal oddness. The structured psychotherapies that the dimensional model points to, dialectical behaviour therapy and schema therapy, are available and being culturally adapted in the metros and academic centres but unevenly accessible elsewhere; and antisocial personality disorder carries the medico-legal weight, cross-referenced to the forensic notes.

3 / 10	5	5+	87%
DSM-5-TR CATEGORICAL CLUSTERS / TYPES	DIMENSIONAL TRAIT DOMAINS (ICD-11 AND AMPD)	OF NINE BORDERLINE CRITERIA (THE POLYTHETIC THRESHOLD)	OF PD EXPERTS JUDGED PATHOLOGY DIMENSIONAL (2007 SURVEY)

HOLD THIS

The categorical approach treats a personality disorder as a discrete type (familiar and communicable, but comorbid, heterogeneous, arbitrarily thresholded and poor at covering the subthreshold majority); the dimensional approach treats it as severity plus traits on continua (better validity and coverage, but less familiar); the field moved to dimensional because the discrete kinds do not appear to exist, and ICD-11 abolished the types while DSM-5-TR keeps them in front with the AMPD hybrid behind as the evidence-driven compromise.

The personality disorders by cluster

5 . Cluster A: paranoid, schizoid and schizotypal

Why this cluster is worth its marks. **cluster a** is the **odd or eccentric** group, and it rewards a candidate who can do two things: give the one-line essential feature of each of its three types cold, and defend the boundaries that separate them from one another and from frank psychosis. The three are paranoid personality disorder (a pervasive distrust and suspiciousness in which others' motives are read as malevolent), schizoid personality disorder (detachment from social relationships with a restricted range of emotional expression), and schizotypal personality disorder (acute discomfort in close relationships together with cognitive or perceptual distortions and eccentricities of behaviour) (DSM-5-TR). The thread that ties them is a retreat from, or a distortion of, ordinary social relatedness, and at the schizotypal end that thread runs into the **schizophrenia spectrum**.

This fragment first frames the cluster on one grid, then takes each type through its defining criterion and the discriminator an examiner rewards, and finally isolates the single highest-yield boundary of the group, schizotypal versus schizophrenia, with the nosological twist that schizotypal is the one member that both manuals place, wholly or partly, among the psychotic disorders rather than the personality disorders. Two prior cautions carry over from the

framework topics of this chapter and are assumed throughout: the general personality-disorder criteria (an enduring, pervasive, inflexible pattern, culturally deviant, with onset by adolescence, causing impairment, and not better explained otherwise) must be cleared before any of these types is named; and ICD-11 has abolished the categorical types, so "paranoid" and "schizoid" as labels survive only in DSM-5-TR and in clinical shorthand. The deep pharmacology sits in the Schizophrenia: management, antipsychotics and adverse effects notes, the schizophrenia boundary in the Schizophrenia: aetiology, phenomenology, classification and course notes, and the wider psychotherapy technique in the Psychotherapies, clinical assessment, MSE and nosology notes.

5.1 The cluster on one frame

Three types, one thread, graded by how far from reality they drift. DSM-5-TR groups the three types whose sufferers "often appear odd or eccentric" (DSM-5-TR). Read the cluster as a gradient of departure from normal relatedness: paranoid personality disorder distrusts other people but keeps a firm hold on reality; schizoid personality disorder withdraws from other people without distorting them; schizotypal personality disorder adds to that withdrawal a layer of cognitive and perceptual oddness that shades toward, but never reaches, frank psychosis. Learning the three essential features and their thresholds as one block is the fastest route to every cluster A question.

TYPE	ESSENTIAL FEATURE (DSM-5-TR)	THRESHOLD	CORE DISCRIMINATOR
Paranoid	A pervasive distrust and suspiciousness such that others' motives are interpreted as malevolent	Four or more of the seven features	**Suspiciousness with reality intact; no cognitive-perceptual distortion**
Schizoid	Detachment from social relationships with a restricted range of emotional expression	Four or more of the seven features	**A contented loner: no desire for closeness at all**
Schizotypal	Acute discomfort in close relationships, plus cognitive or perceptual distortions and eccentricities of behaviour	Five or more of the nine features	**Odd cognition and perception; the schizophrenia-spectrum edge**

The three DSM-5-TR Cluster A types with their essential features, criterion thresholds and core discriminators; the accompanying figure lays the same three on a distrust-to-distortion gradient.

PEARL

A one-word tag per type keeps them apart under pressure: paranoid is *distrust*, schizoid is *detachment*, and schizotypal is *distortion* laid on top of detachment. The suspiciousness of paranoid and the aloofness of schizoid can both appear in schizotypal, but only schizotypal carries the odd beliefs, perceptions and speech; that added layer is the whole diagnosis.

5.2 Paranoid personality disorder

Malevolent motives read into a neutral world. The essential feature of paranoid personality disorder is a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present across contexts, shown by **four or more of the seven** features (DSM-5-TR). The seven are: unjustified suspicion that others are exploiting, harming or deceiving them; preoccupation with doubts about the loyalty or trustworthiness of associates; reluctance to confide for fear the information will be used against them; reading hidden demeaning or threatening meaning into benign remarks or events; persistently bearing grudges; perceiving attacks on their character that are not apparent to others, with a quick angry counterattack; and recurrent unjustified suspicions about a partner's fidelity. The interpersonal signature is a person who scrutinises every action for hostile intent and cannot accept loyalty when it is shown. Crucially the beliefs are held with suspicion, not with delusional conviction: the patient can, at least in principle, acknowledge an alternative reading, which is exactly what separates this from a persecutory delusion (Companion).

GOOD TO REMEMBER

- **Paranoid personality disorder:** defining criterion is a pervasive distrust and suspiciousness in which others' motives are read as malevolent, four or more of the seven features present, from early adulthood. Discriminator upward from psychosis: the suspicions are not of delusional intensity and alternatives can be acknowledged (from delusional disorder and schizophrenia). Discriminator within the cluster: no cognitive-perceptual distortion or eccentricity, which would move it to schizotypal. First step: confirm the general personality-disorder criteria, then that the suspiciousness is pervasive and reality-based, not a fixed delusion.

5.3 Schizoid personality disorder

The genuine loner, not the frightened one. The essential feature of schizoid personality disorder is a pervasive pattern of detachment from social relationships and a restricted range of emotional expression in interpersonal settings, from early adulthood, shown by **four or more of the seven** features (DSM-5-TR). The seven are: neither desiring nor enjoying close relationships, including being part of a family; almost always choosing solitary activities; little interest in sexual experiences with another person; taking pleasure in few activities; lacking close friends or confidants other than first-degree relatives; indifference to praise or criticism; and emotional coldness, detachment or flattened affect. The person is a contented loner who does not want closeness, presenting a bland exterior with little visible emotional reactivity. The examiner's favourite contrast is with avoidant personality disorder: the avoidant person longs for relationships but is held back by fear of rejection, whereas the schizoid person has no desire for them in the first place. That single question, "do they want closeness?", separates the two.

GOOD TO REMEMBER

- **Schizoid personality disorder:** defining criterion is detachment from social relationships with a restricted, flattened range of emotional expression, four or more of the seven features, from early adulthood. Discriminator from avoidant: absence of any desire for closeness (avoidant desires it but fears rejection). Discriminator from schizotypal: detachment without cognitive-perceptual distortion or eccentricity. First step: establish that solitariness is preferred and pervasive, not a secondary retreat from anxiety, depression or psychosis.

5.4 Schizotypal personality disorder

Attenuated oddness, not frank psychosis. The essential feature of schizotypal personality disorder is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships, together with cognitive or perceptual distortions and eccentricities of behaviour, shown by **five or more of the nine** features (DSM-5-TR). The nine are: ideas of reference (incorrect readings of casual events as having special personal meaning, but short of delusional conviction); odd beliefs or magical thinking influencing behaviour (superstition, belief in clairvoyance, telepathy or a "sixth sense"); unusual perceptual experiences including bodily illusions; odd thinking and speech (vague, digressive or over-elaborate, but without derailment or incoherence); suspiciousness or paranoid ideation; inappropriate or constricted affect; behaviour or appearance that is odd, eccentric or peculiar; lack of close friends other than first-degree relatives; and excessive social anxiety that does not ease with familiarity and is tied to paranoid fears rather than to negative self-judgement. Two distinctions matter. Ideas of reference are not delusions of reference: the difference is conviction. And the social anxiety, unlike the avoidant type's, does not settle as the person gets to know the setting, because it is driven by suspiciousness. Under stress these patients may have transient psychotic-like episodes lasting minutes to hours, usually too brief to meet the threshold for a brief psychotic disorder.

GOOD TO REMEMBER

- **Schizotypal personality disorder:** defining criterion is social and interpersonal deficits plus cognitive or perceptual distortions and eccentricity, five or more of the nine features, from early adulthood. Discriminator within the cluster: it is paranoid plus schizoid plus the distortion layer (odd beliefs, unusual perceptions, odd speech, eccentricity), which neither of the others has. Discriminator upward: the distortions are attenuated, ideas of reference not delusions, no sustained frank psychosis. First step: demonstrate the cognitive-perceptual oddness is enduring and trait-level, then that it never crosses into frank, sustained psychosis.

5.5 Schizotypal versus schizophrenia, and the schizophrenia-spectrum placement

The one member that belongs to the psychosis family. Schizotypal is the boundary the day is built to test. It is characterised by an enduring pattern of unusual speech, perceptions, beliefs and behaviours that resemble *attenuated* forms of the defining symptoms of schizophrenia (ICD-11 CDDR). The line from schizophrenia is drawn on intensity alone: schizophrenia is diagnosed when the symptoms are severe and sustained enough to meet its own threshold, and until then the presentation stays eccentric or peculiar rather than overtly psychotic. The familial evidence backs the kinship: schizotypal aggregates in the first-degree biological relatives of people with

schizophrenia and is regarded as part of the schizophrenia-related spectrum of psychopathology. This is why the classification treats it as a half-member of the personality-disorder family. DSM-5-TR lists it in the personality-disorders chapter but cross-lists it in the Schizophrenia Spectrum and Other Psychotic Disorders chapter and codes it F21. ICD-11 goes further and places schizotypal disorder (6A22) squarely within the schizophrenia and other primary psychotic disorders grouping, not among the personality disorders at all, continuing what ICD-10 did with F21. So while ICD-11 abolished paranoid and schizoid as categories, it kept schizotypal, but moved it out of the personality chapter entirely.

BOUNDARY	CLUSTER A SIDE	THE OTHER SIDE	DISCRIMINATOR
Schizotypal vs schizophrenia	Attenuated distortions; eccentric or peculiar; transient stress-related psychosis of minutes to hours	Frank, sustained delusions or hallucinations meeting threshold	**Intensity alone: attenuation versus frank sustained psychosis**
Schizotypal vs paranoid or schizoid	Cognitive-perceptual distortions and marked eccentricity present	Suspiciousness alone (paranoid) or detachment alone (schizoid)	Presence of the distortion and eccentricity layer
Schizoid vs avoidant	No desire for relationships; content in solitude	Desires relationships but fears rejection	Whether closeness is wanted at all
Paranoid vs delusional disorder	Suspicion not of delusional intensity; alternatives can be acknowledged	Fixed persecutory delusion held with conviction	Delusional conviction and intensity

The four boundaries most often tested around Cluster A; the highlighted cell is the single discriminator that decides schizotypal versus schizophrenia. The schizophrenia side is developed in the Schizophrenia: aetiology, phenomenology, classification and course notes.

RULE **Schizotypal is schizophrenia-spectrum, and the line is intensity.** ICD-11 codes schizotypal disorder 6A22 with the primary psychotic disorders, not the personality disorders; it is separated from schizophrenia by the attenuation of its symptoms alone, not by a different set of symptoms.

TRAP **Calling attenuated schizotypal features schizophrenia.** Ideas of reference, magical thinking, odd speech and eccentricity that never reach frank, sustained delusions or hallucinations are schizotypal, not schizophrenia; upgrading them to a psychotic diagnosis on their oddness alone is the classic error.

WORKED EXAMPLE

A man in his late twenties is referred as "possible schizophrenia". He has always been a fringe figure: he believes he can sense events before they happen, dresses in a way that does not quite fit together, speaks in a vague, over-elaborate way, and keeps to himself because he suspects colleagues mean him harm. There are no sustained delusions and no hallucinations; under stress he has had brief spells of feeling watched that pass within an hour or two. This is schizotypal personality disorder (or ICD-11 schizotypal disorder), not schizophrenia: the cognitive-perceptual features are attenuated and enduring, never crossing into frank, sustained psychosis. The label you avoid saves him a lifelong psychotic diagnosis and its treatment.

5.6 Management in outline, and the cultural reading

Engagement is the treatment; drugs are narrow and symptom-targeted. Cluster A is managed, not cured, and the deep detail is cross-referenced. No drug is disorder-specific for any of the three. The working mode is a structured, supportive psychotherapy delivered with a reliable, low-intensity, non-intrusive stance: for the paranoid and schizoid patient the whole difficulty is engagement, because suspiciousness or a genuine preference for solitude makes them slow to enter therapy and quick to leave it, and over-warmth or forced intimacy can rupture the alliance. For schizotypal personality disorder, a low-dose second-generation antipsychotic (for example, risperidone) can be used in a symptom-targeted, adjunctive way for the cognitive-perceptual features, with the dosing and adverse-effect detail carried in the Schizophrenia: management, antipsychotics and adverse effects notes rather than re-taught here. The broader psychotherapy technique sits in the Psychotherapies, clinical assessment, MSE and nosology notes.

GOOD TO REMEMBER

- **Structured supportive psychotherapy (Cluster A):** mechanism is a reliable, low-intensity working alliance that reduces isolation and reality-tests suspicion without forcing intimacy; indication is all three Cluster A types, chosen because they rarely tolerate intensive, emotionally demanding therapy; signature caution is that engagement itself is the obstacle, so over-familiarity or a pushed pace ruptures the alliance in the paranoid and schizoid patient. For schizotypal, a low-dose second-generation antipsychotic is adjunctive and symptom-targeted only, never disorder-specific.

INDIA

Two genuine India angles converge on Cluster A. First, under-recognition: these are the quietest personality disorders, ego-syntonic and rarely self-referred, so the paranoid and schizoid patient reaches services only through a comorbidity or a family crisis, and the diagnosis is made only when it is actively sought. Second, and more testable, the cultural reading of schizotypal features. Both DSM-5-TR and the ICD-11 CDDR warn explicitly that culturally sanctioned beliefs and practices, belief in the evil eye, a sixth sense, spirit visitation of a deceased relative, shamanic or trance experience, speaking in tongues, magical beliefs about health and illness, can look schizotypal to an uninformed clinician and must not be scored as cognitive-perceptual distortion when they are normative for the person's community. The cultural expression of personality pathology has to be weighed against the patient's own milieu, with an informant where needed, before any Cluster A type is fixed. Structured psychotherapy is available unevenly and mostly at tertiary and private centres.

5.7 The countable skeleton

One line rebuilds the cluster. Three types, two thresholds and one spectrum placement are the whole of Cluster A worth carrying into the hall. Hook them once and each type unpacks from the tag.

MNEMONIC

DISTRUST, DETACH, DISTORT

The three Cluster A types by their one-word core. **DISTRUST** is paranoid personality disorder (suspiciousness, motives read as malevolent, four or more of the seven, reality intact). **DETACH** is schizoid personality disorder (a contented loner, restricted emotion, four or more of the seven, no desire for closeness). **DISTORT** is schizotypal personality disorder (detachment plus cognitive-perceptual oddness and eccentricity, five or more of the nine, the schizophrenia-spectrum edge). Distrust keeps reality; detachment leaves it alone; distortion bends it, but never breaks it.

3	4	5	6A22
CLUSTER A TYPES (ODD OR ECCENTRIC)	OF SEVEN FEATURES: PARANOID OR SCHIZOID THRESHOLD	OF NINE FEATURES: SCHIZOTYPAL THRESHOLD	ICD-11 SCHIZOTYPAL, IN THE SCHIZOPHRENIA SPECTRUM

HOLD THIS

Cluster A is odd or eccentric: paranoid is distrust with reality intact (four or more of the seven), schizoid is detachment with no wish for closeness (four or more of the seven), schizotypal is both plus cognitive-perceptual distortion (five or more of the nine); and schizotypal alone sits on the schizophrenia spectrum (ICD-11 schizotypal disorder 6A22), separated from schizophrenia by attenuation, not by a different symptom.

6 . Borderline personality disorder

The type every examiner returns to. Of the ten categorical types, borderline personality disorder (BPD) is the single highest-yield entity of the chapter: it carries as many criteria as any type, the most differentials, and the only personality-disorder treatment literature dense enough

to examine on its own. The whole picture reduces to one **pervasive pattern of instability**, of interpersonal relationships, of self-image and of affect, welded to marked impulsivity, beginning by early adulthood and present across a variety of contexts. Learn it as a polythetic set of nine features from which **five or more of the nine criteria** must be present, and you can both make the diagnosis and defend it against the two presentations that most often masquerade as it, bipolar II disorder and complex post-traumatic stress disorder.

This fragment walks the nine criteria one by one, spells the threshold, teaches the **course** and the **complications**, and closes on the ICD-11 borderline pattern qualifier as the dimensional equivalent of the same construct. The **affective instability** boundary with the bipolar-II side is cross-referenced to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; the trauma boundary to the Anxiety, OCD and trauma-related disorders notes; and the depth of the disorder-specific psychotherapies (dialectical behaviour therapy, schema therapy, mentalisation-based treatment) to their own topics in this chapter. Everything here sits downstream of the general personality-disorder criteria, which must be cleared before the count begins.

6.1 The essential feature: instability across three domains plus impulsivity

Instability is the signature, in relationships, in the self and in affect. The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image and affects, together with marked **impulsivity**, that begins by early adulthood and is present in a variety of contexts (DSM-5-TR). Three domains are unstable, relationships, self and mood, and a fourth behavioural strand, impulsivity, cuts across all of them; the nine diagnostic criteria are simply these four strands unpacked. Holding the four-strand skeleton first is what stops BPD collapsing into a list to be memorised blind: abandonment and idealisation-devaluation are the *relationship* strand; identity disturbance and chronic emptiness are the *self* strand; reactive mood and inappropriate anger are the *affect* strand; and self-damaging impulsivity, recurrent self-harm and transient stress-related paranoia or dissociation are the *behaviour-under-load* strand. The instability is not situational turbulence but a lifelong, ego-syntonic pattern that the general criteria have already certified as enduring, pervasive and inflexible.

6.2 The nine criteria in full

Reproduce all nine; the count depends on it. The DSM-5-TR criteria (F60.3) are the cleanest form of the construct, and the ICD-11 borderline pattern list mirrors them almost word for word. Carry the block as one table, because a defensible diagnosis names *which* criteria are met, not merely that the patient "seems borderline".

NO.	CRITERION	WHAT IT REQUIRES
1	Abandonment	Frantic efforts to avoid real or imagined **abandonment** (self-harm and suicidal acts are counted separately, under criterion five)

NO.	CRITERION	WHAT IT REQUIRES
2	Unstable relationships	A pattern of unstable and intense interpersonal relationships alternating between extremes of idealisation and devaluation
3	Identity disturbance	**Identity disturbance**: a markedly and persistently unstable self-image or sense of self
4	Impulsivity	Impulsivity in at least two areas that are potentially self-damaging (spending, sex, substance use, reckless driving, binge eating)
5	Self-harm / suicidality	Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour
6	Affective instability	**Affective instability due to a marked reactivity of mood (episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days)**
7	Chronic emptiness	Chronic feelings of emptiness
8	Inappropriate anger	Inappropriate, intense anger or difficulty controlling anger (frequent temper, constant anger, recurrent physical fights)
9	Paranoia / dissociation	Transient, stress-related paranoid ideation or severe dissociative symptoms

The nine DSM-5-TR borderline personality disorder criteria; the highlighted reactivity clause of criterion six is the pivot on which the bipolar-II discrimination turns. The ICD-11 borderline pattern list is materially identical.

6.3 The threshold, and why the disorder is heterogeneous

Five or more of the nine, in any combination. Borderline personality disorder is diagnosed when a pervasive pattern of instability and impulsivity is present, as shown by **five or more of the nine criteria**. Because any five will do, the set is polythetic: two patients can both carry the diagnosis while sharing only one criterion between them, which is why the presentation ranges so widely, from the quietly empty and self-harming to the floridly angry and quasi-psychotic. The count is not the first step, though; the general personality-disorder criteria (enduring, pervasive and inflexible, onset by adolescence, not better explained by another disorder or a substance) are cleared first, and only then are the nine tallied. This is also why heterogeneity is examinable: naming the five you have counted forces the discipline that a pattern-matched label lacks.

MNEMONIC

AM SUICIDE

The nine criteria, one letter each: **A**bandonment fears; **M**ood instability (reactive affect); **S**uicidal or self-mutilating behaviour; **U**nstable, intense relationships (idealisation to devaluation); **I**mpulsivity in two or more self-damaging areas; **C**ontrol of anger poor (inappropriate intense anger); **I**dentity disturbance; **D**issociation or paranoia that is transient and stress-related; **E**mptiness (chronic). Nine letters, nine criteria, threshold five.

9	5	2
BORDERLINE CRITERIA (DSM-5-TR)	MINIMUM MET, OF THE NINE, TO DIAGNOSE	SELF-DAMAGING AREAS FOR THE IMPULSIVITY CRITERION

WORKED EXAMPLE

A woman in her early twenties presents after an overdose following a break-up. On history she describes terror of being left (one), relationships that swing from "he is perfect" to "he is cruel" within days (two), never knowing who she really is (three), recurrent cutting and this overdose (five), moods that flip within an afternoon in response to a text going unanswered (six), and a background sense of emptiness (seven). That is five of the nine met with room to spare, on an enduring pattern predating the current crisis. The diagnosis is defensible not because she "looks borderline" but because you can name the criteria and show they are trait, not a fresh state.

6.4 Abandonment, and the idealisation-devaluation of relationships

The relationship strand is driven by intolerance of aloneness. The frantic efforts to avoid real or imagined **abandonment** (criterion one) are cued by the mere perception of impending separation or the loss of external structure, so that a clinician ending a session on time or arriving a few minutes late can trigger panic or fury out of all proportion. The same sensitivity produces the unstable, intense relationships of criterion two: the patient idealises a new caregiver or lover at the first meeting, demands closeness, then switches abruptly to devaluation when the other is felt not to give or care enough. These sudden reversals in the view of another person, from all-good to all-bad, are the surface of the classical defence of splitting, in which contradictory images of self and other cannot be held together, so they alternate instead.

PEARL

Splitting is the mechanism the object-relations tradition (Otto Kernberg) places at the centre of the borderline structure: the inability to integrate good and bad representations of the same person, so that idealisation and devaluation swing back and forth rather than blending into a whole, ambivalent view. Naming splitting explains criterion two and the "you are the only one who understands me / you are just like all the others" whiplash that clinicians feel in the room.

6.5 Identity disturbance and chronic emptiness

The self strand is a self that will not hold still. Identity disturbance (criterion three) is a markedly and persistently unstable self-image or sense of self: values, goals, career direction, sexual identity and even the felt sense of existing can shift suddenly, and the person may report

at times a feeling that they do not exist at all. It is worst in unstructured settings, where there is no external scaffold to borrow an identity from, which is why performance can collapse in open-ended work or study while holding up under close direction. Running underneath it is criterion seven, chronic feelings of emptiness, a persistent hollowness distinct from the sadness of depression: not "I feel low" but "there is nothing inside". The two together are the self-strand that the disorder-specific psychotherapies target most directly, and they are also the features most easily overlooked when attention fixes on the dramatic behaviours.

6.6 Affective instability and inappropriate anger, and the bipolar-II line

The affect is reactive, fast and interpersonally cued. **Affective instability** (criterion six) is defined by a marked reactivity of mood: episodic dysphoria, irritability or anxiety that is triggered, most often by an interpersonal event, and that usually lasts a few hours and only rarely more than a few days. Criterion eight, inappropriate and intense anger, belongs to the same strand: disproportionate temper, sustained anger, sometimes physical fights, frequently aimed at the very person whose closeness is most wanted. This is the criterion pair that collides with bipolar II disorder, and the collision is the highest-yield discrimination on the topic. Bipolar mood runs as sustained, autonomous episodes lasting days to weeks, carrying change in sleep, energy and goal-directed activity; borderline mood is reactive, brief and settles when the trigger resolves. The full grid sits on the bipolar-II topic; here, hold the discriminator.

RULE **Read the clock and the trigger on the mood.** Borderline affective instability is reactive, interpersonally cued and settles in hours; a mood that runs autonomously for days to weeks with change in sleep, energy and goal-direction is a bipolar episode, not a personality trait.

TRAP **Starting a mood stabiliser for personality-based instability.** Missing the borderline-versus-bipolar-II distinction and reading reactive, hours-long lability as bipolar II disorder medicalises a pattern whose primary treatment is structured psychotherapy; the drug then follows the misdiagnosis rather than the illness.

6.7 Impulsivity, recurrent self-harm and suicidality

The behaviour-under-load strand is where the risk lives. Criterion four requires **impulsivity** in at least two potentially self-damaging areas, spending, sex, substance use, reckless driving or binge eating, and it is counted separately from the self-directed acts. Those acts are criterion five: **recurrent self-harm** and **suicidality**, which is to say recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour. Self-harm in borderline personality disorder frequently functions to regulate unbearable affect or to end dissociation rather than to end life, but the two intentions coexist and the mortality is real, so the presence of a regulatory function never downgrades the risk assessment. Chronic recurrent self-harm and acute suicidality must be held apart in the moment: the enduring pattern is expected, while a change from baseline, a new plan or a fresh stressor, is what escalates management.

6.8 Transient stress-related paranoia and dissociation

The quasi-psychotic criterion is transient and stress-bound. Criterion nine is **transient stress-related paranoia** (paranoid ideation) or severe **dissociation**, arising in states of high

affective arousal, most often under the threat of abandonment, and resolving as the arousal subsides. The qualifiers are load-bearing: *transient* and *stress-related* separate these micro-psychotic experiences from the sustained, autonomous psychosis of a schizophrenia-spectrum disorder, and from the enduring cognitive-perceptual oddness of schizotypal personality. They are brief, reactive, and the patient usually retains some distance from them once calm. This criterion is also the one that overlaps most with the dissociative and hyperarousal features of complex post-traumatic stress disorder, which is the second great mimic of the syndrome.

COMMON TRAP

Collapsing complex post-traumatic stress disorder into borderline personality disorder. Both follow early adversity and share affect dysregulation, dissociation and unstable relationships, but complex post-traumatic stress disorder is built on the trauma triad (re-experiencing, avoidance, hyperarousal) plus disturbances in self-organisation, and its instability is trauma-cued rather than the enduring, abandonment-driven identity pathology of borderline personality disorder. The boundary and its therapeutic consequences are developed in the Anxiety, OCD and trauma-related disorders notes.

6.9 The course: waxing and waning, remission that outpaces recovery

The symptoms remit long before function returns. The **course** of borderline personality disorder is a waxing and waning one that trends, over years, toward **symptomatic remission**: in long-term prospective follow-up (the McLean Study of Adult Development led by Zanarini, and the Collaborative Longitudinal Personality Disorders Study), the majority of patients no longer meet full criteria after several years, and the acute, impulsive features, self-harm, quasi-psychotic episodes, stormy relationships, tend to attenuate earliest. The catch is that *functional* recovery, stable work and durable relationships, lags well behind symptomatic remission; a patient can stop meeting criteria yet remain vocationally and interpersonally disabled. This dissociation between symptom remission and functional recovery is the examinable heart of the prognosis, and it reframes the disorder as more remitting than its acute presentation suggests, while cautioning against calling a symptomatic remission a cure.

6.10 The complications, and the management orientation

The morbidity clusters in four places. The **complications** of borderline personality disorder are, first, repeated self-harm; second, completed suicide, whose lifetime rate is substantial and highest in the early acute years; third, comorbid substance use, mood and eating disorders that both worsen impulsivity and confound the diagnosis; and fourth, the corrosive impact on relationships and on work, which is the burden that outlasts the symptoms. The management orientation follows directly from the course: structured psychological therapy is the primary treatment, the disorder-specific models (dialectical behaviour therapy, schema therapy, mentalisation-based treatment) are taught on their own topics, and pharmacotherapy is symptom-targeted, adjunctive and time-limited rather than a treatment for the disorder itself; the deep drug detail sits in the Mood disorders: pharmacotherapy notes. Crucially, a diagnosis of borderline personality disorder is never grounds to exclude a patient from care.

INDIA

Borderline personality disorder is markedly under-recognised in Indian practice. Patients reach services through the self-harm or the overdose, which is coded as the attempt rather than the pattern, so the underlying disorder is captured only when it is deliberately sought. Two adaptations matter. First, cultural expression: transient dissociative and possession-trance presentations are normative idioms of distress in many Indian settings and must not be over-read as the criterion-nine dissociation, just as family interdependence must not be read as pathological abandonment fear; judge every criterion against the person's own culture. Second, access: dialectical behaviour therapy and schema therapy are being delivered and culturally adapted at Indian tertiary and private centres rather than being widely available, which is what a realistic management plan must reckon with.

6.11 The ICD-11 borderline pattern qualifier: the dimensional equivalent

The same construct, carried forward into the dimensional model. ICD-11 abolished the categorical types, but it did not abolish borderline; it preserved the construct as an optional *borderline pattern* specifier (6D11.5), applied on top of a rated severity level and the trait-domain qualifiers. A complete ICD-11 formulation reads, for example, "moderate personality disorder with negative affectivity, dissociality and disinhibition, borderline pattern": severity first, trait domains next, borderline pattern last. The specifier is defined by the same list of features, a pervasive pattern of instability of relationships, self-image and affects with marked impulsivity, and the CDDR applies the *same* formal threshold as DSM-5-TR, five or more of nine features, so the count is not a DSM-only device; it overlaps most with the negative affectivity, dissociality and disinhibition domains. It was retained for a frankly pragmatic reason, which examiners like: to flag the patients who respond to the established borderline-specific psychotherapies. The categorical name therefore survives inside the dimensional system, which is why both are testable.

GOOD TO REMEMBER

- **Borderline personality disorder:** defining requirement is a pervasive pattern of instability of relationships, self-image and affect with marked impulsivity, meeting five or more of the nine criteria (abandonment, unstable idealising-devaluing relationships, identity disturbance, self-damaging impulsivity in at least two areas, recurrent self-harm or suicidality, reactive affective instability, chronic emptiness, inappropriate anger, transient stress-related paranoia or dissociation). Discriminator: the affect is rapidly reactive and interpersonally triggered and lasts hours, versus the sustained autonomous episodes of bipolar II disorder. First diagnostic step: clear the general personality-disorder criteria, then count the nine. ICD-11 keeps the construct as the optional borderline pattern qualifier on the dimensional model.

HOLD THIS

Borderline personality disorder is five or more of the nine, on a pervasive base of unstable relationships, unstable identity and reactive affect with impulsivity; the affect swings in hours and tracks interpersonal triggers, which is exactly what separates it from the sustained, autonomous episodes of bipolar II disorder.

7 . Antisocial personality disorder and forensic implications

The type the courts ask about. antisocial personality disorder (**aspd**; dissocial personality disorder in the older ICD terms) is the Cluster B type defined by a pervasive **disregard for and violation of the rights of others**, and it is the one personality disorder the examination reliably pushes into the medico-legal arena. Two features make it examinable beyond the criteria list. First, it is the only personality disorder with a hard developmental gate: it may not be diagnosed without evidence of conduct disorder before adolescence and it may not be diagnosed before adulthood, so the **age criterion** is part of the definition rather than a footnote. Second, it carries the **forensic implications** of the chapter, offending, the assessment of dangerousness, and the court report, and it forces the candidate to hold apart three things that are constantly conflated: the disorder, the construct of psychopathy, and criminality itself.

This fragment states the essential feature and walks the seven adult criteria, fixes the conduct-disorder precursor and the two ages, separates **aspd** from psychopathy and its **pcl-r** construct, cross-maps the categorical name onto the ICD-11 dimensional model, and then develops the two forensic tasks the psychiatrist is actually asked to perform, the structured assessment of dangerousness and the court report. The deep offender-management and legislative detail is carried in the Mental health legislation and forensic psychiatry notes; the general psychotherapy technique in the Psychotherapies, clinical assessment, MSE and nosology notes; and any symptom-targeted pharmacology in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes. Everything here sits downstream of the general personality-disorder criteria, which must be cleared before the count begins.

7.1 The essential feature: a pervasive disregard for the rights of others

The pattern violates the rights of others, and it began in childhood. The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others, occurring since the age of fifteen years and continuing into adulthood (DSM-5-TR, F60.2). The manual notes in the same breath that this pattern has also been called **psychopathy**, sociopathy or dyssocial personality disorder, which is precisely the overlap the topic exists to disentangle. The behaviour is not a run of bad choices but an enduring, ego-syntonic trait structure: callous unconcern for others' feelings, a readiness to deceive and exploit, impulsive action without forethought, irritable aggression, reckless indifference to safety, chronic irresponsibility, and an absence of guilt. Because deceit and manipulation are central to the presentation, DSM-5-TR advises explicitly that the clinical account be corroborated from collateral and documentary sources rather than taken on the patient's word, a caution that matters even more when the assessment is destined for a court.

7.2 The seven adult criteria, and the three-of-seven threshold

Three or more of the seven, on the enduring pattern. Criterion A is met by **three or more of the seven** features below, present since the age of fifteen years (DSM-5-TR). Carry the block as one table, because a defensible antisocial diagnosis names which features are met, and the

affective item, **lack of remorse**, is the one that later separates the disorder from the narrower construct of psychopathy.

NO.	CRITERION (DSM-5-TR)	WHAT IT REQUIRES
1	Failure to conform to law	Failure to conform to social norms with respect to lawful behaviour, repeatedly performing acts that are grounds for arrest (whether or not arrest follows)
2	Deceitfulness	**deceitfulness**: repeated lying, use of aliases, or conning others for personal profit or pleasure
3	Impulsivity	Impulsivity or failure to plan ahead; decisions made on the spur of the moment without regard for consequences
4	Irritability and aggressiveness	Irritability and aggressiveness, indicated by repeated physical fights or assaults (acts in self-defence do not count)
5	Reckless disregard for safety	Reckless disregard for the safety of self or others (dangerous driving, high-risk behaviour, endangering a dependent)
6	Consistent irresponsibility	Consistent **irresponsibility**: repeated failure to sustain work or to honour financial obligations
7	Lack of remorse	**lack of remorse: being indifferent to, or rationalising, having hurt, mistreated or stolen from another**

The seven DSM-5-TR antisocial personality disorder criteria, of which three or more must be present; the highlighted affective item, lack of remorse, is the feature that most nearly touches the psychopathy construct and is the least likely to be present in ordinary offending.

MNEMONIC

CORRUPT

The seven criteria, one letter each. **C**onformity to law lacking (acts that are grounds for arrest); **O**bligations ignored (consistent irresponsibility, work and money); **R**eckless disregard for safety; **R**emorselessness (lack of remorse); **U**nderhandedness (deceitfulness, lying and conning); **P**lanning absent (impulsivity, failure to plan ahead); **T**emper (irritability and aggressiveness, repeated fights). Seven letters, seven criteria, threshold three.

Two exclusions close the definition. Two further clauses complete Criterion A's scaffolding. The individual must be at least eighteen years old (Criterion B) and must have shown evidence of conduct disorder with onset before fifteen years (Criterion C); and the antisocial behaviour must

not occur exclusively during the course of schizophrenia or a bipolar disorder (Criterion D), so that antisociality driven by mania or by psychosis is excluded from the personality diagnosis.

GOOD TO REMEMBER

- **Antisocial personality disorder:** defining requirement is a pervasive pattern of disregard for and violation of the rights of others since age fifteen, meeting three or more of the seven criteria (failure to conform to law, deceitfulness, impulsivity, irritability and aggressiveness, reckless disregard for safety, consistent irresponsibility, lack of remorse), with the individual at least eighteen and with documented conduct disorder before fifteen, and the behaviour not confined to schizophrenia or bipolar disorder. Discriminator: it is a trait pattern with a childhood-conduct-disorder precursor, not a synonym for a criminal record. First diagnostic step: clear the general personality-disorder criteria, confirm the conduct-disorder history and the age, then count the seven.

7.3 The conduct-disorder precursor and the age criterion

The developmental spine: oppositional to conduct to antisocial. The **age criterion** is what makes this a developmental diagnosis. The disorder cannot be given before eighteen years, and it cannot be given at all without evidence of conduct disorder with onset before fifteen years (DSM-5-TR). Conduct disorder is itself a repetitive, persistent violation of the basic rights of others or of major age-appropriate norms, and its behaviours fall into four groups, aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules; oppositional defiant disorder is a frequent earlier precursor of the childhood-onset type. The line runs, in the minority who progress, from oppositional through conduct disorder into the adult antisocial pattern, and the childhood-onset conduct disorder carries the worse prognosis. Most children with conduct disorder do not become antisocial adults, but essentially every antisocial adult has a conduct-disordered childhood, which is exactly why the history is a mandatory gate and not an optional descriptor. The developmental trajectory is laid out in the accompanying figure.

RULE **No conduct disorder before fifteen, no antisocial personality disorder.** Evidence of childhood conduct disorder and an age of at least eighteen are hard gates in the criteria; the antisocial diagnosis is a developmental one and cannot be built from an adult offending history alone.

TRAP **Reading a criminal record as antisocial personality disorder.** Offending, gang membership or survival-driven rule-breaking is not the disorder without the enduring, pervasive trait pattern and the conduct-disorder precursor; and antisociality seen only during mania or psychosis is excluded by Criterion D. Crime is neither necessary nor sufficient for the diagnosis.

7.4 Antisocial personality disorder versus psychopathy: the affective-interpersonal core and the PCL-R

Psychopathy is the narrower, affect-defined construct. psychopathy overlaps with antisocial personality disorder but is not the same thing, and treating them as interchangeable is the classic error. The categorical diagnosis is defined largely by observable antisocial *behaviour*; psychopathy is defined by an affective-interpersonal *core*, the glib superficial charm, grandiosity, pathological lying, callousness and, above all, the absence of guilt, remorse or empathy that Hervey Cleckley

described in *The Mask of Sanity* (1941). The construct has been dropped from the formal classifications but survives in forensic psychology and the prison service, where it is assessed with the Hare Psychopathy Checklist-Revised (the **pcl-r**; Robert Hare, 1991), a rater-scored instrument of twenty items, each scored zero to two, to a maximum of forty. The items load onto two factors: an interpersonal-affective factor (the charm, callousness and exploitation, the true psychopathic core) and a lifestyle-antisocial factor (the impulsive, irresponsible and violent behaviour that overlaps heavily with the antisocial criteria). Most people who meet the antisocial criteria do *not* reach a high psychopathy score; psychopathy is the smaller, affect-defined subset carrying the interpersonal-affective factor, and it is that factor, not the criminal record, that predicts the most instrumental and remorseless offending. The overlap and the nesting are shown in the figure alongside.

PEARL

Karpman, paralleling Cleckley's clinical description, distinguished *primary* from *secondary* psychopathy: the primary psychopath acts without anxiety, guilt or autonomic arousal, the mark of the affective deficit, while the secondary psychopath reports guilt and fear but offends through poor impulse control and emotional lability. The distinction maps loosely onto the two PCL-R factors, and it is why "psychopathy" is best reserved for the affective-interpersonal core and, as the general-psychiatry texts advise, largely avoided as a loose synonym for antisocial personality disorder.

GOOD TO REMEMBER

- **Psychopathy and the PCL-R:** the defining feature is the affective-interpersonal core, callousness and the absence of guilt, remorse and empathy (Cleckley), which the behaviour-based antisocial criteria do not require; the instrument is the Hare Psychopathy Checklist-Revised, twenty items scored zero to two to a maximum of forty, with an interpersonal-affective factor and a lifestyle-antisocial factor. Discriminator from antisocial personality disorder: psychopathy is the smaller, affect-defined subset, so most antisocial patients are not psychopathic; the two terms are not interchangeable, and psychopathy is not a diagnostic category in DSM-5-TR or ICD-11.

7.5 The classification frame: DSM-5-TR categorical, ICD-10 dissocial, ICD-11 dissociality

The same construct across three systems. In DSM-5-TR Section II the disorder is the antisocial type in Cluster B (the dramatic, emotional or erratic cluster). ICD-10 kept an almost identical categorical entity under the name dissocial personality disorder, requiring at least three of six traits, callous unconcern for others' feelings, gross and persistent irresponsibility and disregard for social norms, incapacity to maintain enduring relationships, very low frustration tolerance with a low threshold for aggression, incapacity to experience guilt or to profit from experience or punishment, and a marked proneness to blame others, with a childhood conduct-disorder history offered as supporting evidence. ICD-11 then abolished the categorical types altogether: there is now a single personality-disorder diagnosis rated first by severity (personality difficulty, then mild, moderate or severe) and qualified by the five trait domains. The antisocial construct is captured dimensionally by prominent **dissociality** (the ICD-11 domain 6D11.2, whose core feature is a disregard for the rights and feelings of others, self-centredness and lack of empathy),

usually together with **disinhibition** (impulsivity, irresponsibility, recklessness), at a moderate or severe level. The forward teaching of the ICD-11 dimensional model, its severity gradient and its five domains, is developed on the framework topics; here, hold the cross-map. The categorical names still dominate the examination and the courtroom because DSM-5-TR retains them and the case-law is written in them, which is why "antisocial" and "dissocial" remain testable even after ICD-11 has moved on.

7.6 Forensic implications: offending and the assessment of dangerousness

The task is a structured, defensible estimate of future risk. The **forensic implications** begin with offending: antisocial personality disorder is far commoner in men and is markedly over-represented in prison populations, and it frequently co-occurs with substance misuse, which amplifies impulsive aggression. The recurring clinical demand is the **assessment of dangerousness**, an estimate of the risk of future violence. Three approaches exist, and the examinable point is which is preferred. Unstructured clinical judgement is variable and biased; purely actuarial scoring is reliable but ignores the individual's own risk and protective factors; the recommended middle path is **structured professional judgement**, in which the clinician rates empirically derived risk factors systematically and then integrates them with the individual case (Clinical Methods in Psychiatry, AIIMS 2024). The most researched such instrument is the HCR-20, a twenty-item scheme across three scales, ten Historical (static) factors including past violence, young age at first violence, psychopathy and personality disorder, five Clinical (dynamic) factors, and five Risk-Management (dynamic) factors; each item is scored absent, partial or present, and the clinician then makes a summary rating of low, moderate or high, which is deliberately *not* a mechanical sum of ticks. A high PCL-R psychopathy score is itself one of the strongest single predictors of violent recidivism, which is why the two instruments are used together. Whenever risk is judged to be directed at an identifiable person, the duty to protect can override confidentiality. The three approaches are contrasted in the accompanying figure.

RULE **Structure the risk estimate, then judge it; never tick and total.** Dangerousness is assessed by structured professional judgement, empirically derived factors rated systematically and then weighed for the individual, ending in a reasoned low, moderate or high rating, not by the raw count on any checklist.

7.7 Forensic implications: court reports and the medico-legal frame

Antisocial personality disorder is a matter of disposal, not of exculpation. The second forensic task is the court report, and its central caution is that the antisocial diagnosis rarely excuses a crime. The insanity defence turns on a defect of reason from unsoundness of mind such that the accused did not know the nature of the act or that it was wrong, and the courts distinguish this *legal* insanity sharply from any *medical* diagnosis; a personality disorder, being a stable trait pattern rather than a disorder that clouds the knowledge of nature or wrongfulness, seldom meets that test. Psychiatric evidence is treated as relevant, not determinative. So the forensic weight of antisocial personality disorder falls on the assessment of dangerousness, on fitness to stand trial, and on disposal and sentencing, and on the psychiatric prediction of future dangerousness that the law can demand before an insanity-acquitted person is discharged, rather

than on culpability itself. In the report the clinician is an expert assisting the court: the opinion must be evidence-based, non-pejorative, carefully recorded (what is not written is treated as not done), and explicit about the limits of prediction. This medico-legal frame, the statutes, the fitness assessment, the disposal pathways and the report structure, is developed in the Mental health legislation and forensic psychiatry notes.

Criminal responsibility (insanity defence)

Whether unsoundness of mind prevented the accused knowing the nature of the act or that it was wrong; a legal test, judged against medical evidence, that antisocial personality disorder rarely satisfies.

Fitness to stand trial

Whether the accused can understand the charge and proceedings and instruct a defence; assessed before culpability is considered.

Assessment of dangerousness

A structured, professionally judged estimate of the risk of future violence, informing bail, disposal, discharge and management, not guilt.

The expert witness / court report

The psychiatrist assists the court with an impartial, evidence-based, well-documented opinion; relevant to the court's decision but never determinative of it.

The four medico-legal points where antisocial personality disorder meets the court; note that all four concern process, risk and disposal, not the excusing of the offence, whose statutory detail sits in the Mental health legislation and forensic psychiatry notes.

WORKED EXAMPLE

A man in his thirties is remanded after a violent robbery and referred for a court report and a "diagnosis of psychopathy". The history shows truanting, cruelty and theft from before the age of twelve, expulsions, repeated adult convictions, a chaotic work record, unpaid debts, and a flat indifference to the people he has hurt. He meets the antisocial criteria comfortably, with conduct disorder well before fifteen. The report says three things and no more than it can defend: the diagnosis is antisocial personality disorder (not, on this assessment, formally psychopathy, which would need a rated PCL-R); the disorder does not amount to the unsoundness of mind that founds an insanity defence, so it does not reduce his responsibility for the act; and his risk of future violence, assessed by structured professional judgement, is high and should guide disposal. The value of the report lies in what it declines to claim as much as in what it asserts.

RULE **Antisocial personality disorder is not an insanity defence.** As a stable trait pattern it seldom meets the legal test of unsoundness of mind; its forensic relevance is to dangerousness, fitness and disposal, not to exculpation, and the psychiatric opinion is relevant to the court, never determinative.

7.8 Management: guideline-anchored, psychological-first, and drug-sparing

Structured psychological work leads; no drug treats the personality. Management is modest and guideline-anchored, and the deep detail is cross-referenced. NICE recommends offering people with antisocial personality disorder group-based cognitive and behavioural interventions, involving the person in choosing their duration and intensity, and delivered where relevant in

criminal-justice as well as health settings, and it stresses a structured clinical assessment to make the diagnosis in the first place (NICE 2015). No drug is recommended or licensed for the antisocial personality itself; pharmacotherapy is reserved for a comorbid mental disorder, and where impulsive aggression is a treatment target it is addressed adjunctively and off-licence, for example with a mood stabiliser such as divalproex (Valprol, Encorate) or a second-generation antipsychotic, with the dosing and adverse-effect detail carried in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes rather than re-taught here. Engagement is the perennial obstacle: the condition is ego-syntonic, motivation is external, and manipulation of the therapeutic frame is expected, so treatment leans on structure, clear limits and realistic goals. Mentalisation-based treatment, adapted for antisocial personality disorder (Bateman and Fonagy), is an emerging structured option under trial; its general technique sits in the Psychotherapies, clinical assessment, MSE and nosology notes.

GOOD TO REMEMBER

- **Group cognitive-behavioural therapy for antisocial personality disorder:** mechanism is a structured, skills-based group intervention targeting the cognitions and behaviours that drive offending, delivered with firm limits; indication is antisocial personality disorder, especially with an offending history, and it is the NICE-recommended mainstay (NICE 2015), the person sharing the choice of duration and intensity; signature caution is that no drug is recommended for the personality itself, that medication is only for a comorbid disorder or, adjunctively and off-licence, for impulsive aggression, and that poor engagement and manipulation of the frame are the rule, not the exception.

INDIA

Three genuine India angles converge on antisocial personality disorder. First, under-recognition: personality disorders are markedly under-recognised in routine Indian practice, and the antisocial pattern in particular surfaces through its comorbidities, a substance-use disorder, repeated violence, or a legal referral, rather than as a personality diagnosis, so it is captured only when actively sought and a corroborated developmental history is taken. Second, the medico-legal frame is where the label carries the most force in India: the insanity defence rests on the unsoundness-of-mind test derived into the Indian Penal Code, which antisocial personality disorder rarely satisfies, so the psychiatrist's work is court reports, fitness assessment and the prediction of dangerousness rather than exculpation, and the dedicated forensic and secure-service infrastructure to support it is thin, developed in the Mental health legislation and forensic psychiatry notes. Third, the cultural expression of personality pathology: deviation must be judged against the person's own cultural, social and economic milieu, so that survival-driven or subcultural offending, or antisociality confined to a substance-use context, is not scored as trait pathology, and the diagnosis is not read through a single culture's norms. Structured group and mentalisation-based programmes for the disorder are scarcely available outside a few tertiary and forensic centres.

COMMON TRAP

Collapsing psychopathy into antisocial personality disorder and treating the two as one label. The antisocial criteria are behaviour-based and are met by a large, heterogeneous group, most of whom are not psychopathic; psychopathy is the narrower affective-interpersonal construct measured by the PCL-R, and it, not the criminal record, drives the most instrumental and remorseless offending. Writing "psychopath" where the assessment supports only antisocial personality disorder, or vice versa, is a straight error, and in a court report it is a consequential one.

3	15	18	20
OF THE SEVEN CRITERIA TO DIAGNOSE ANTISOCIAL PERSONALITY DISORDER	AGE (YEARS) BEFORE WHICH CONDUCT DISORDER MUST BE EVIDENT	MINIMUM AGE (YEARS) FOR THE ANTISOCIAL DIAGNOSIS	ITEMS ON THE HARE PSYCHOPATHY CHECKLIST-REVISED (PCL-R)

HOLD THIS

Antisocial personality disorder is a pervasive disregard for the rights of others, three or more of the seven criteria (failure to conform to law, deceitfulness, impulsivity, irritability and aggressiveness, reckless disregard for safety, consistent irresponsibility, lack of remorse), gated by conduct disorder before fifteen and an age of at least eighteen; it is not a synonym for psychopathy (the narrower affective-interpersonal PCL-R construct) nor for criminality, and its forensic weight is in the structured assessment of dangerousness and the court report, not in the insanity defence.

8 . Histrionic and narcissistic personality disorders

Why these two share a page. Both sit in **cluster b**, the dramatic, emotional or erratic group, and both are built around a hunger for the regard of others, so the examiner tests them together and rewards the candidate who can separate them cleanly. histrionic personality disorder is a pervasive pattern of excessive emotionality and **attention-seeking** (DSM-5-TR), and narcissistic personality disorder is a pervasive pattern of grandiosity, a **need for admiration** and a lack of empathy (DSM-5-TR). They look alike from a distance, two people who must be regarded, but the object of the wanting differs: the histrionic person needs to be the centre of attention and will take any role to get there, while the narcissistic person needs admiration for a superiority they believe is real.

This fragment frames the pair on one grid, takes each through its essential feature and criterion threshold, then isolates the single modern high-yield point, the split within narcissism between **grandiose narcissism** and **vulnerable narcissism**, the overt entitled presentation and the covert, hypersensitive, shame-prone one. Two cautions carry over and are assumed throughout: the general personality-disorder criteria (an enduring, pervasive, inflexible pattern, deviant from the person's own culture, with onset by adolescence or early adulthood, causing impairment, and not better explained otherwise) must be cleared before either type is named; and ICD-11 has abolished both as categories, so histrionic and narcissistic survive as labels only in DSM-5-TR and in clinical shorthand. The fully taught structured psychotherapies of this chapter and the general technique sit in the Psychotherapies, clinical assessment, MSE and nosology notes; the

borderline neighbour that both are most often confused with is developed elsewhere in this chapter.

8.1 The two on one frame

Both crave regard; the object of the craving divides them. Read the pair as a single question asked two ways. The histrionic patient organises a whole personality around being noticed, with emotion as the currency; the narcissistic patient organises it around being admired as superior, with a fragile self-esteem underneath. Learn the essential feature, the threshold and the one discriminator for each as a block, and most stems fall out of it.

TYPE	ESSENTIAL FEATURE (DSM-5-TR)	THRESHOLD	CORE DISCRIMINATOR
Histrionic	Pervasive and excessive emotionality and attention-seeking; discomfort when not the centre of attention	Five or more of the eight features	**Wants attention itself; will be fragile, seductive or dependent, whatever draws the eye**
Narcissistic	Grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy	Five or more of the nine features	**Wants admiration for a believed superiority; entitlement and empathy failure, over a fragile self-esteem**

The two Cluster B attention-oriented types with their essential features, criterion thresholds and the single dividing discriminator; the accompanying figure sets attention-seeking against need for admiration on one axis.

PEARL

One question separates them at the bedside: *what does the attention buy?* For histrionic personality disorder attention is the goal in itself, and the person will happily be seen as fragile, ill or dependent if that is what turns heads. For narcissistic personality disorder attention must come as admiration of superiority; being pitied or seen as needy is intolerable, because it threatens the grandiose self.

8.2 Histrionic personality disorder

Emotion as performance, staged to be watched. The essential feature of histrionic personality disorder is a pervasive pattern of excessive emotionality and attention-seeking behaviour, beginning by early adulthood and present across contexts, shown by **five or more of the eight** features (DSM-5-TR). The eight are: discomfort in situations where they are not the centre of attention; interaction often marked by inappropriate sexually seductive or provocative behaviour; rapidly shifting and shallow expression of emotions; consistent use of physical appearance to draw attention to the self; a style of speech that is excessively impressionistic and lacking in detail; self-dramatisation, theatricality and exaggerated expression of emotion; suggestibility, being easily influenced by others or by circumstances; and considering relationships to be more intimate than they actually are. The signature is a person who is lively, charming and flirtatious on first meeting but whose emotions seem turned on and off too quickly to be deeply felt, whose strong opinions come with dramatic flair but no supporting detail, and

who becomes uncomfortable or aggrieved the moment the spotlight moves. Impairment tends to be milder than in the other Cluster B types and is chiefly interpersonal, with romantic and same-sex friendships strained by the demand for constant attention and the provocative style.

GOOD TO REMEMBER

- **Histrionic personality disorder:** defining criterion is pervasive excessive emotionality and attention-seeking, five or more of the eight features, from early adulthood, with discomfort when not the centre of attention as the anchoring item. Discriminator from narcissistic: it wants attention as such and will accept a fragile or dependent role to get it, where narcissistic wants admiration for superiority. Discriminator from borderline: no chronic emptiness, identity disturbance, self-destructiveness or angry abandonment ruptures. Discriminator from dependent: the flamboyant, theatrical, exaggerated emotionality that dependent lacks. First step: confirm the general personality-disorder criteria, then that the emotionality and attention-seeking are trait-level and pervasive, not a phase or a state.

8.3 Narcissistic personality disorder

Grandiosity above, fragility below. The essential feature of narcissistic personality disorder is a pervasive pattern of grandiosity in fantasy or behaviour, a need for admiration and a lack of empathy, beginning by early adulthood and present across contexts, shown by **five or more of the nine** features (DSM-5-TR). The nine are: a grandiose sense of self-importance; preoccupation with fantasies of unlimited success, power, brilliance, beauty or ideal love; a belief in being special and unique, understood only by, or fit to associate only with, other special or high-status people or institutions; a requirement for excessive admiration; a sense of entitlement, meaning unreasonable expectations of especially favourable treatment or automatic compliance; interpersonal exploitativeness, taking advantage of others to reach one's own ends; a lack of empathy, an unwillingness to recognise or identify with the feelings and needs of others; envy of others or a belief that others envy oneself; and arrogant, haughty behaviours or attitudes. The clinically important addition, spelled out in the DSM-5-TR text, is that the self-esteem beneath the grandiosity is almost always fragile: criticism or defeat can leave the person feeling ashamed, humiliated, hollow and empty, reacting with disdain, rage, or a withdrawal that masks the grandiosity rather than removing it. Empathy is typically cognitive but not emotional, they can read another's perspective yet do not feel with them.

GOOD TO REMEMBER

- **Narcissistic personality disorder:** defining criterion is grandiosity, a need for admiration and a lack of empathy, five or more of the nine features, from early adulthood. Discriminator from histrionic: admiration must be for a believed superiority, and a needy or fragile role is intolerable. Discriminator from antisocial: narcissistic lacks the impulsivity, aggression, deceit and childhood conduct-disorder history, and exploits to enhance the self rather than for material gain. Discriminator from borderline: relatively stable self-image and far less physical self-destructiveness and abandonment terror. First step: confirm the general criteria, then look past the grandiose surface for the fragile self-esteem that the presentation is defending.

8.4 Grandiose versus vulnerable narcissism

One disorder, two faces. The highest-yield modern point is that narcissism presents along two phenotypes rather than one. grandiose narcissism is the overt, textbook picture: openly entitled,

arrogant, exhibitionistic, admiration-demanding, thick-skinned. vulnerable narcissism is the covert picture: hypersensitive, shame-prone, anxiously self-conscious, socially withdrawn, quietly nursing the same grandiose fantasies but defending them behind apparent humility or complaint. DSM-5-TR anchors both in its own text and in its alternative model: it describes narcissistic self-esteem as "variable and vulnerable," regulated through approval-seeking, with grandiosity that may be "either overt or covert," and it records the more vulnerable presentations by adding negative-affectivity traits such as depressivity and anxiousness. The two are not different disorders but different surfaces over a shared core of fragile self-worth; many patients oscillate between them, showing grandiosity when supplied with admiration and collapsing into the vulnerable state when it is withheld. The examiner's trap is to recognise only the loud, grandiose form and miss the quiet, shame-driven one, which is easily mistaken at face value for depression or social anxiety.

FACET	GRANDIOSE (OVERT)	VULNERABLE (COVERT)
Surface presentation	Entitled, arrogant, exhibitionistic, self-assured	**Hypersensitive, shy, self-effacing, complaining**
Self-esteem	Openly inflated, thick-skinned to criticism	Fragile, shame-prone, easily wounded
Response to a slight	Disdain, rage, counterattack	Withdrawal, humiliation, resentment, rumination
Grandiosity	Displayed openly in behaviour	Kept in private fantasy, masked by humility
Common misread	Simple arrogance or a difficult personality	**Depression or social-anxiety disorder**

Grandiose and vulnerable narcissism as two surfaces over one fragile core; the highlighted cells are the covert features most often missed and the diagnosis they are mistaken for.

WORKED EXAMPLE

A man in his thirties presents with low mood, social withdrawal and a sense of being chronically slighted. On the surface this reads as depression. Listening closer, the withdrawal follows a series of perceived humiliations, each one a failure of the world to recognise a talent he privately believes is exceptional; he is exquisitely sensitive to criticism, envious of colleagues he considers his inferiors, and empty when admiration is not forthcoming. There is no overt boastfulness. This is vulnerable narcissism, the covert face of narcissistic personality disorder, not a primary depressive disorder, and treating only the mood while missing the fragile grandiose core underneath is why the presentation keeps returning.

RULE **Attention itself versus admiration for superiority.** The histrionic person wants to be the centre of attention and will take any role, even a fragile or dependent one, to get it; the narcissistic person wants admiration specifically for a superiority they believe is real, and a needy role is intolerable. That is the dividing line.

TRAP **Seeing only the loud narcissist.** Expecting only the grandiose, arrogant presentation and missing vulnerable narcissism, whose covert shame, hypersensitivity and withdrawal are read at face value as depression or social anxiety, leaves the diagnosis and the fragile grandiose core underneath untouched.

8.5 Telling them apart from their neighbours

The confusions the paper actually sets. Both types share features with their Cluster B neighbours, and the marks are in the discriminators, drawn straight from the DSM-5-TR differential text. Hold the grid below and each boundary is a one-line answer.

BOUNDARY	SHARED FEATURE	DISCRIMINATOR
Histrionic vs narcissistic	Both crave attention from others	**Histrionic wants attention as such and accepts a fragile role; narcissistic wants praise for superiority and emphasises status**
Histrionic vs borderline	Attention-seeking, manipulative behaviour, rapidly shifting emotions	Borderline adds self-destructiveness, angry relationship ruptures, chronic emptiness and identity disturbance
Histrionic vs antisocial	Impulsive, superficial, seductive, manipulative	Histrionic manipulates for nurturance and is more exaggerated in emotion; antisocial manipulates for material gain
Histrionic vs dependent	Reliance on others for reassurance	Dependent lacks the flamboyant, exaggerated, theatrical emotionality of histrionic
Narcissistic vs antisocial	Exploitative, lacking empathy	Narcissistic lacks impulsivity, aggression, deceit and a conduct-disorder history; exploits to enhance the self, not for profit
Narcissistic vs borderline	Anger to minor slights	Narcissistic keeps a relatively stable self-image with little physical self-destructiveness or abandonment terror

The six boundaries most often tested around the two types; the highlighted cell is the single discriminator that decides histrionic from narcissistic. The borderline side is developed elsewhere in this chapter.

8.6 The classification shift: ICD-11 and the alternative model

Both categories are gone, but the vocabulary survives. This is where the day's headline nosology point lands on these two types. ICD-11 abolished the categorical personality-disorder types entirely: there is no ICD-11 code for histrionic or narcissistic personality disorder. A histrionic-like presentation is now captured by rating **severity** first (personality difficulty, then mild, moderate or severe) and adding the trait qualifier of negative affectivity for the dramatic, labile emotionality, with the attention-seeking element falling under dissociality. A narcissistic-like presentation is captured by severity plus dissociality, whose text explicitly names self-

centredness, a sense of entitlement, expectation of others' admiration and attention-seeking to remain the centre of focus, with the vulnerable, shame-prone features added under negative affectivity (ICD-11 CDDR). The DSM-5-TR alternative hybrid model treats the two unequally: narcissistic personality disorder is one of the six specific types it retains, defined by impairment plus the antagonism traits of grandiosity and attention-seeking, whereas histrionic is one of the four categorical types it drops, becoming personality disorder, trait specified when the general criteria are met without a named set.

ICD-10 TO ICD-11: WHAT CHANGED

ICD-10 (F60) kept histrionic personality disorder (F60.4) as a named categorical type, but narcissistic never had its own ICD-10 category at all, sitting only under "other specific personality disorder" (F60.8). ICD-11 then removed every categorical type, rebuilding the diagnosis as a severity level plus trait-domain qualifiers, so both histrionic and narcissistic now exist only as descriptive patterns within that dimensional frame. Exams still test the categorical names because DSM-5-TR retains them in its main text and clinicians still speak in them, so read fluently in both languages.

8.7 Management in outline, and the cultural reading

Psychotherapy is the frame; drugs are for comorbidity only. Neither type has a disorder-specific drug, and neither is a receptor problem to be medicated. The working approach is a structured, long-term psychotherapy, with the transference-focused and schema-based models the ones with the most traction for narcissistic pathology (their mechanism and indication are taught in full in their own topics of this chapter). The narcissistic patient tests the alliance hardest, because the very grandiosity that brings collapse also resists the therapist's help, and the vulnerable, shame-prone presentation must be handled without either colluding with the grandiosity or shaming the fragile self beneath it. Medication is reserved for a comorbid depressive or anxiety disorder, or a short crisis, never for the personality itself, and the deep pharmacology is cross-referenced to the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes rather than re-taught here.

INDIA

Three genuine India angles converge here. First, under-recognition: personality disorders are diagnosed far less often in routine Indian practice than Western prevalence would predict, and these two surface through their comorbidities, a mood or anxiety disorder, a relational crisis, rather than as a personality label that clinicians often avoid for fear of stigma. Second, the cultural expression of pathology: the general criteria require deviation from the person's *own* culture, so narcissistic-looking traits inflate in individualistic settings and warrant less clinical weight where they are normative, while a warm, expressive, family-embedded emotional style must not be scored as histrionic through a colder cultural lens, and the historical over-diagnosis of histrionic personality disorder in women along gendered social scripts is a bias to guard against actively. Third, availability: the structured psychotherapies these patients need, transference-focused and schema therapy, are unevenly available and still being culturally adapted for India, concentrated at tertiary and private centres. The medico-legal weight of personality pathology attaches to antisocial personality disorder, handled in the Mental health legislation and forensic psychiatry notes, not to these two.

8.8 The countable skeleton

Two essential features, two thresholds, one split. Everything worth carrying into the hall about these two types hooks onto a handful of counts and one distinction. Anchor the mnemonics and each criterion set unpacks.

MNEMONIC

PRAISE ME · GRANDIOSE

PRAISE ME for the eight histrionic criteria: **P**rovocative or seductive; **R**elationships thought more intimate than they are; **A**ttention (uncomfortable when not its centre); **I**nfluenced easily (suggestible); **S**tyle of speech impressionistic and vague; **E**motions shallow and rapidly shifting; **M**ade-up appearance used to draw the eye; **E**xaggerated, theatrical emotional display.
GRANDIOSE for the nine narcissistic criteria: **G**randiose self-importance; **R**equires excessive admiration; **A**rrogant and haughty; **N**eeds to be seen as special and unique; **D**reams of unlimited success, power, brilliance, beauty or ideal love; **I**nterpersonally exploitative; **O**btuse to others' feelings (lacks empathy); **S**ense of entitlement; **E**nvious of others or believes others envy them.

8	9	4	5
HISTRIONIC CRITERIA; FIVE OR MORE NEEDED	NARCISSISTIC CRITERIA; FIVE OR MORE NEEDED	CLUSTER B DRAMATIC TYPES	ICD-11 TRAIT DOMAINS; BOTH TYPES ABOLISHED

HOLD THIS

Histrionic personality disorder is excessive emotionality and attention-seeking (five or more of the eight, uncomfortable when not the centre of attention); narcissistic personality disorder is grandiosity, a need for admiration and a lack of empathy (five or more of the nine); and grandiose and vulnerable narcissism are one disorder's two faces, the overt entitled and the covert shame-prone, over a shared core of fragile self-esteem.

9 . Cluster C: avoidant, dependent and anankastic

Why the anxious cluster earns its marks. **cluster c** is the **anxious or fearful** group, and it rewards the candidate who can give the one-line essential feature of each type cold and then defend the two boundaries an examiner reaches for first: avoidant personality disorder against a genuine loner and against social anxiety disorder, and anankastic personality disorder against obsessive-compulsive disorder. The three types are avoidant personality disorder (social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation, with avoidance of activities involving interpersonal contact), dependent personality disorder (a pervasive and excessive need to be taken care of leading to submissive and clinging behaviour and fears of separation), and obsessive-compulsive personality disorder, the anankastic type (a preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness and efficiency) (DSM-5-TR 2022). The thread that ties them is that fear, not oddness and not drama, is the organising affect: fear of rejection, fear of being left, and fear of losing control.

This fragment frames the cluster on one grid, takes each type through its defining criterion and the discriminator that decides it, then isolates the single highest-yield boundary of the group, the anankastic character against the anxiety disorder that shares its name. Two cautions from the framework topics of this chapter are assumed throughout: the general personality-disorder criteria (an enduring, pervasive, inflexible pattern, from early adulthood, causing impairment and not better explained otherwise) must be cleared before any type is named; and ICD-11 has abolished the categorical types, so "avoidant", "dependent" and "anankastic" survive as labels only in the legacy classifications and in clinical shorthand, with the dimensional model taught on the framework topics. The OCD side sits in the Anxiety, OCD and trauma-related disorders notes and the wider psychotherapy technique in the Psychotherapies, clinical assessment, MSE and nosology notes.

9.1 The cluster on one frame

Three types, one affect, three fears. DSM-5-TR groups the three types whose sufferers "often appear anxious or fearful" (DSM-5-TR 2022). Read the cluster by what each type is afraid of and what it does about the fear: the avoidant person wants closeness but withdraws from it for fear of criticism and rejection; the dependent person clings to a caretaker for fear of being left to cope alone; the anankastic person controls and orders the world for fear of anything going wrong. Learning the three essential features with their exact thresholds as one block is the fastest route to every cluster C question, because the thresholds differ across the three and are a favourite trip-wire.

TYPE	ESSENTIAL FEATURE (DSM-5-TR)	THRESHOLD	CORE DISCRIMINATOR
Avoidant	Social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation, with avoidance of interpersonal contact	Four or more of the seven features	**Wants closeness but fears rejection (vs schizoid, who has no desire)**
Dependent	A pervasive, excessive need to be taken care of, leading to submissive, clinging behaviour and fears of separation	Five or more of the eight features	**Appeasement and a replacement caretaker, not rage (vs borderline)**
Anankastic (obsessive-compulsive)	Preoccupation with orderliness, perfectionism and mental and interpersonal control, at the expense of flexibility, openness and efficiency	Four or more of the eight features	**Ego-syntonic traits; no true obsessions or compulsions (vs OCD)**

The three DSM-5-TR Cluster C types with their essential features, criterion thresholds and core discriminators; the accompanying figure lays the same three on a fear-and-response map (fear of rejection, of separation, of loss of control).

PEARL

Tag each type by the fear that drives it: avoidant fears *rejection*, dependent fears *separation*, anankastic fears *loss of control*. Then hold the three thresholds apart, because they are not the same number: avoidant is **four or more of the seven**, dependent is **five or more of the eight**, and anankastic is **four or more of the eight**. Dependent is the odd one out that needs five.

9.2 Avoidant personality disorder

The person who longs for closeness and flees it. The essential feature of avoidant personality disorder is a pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation, beginning by early adulthood and present across contexts, shown by **four or more of the seven** features (DSM-5-TR 2022). The seven are: avoiding occupational activities that involve significant interpersonal contact for fear of criticism, disapproval or rejection; being unwilling to get involved with people unless certain of being liked; showing restraint within intimate relationships for fear of being shamed or ridiculed; being preoccupied with being criticised or rejected in social situations; being inhibited in new interpersonal situations because of feelings of inadequacy; viewing the self as socially inept, unappealing or inferior; and being unusually reluctant to take personal risks or try new activities for fear of embarrassment. The signature is a person who deeply wants relationships and feels the loneliness of their absence, but assumes others are critical until stringently proven otherwise. Two contrasts do most of the work. Against schizoid personality disorder, the single question is whether closeness is wanted at all: the avoidant person wants it and fears rejection, the schizoid person has no desire for it. Against social anxiety disorder, the difference is pervasiveness and self-concept: avoidant personality disorder is a trait-level pattern with an entrenched sense of inferiority, present even without the

anxiety disorder, whereas social anxiety may be more situational, though the two overlap heavily and some regard avoidant personality disorder as a more severe form.

GOOD TO REMEMBER

- **Avoidant personality disorder:** defining criterion is pervasive social inhibition, feelings of inadequacy and hypersensitivity to negative evaluation, four or more of the seven features, from early adulthood. Discriminator from schizoid: closeness is wanted but feared (schizoid does not want it). Discriminator from social anxiety disorder: trait-level and pervasive with an entrenched inferiority, present even without the anxiety disorder. First step: confirm the general personality-disorder criteria, then that the avoidance is pervasive and character-level, not confined to circumscribed performance situations.

9.3 Dependent personality disorder

The excessive need to be cared for. The essential feature of dependent personality disorder is a pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, from early adulthood, shown by **five or more of the eight** features (DSM-5-TR 2022). The eight are: difficulty making everyday decisions without excessive advice and reassurance; needing others to assume responsibility for most major areas of life; difficulty expressing disagreement for fear of losing support or approval; difficulty initiating projects or doing things alone from a lack of self-confidence; going to excessive lengths to obtain nurturance and support, even volunteering for unpleasant tasks; feeling uncomfortable or helpless when alone from exaggerated fears of being unable to cope; urgently seeking another relationship as a source of care when a close one ends; and being unrealistically preoccupied with fears of being left to care for oneself. The behaviours are designed to elicit caregiving and arise from a self-perception of being unable to function alone. The examiner's favoured contrast is with borderline personality disorder: both fear abandonment, but the person with dependent personality disorder responds with increasing appeasement and submissiveness and urgently seeks a replacement caretaker, whereas the person with borderline personality disorder responds with rage, emptiness and demands, against a background of unstable and intense relationships. From avoidant personality disorder it is separated by direction: the dependent person seeks proximity, the avoidant person avoids it, though both share feelings of inadequacy.

GOOD TO REMEMBER

- **Dependent personality disorder:** defining criterion is a pervasive, excessive need to be taken care of leading to submissive, clinging behaviour and fears of separation, five or more of the eight features (the only cluster C type that needs five), from early adulthood. Discriminator from borderline: appeasement and a replacement caretaker, not rage and emptiness; relationships stable-clinging, not unstable-intense. Discriminator from avoidant: proximity-seeking, not proximity-avoiding. First step: confirm the general criteria, then that the dependence is excessive and unrealistic beyond situational and cultural norms, not normative interdependence.

9.4 Anankastic (obsessive-compulsive) personality disorder

Control at the cost of flexibility. The essential feature of obsessive-compulsive personality disorder, the anankastic type, is a preoccupation with orderliness, perfectionism and mental and interpersonal control, at the expense of flexibility, openness and efficiency, from early adulthood,

shown by **four or more of the eight** features (DSM-5-TR 2022). The eight are: preoccupation with details, rules, lists, order, organisation or schedules to the point that the major purpose is lost; perfectionism that interferes with task completion; excessive devotion to work and productivity to the exclusion of leisure and friendships, not explained by economic necessity; over-conscientiousness, scrupulousness and inflexibility about matters of morality, ethics or values, not explained by culture or religion; inability to discard worn-out or worthless objects even when they have no sentimental value; reluctance to delegate unless others submit to exactly one's own way; a miserly spending style, money hoarded against future catastrophe; and rigidity and stubbornness. The core is control: the perfectionism is so complete that projects are never finished and time is poorly allocated, and the rigidity holds even when compromise would clearly serve the person's own interest. The whole pattern is **ego-syntonic**, experienced as reasonable and correct, which is exactly what sets up the marquee trap of the topic.

GOOD TO REMEMBER

- **Anankastic (obsessive-compulsive) personality disorder:** defining criterion is a pervasive preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness and efficiency, four or more of the eight features, from early adulthood. Discriminator from OCD: the traits are ego-syntonic character, with no true obsessions and no compulsions. First step: confirm the general criteria and that the perfectionism and control are a pervasive, ego-syntonic trait, then search for (and either exclude or separately co-diagnose) the true obsessions and compulsions of OCD.

9.5 Anankastic versus OCD: ego-syntonic character against ego-dystonic illness

Similar names, different animals. This is the boundary the topic is built to test. Despite the shared name, obsessive-compulsive personality disorder and obsessive-compulsive disorder are clinically quite different (DSM-5-TR 2022). The anankastic personality is not characterised by intrusive thoughts, images or urges, nor by repetitive behaviours performed in response to them; it is an enduring, pervasive maladaptive pattern of excessive perfectionism and rigid control, and it is **ego-syntonic**, the person sees the traits as sensible and right and is not distressed by them, though the people around them often are. Obsessive-compulsive disorder is defined by true **obsessions** (intrusive, unwanted thoughts, images or urges) and **compulsions** (repetitive acts performed to neutralise the distress), and it is **ego-dystonic**, the symptoms are experienced as alien, unwanted and resisted. The presence or absence of true obsessions and compulsions is the line. The two are not mutually exclusive: when the criteria for both are met, both are diagnosed, and comorbid anankastic personality is found in roughly a quarter to a third of people with OCD in longitudinal cohorts. The obsessive-compulsive disorder side, its phenomenology and its treatment, is developed in the Anxiety, OCD and trauma-related disorders notes.

FEATURE	ANANKASTIC (OBSESSIVE-COMPULSIVE) PERSONALITY DISORDER	OBSESSIVE-COMPULSIVE DISORDER (OCD)
Relation to self	Ego-syntonic: traits seen as reasonable, right and desirable	Ego-dystonic: symptoms alien, unwanted, resisted
Core content	A pervasive character style of perfectionism, orderliness and rigid control	Discrete intrusive symptoms sitting on the background personality
Obsessions and compulsions	**Absent: no true obsessions and no compulsions**	Present and defining
Distress	Little distress about the traits themselves; others carry the frustration	Marked distress and active resistance to the symptoms
If both present	When the criteria for both are met, both diagnoses are recorded	

The anankastic-versus-OCD discrimination; the highlighted cell is the single feature that decides it, the absence of true obsessions and compulsions in the personality disorder. The OCD side is developed in the Anxiety, OCD and trauma-related disorders notes.

RULE **The line is true obsessions and compulsions, and ego-tone.** Anankastic personality is an ego-syntonic character of perfectionism and control with no true obsessions or compulsions; OCD is defined by ego-dystonic, resisted obsessions and compulsions. Their presence or absence, not the shared name, decides the diagnosis.

TRAP **Calling a rigid perfectionist "OCD".** Orderliness, perfectionism, hoarding of worthless items and inability to delegate, experienced by the person as simply being thorough and correct, are anankastic personality, not OCD, unless there are genuine intrusive obsessions and neutralising compulsions the person resists.

WORKED EXAMPLE

An accountant in his forties is referred as "OCD". He is a relentless perfectionist who cannot discard years of worn-out paperwork, refuses to delegate, and misses deadlines because he rechecks his work endlessly; he regards all of this as ordinary diligence and is untroubled by it, though his family and colleagues are worn down. He describes no intrusive unwanted thoughts and performs no rituals to neutralise anxiety. This is obsessive-compulsive personality disorder, the anankastic type, not OCD: the pattern is ego-syntonic character without true obsessions or compulsions. Had he also described intrusive contamination fears and washing rituals he resisted, both diagnoses would stand together.

9.6 How cluster C maps onto the dimensional and legacy systems

The categorical names decoded into traits. The framework topics of this chapter teach the dimensional model in full; three cluster-C-specific facts are worth carrying. First, the ICD-11 anankastia trait domain, a narrow focus on a rigid standard of perfection and on controlling oneself, others and situations to enforce it, is essentially the OCPD phenotype re-cast as a dimension, and it is the domain with no counterpart in the DSM-5 alternative model. Second, the avoidant and dependent phenotypes load mainly on negative affectivity with detachment, the

anxious-fearful traits. Third, and high-yield, the DSM-5-TR alternative model of personality disorders retains only six categorical types, antisocial, avoidant, borderline, narcissistic, obsessive-compulsive and schizotypal: avoidant and obsessive-compulsive survive the cut, but dependent personality disorder is one of the four types dropped. In the legacy ICD-10, the same phenotypes carried different names, anankastic for obsessive-compulsive and anxious for avoidant, with dependent kept as it is; exams still test these categorical names because DSM-5-TR retains them and the literature is written in them.

PEARL

Two cluster C facts examiners like: the ICD-11 fifth domain is *anankastia* (the OCPD phenotype), where the DSM-5 alternative model instead has psychoticism; and the alternative model keeps avoidant and obsessive-compulsive but drops dependent, so "which cluster C type is not in the DSM-5 alternative model?" has a clean answer, dependent.

9.7 Management in outline, and the cultural reading

Psychological therapy leads; drugs treat comorbidity only. Cluster C is managed, not cured, and no drug is disorder-specific for any of the three. The primary mode is structured psychological therapy: graded exposure to the avoided or feared situation with cognitive restructuring of the beliefs of inadequacy for avoidant personality disorder (the technique overlaps with the treatment of social anxiety disorder), assertiveness and autonomy-building for dependent personality disorder, and work on rigidity and control for the anankastic patient. The schema-mode and dialectical approaches, and the deeper psychotherapy technique, are developed on the psychotherapy topics of this chapter and in the Psychotherapies, clinical assessment, MSE and nosology notes. Pharmacotherapy stays narrow: where avoidant personality disorder carries a comorbid social anxiety disorder, a serotonin reuptake inhibitor may help that comorbidity, with the agents, Indian brands and dosing carried in the Anxiety, OCD and trauma-related disorders notes rather than re-taught here.

GOOD TO REMEMBER

- **Structured cognitive-behavioural therapy (Cluster C):** mechanism is graded exposure to avoided or feared situations plus cognitive restructuring of the core beliefs (inadequacy in avoidant, helplessness in dependent, the need for control in anankastic), with assertiveness and autonomy skills; indication is all three cluster C types, and it engages fastest in avoidant and dependent personality disorder, where the anxious behaviour is distressing to the person; signature caution is the alliance and pace, shame drives drop-out in the avoidant patient, the anankastic patient resists surrendering control, and the dependent patient can transfer their dependence onto the therapist. Medication is for a comorbidity only, never disorder-specific.

INDIA

Two genuine India angles meet on cluster C. First, under-recognition: the anankastic patient is ego-syntonic and almost never self-refers, reaching services only through burnout, a comorbid depression or a family complaint, while the avoidant and dependent patient usually presents for a comorbid anxiety or depressive disorder rather than for the personality itself, so the diagnosis is made only when it is actively sought. Second, and the more testable, is the cultural reading of dependent personality disorder. In collectivist Indian family life, interdependence, deference to elders, and decisions made jointly or by the family (about marriage, work or money) are normative, not pathological; scoring them as dependent personality disorder through a single culture's autonomy norms is a straight error, and DSM-5-TR itself requires that dependence be judged excessive relative to the person's own cultural and situational context, weighed with an informant. The same caution applies to over-conscientiousness read as anankastic when it reflects religious or cultural observance. Structured psychotherapy for these disorders is available unevenly and mostly at tertiary and private centres.

9.8 The countable skeleton

One line rebuilds the cluster. Three types, three fears, three thresholds and one marquee boundary are the whole of cluster C worth carrying into the hall. Hook them once and each type unpacks from its fear.

MNEMONIC

FLEE, CLING, CONTROL

The three cluster C types by the fear they answer. **FLEE** is avoidant personality disorder (wants closeness, flees it for fear of rejection, four or more of the seven). **CLING** is dependent personality disorder (needs to be cared for, clings for fear of separation, five or more of the eight). **CONTROL** is anankastic or obsessive-compulsive personality disorder (orders the world for fear of anything going wrong, ego-syntonic, no true obsessions or compulsions, four or more of the eight). Flee from people, cling to a person, control the world.

3	5	6
CLUSTER C TYPES (ANXIOUS OR FEARFUL)	ICD-11 TRAIT DOMAINS (ANANKASTIA IS THE CLUSTER C ONE)	DSM-5 ALTERNATIVE-MODEL TYPES KEPT (DEPENDENT DROPPED)

HOLD THIS

Cluster C is anxious or fearful: avoidant wants closeness but fears rejection (four or more of the seven), dependent needs to be cared for and clings for fear of separation (five or more of the eight), anankastic controls and perfects the world (four or more of the eight); and the marquee line is anankastic personality (ego-syntonic character, no true obsessions or compulsions) against OCD (ego-dystonic, resisted obsessions and compulsions).

10 · Borderline personality disorder versus bipolar II

The discriminator the whole chapter builds toward. Two conditions share a surface, mood that will not hold still and behaviour that runs ahead of judgement, and the examiner exploits the overlap: is this borderline personality disorder or is this bipolar II disorder? Getting **borderline**

versus bipolar right is not a fine academic point but the fork on which the management plan turns, because one answer sends the patient to a structured psychotherapy and the other to a mood stabiliser. This note owns that **discrimination**. The bipolar-II side of the picture, the hypomanic and depressive syndromes and their neurobiology, is developed in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; here the two are held side by side and pulled apart.

The trick is to resist matching on the shared symptom and instead read **one discriminator** at a time, each of which points reliably to one diagnosis. The **bipolar ii differential** reduces to a small grid of these discriminators, the tempo and trigger of the mood change, the duration of a shift, the presence of an unstable identity and chronic emptiness, the character of the self-harm and impulsivity, the family history, and the response to a mood stabiliser. Read across the grid and the answer usually declares itself. The accompanying figure lays the same discriminators out as a two-column contrast, and it is the single image to carry for this topic.

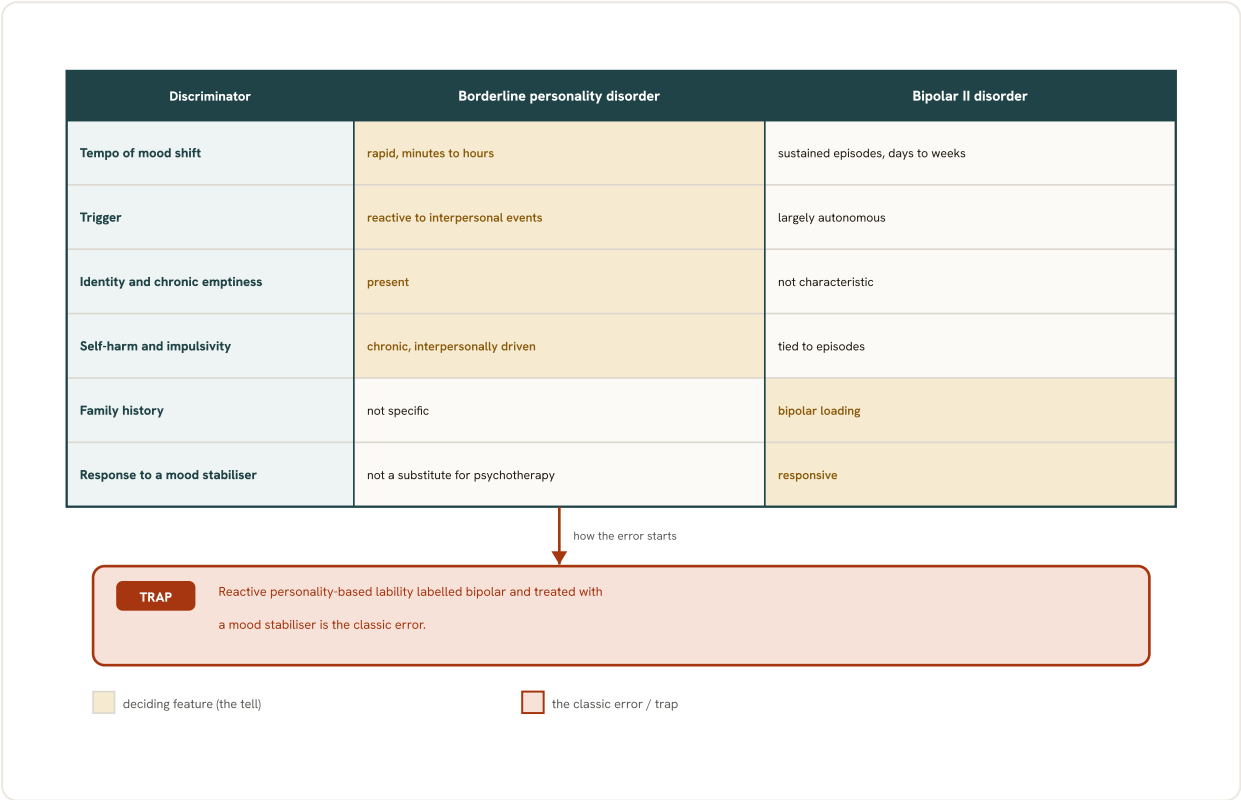


Fig 16.5 Borderline mood instability is rapid and reactive to interpersonal triggers, with identity disturbance and chronic emptiness; bipolar II episodes are sustained and autonomous with a bipolar family history and a mood-stabiliser response. The bipolar syndromes are taught in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

10.1 The shared surface, and why the misdiagnosis is easy

Both present with mood lability and impulsivity, so the overlap is real. A patient who describes moods that flip, relationships that combust and impulsive acts they regret can fit either label on first telling, and the temptation is to hear "unstable mood" and reach for bipolar II disorder. The overlap is genuine: affective instability and impulsivity are cardinal in borderline personality disorder and are also the texture of the hypomanic and depressive swings of bipolar II. But the two instabilities have a different *form*, and the discipline of this topic is to describe the

mood change rather than name it, then let its tempo, its trigger and its duration decide. The discrimination fails only when the clinician pattern-matches on the shared word and stops looking.

RULE **Read the mood, do not name it.** Discriminate borderline from bipolar II on the tempo, the trigger and the duration of the affective change: reactive, interpersonally cued shifts over minutes to hours are borderline; autonomous, sustained episodes over days to weeks are bipolar.

10.2 The discriminator grid: one discriminator per row

The object to reproduce cold. Hold the differential as a grid in which each row turns on a single discriminator, and each discriminator points to one side. The highlighted cell in every row is the one that settles that row; read the whole column on either side and the diagnosis emerges as a pattern, not a single sign. This is the same grid drawn in the figure alongside.

DISCRIMINATOR	BORDERLINE PERSONALITY DISORDER	BIPOLAR II DISORDER
Tempo of affective instability	**Rapid shifts over minutes to hours, often several within one day**	Sustained episodes evolving over days to weeks
Trigger of the mood change	**Reactive, cued by an interpersonal event (rejection, criticism, a threat of abandonment)**	Largely autonomous; episodes arise and remit on their own timetable, frequently unprovoked
Duration of a mood shift	Dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days	**Hypomania at least four consecutive days; a depressive episode at least two weeks**
Baseline between shifts	Chronic dysphoria and emptiness; rarely a settled euthymic baseline	**Return to a euthymic baseline between discrete episodes**
Identity and emptiness	**Identity disturbance and chronic emptiness are core and enduring**	Identity is stable; emptiness is not a defining feature
Self-harm and impulsivity	**Self-harm is recurrent and affect-regulating, interpersonally cued; impulsivity is a pervasive lifelong trait**	Risk-taking and impulsivity are state-bound to the hypomanic phase; self-harm clusters in depressive episodes
Family history	Loads toward cluster B traits, trauma, mood and substance problems	**A strong loading for bipolar disorder points toward bipolar**
Response to a mood stabiliser	Modest and symptom-targeted at best; never a substitute for structured psychotherapy	**Often clearly effective; the mainstay of treatment**

The borderline-versus-bipolar-II discriminator grid; each row turns on one discriminator, and the highlighted cell is the one that decides it. No single row is definitive alone; the diagnosis is the whole pattern read across the columns.

5+	4	5
OF NINE BORDERLINE CRITERIA TO DIAGNOSE	DBT SKILLS MODULES (THE THERAPY BORDERLINE RESPONDS TO)	ICD-11 TRAIT DOMAINS (THE DIMENSIONAL CROSS-MAP)

10.3 The affective instability tempo, and the duration of mood shifts

The clock is the first and best discriminator. The **affective instability tempo** in borderline personality disorder is fast: mood swings over minutes to hours, sometimes several times within an afternoon, and it settles as quickly as it flared. The DSM-5-TR criterion says as much, episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days. The **duration of mood shifts** in bipolar II disorder is categorically longer: hypomania requires a distinct period of persistently elevated or irritable mood lasting **at least four consecutive days**, and a major depressive episode lasts **at least two weeks**. Between those episodes the bipolar patient typically returns to a euthymic baseline, whereas the borderline patient rarely does, sitting instead on a floor of chronic dysphoria. So the two questions to ask are: how long does a low or an irritable spell last, and where does the mood return to when it passes.

10.4 The trigger: reactivity to interpersonal triggers versus autonomy

Ask what set the mood off. The second discriminator is the **reactivity to interpersonal triggers**. Borderline affective instability is characteristically reactive: a text left unanswered, a perceived slight, a looming separation, and the mood collapses or the anger flares, then eases when the relationship is repaired. Bipolar mood is largely autonomous; a hypomanic or depressive episode arrives and departs on its own timetable, often with no proportionate external cause, and it does not switch off the moment an interpersonal rupture is mended. This is why the history should chase the antecedent of every mood change: a mood that tracks the state of a relationship minute by minute is borderline reactivity, whereas a mood that runs for a week regardless of what is happening around the person is a bipolar episode. Rejection sensitivity, the exquisite reactivity to perceived abandonment, is the borderline signature that has no bipolar counterpart.

WORKED EXAMPLE

A woman in her twenties is referred as "query bipolar II, mood swings". On history the swings last two to three hours, always follow a fight with her partner or a fear he is pulling away, and lift the moment he reassures her; she describes never knowing who she is and a constant hollow emptiness, and she cuts when the distress peaks. Nothing here is a sustained, autonomous, days-long episode with a euthymic return. Read one discriminator at a time, the hours-long tempo, the interpersonal trigger, the identity disturbance and emptiness, and the picture is borderline personality disorder, not bipolar II. The label matters: it points to a structured psychotherapy, not to a mood stabiliser prescribed for a bipolarity she does not have.

10.5 Identity, chronic emptiness, and the character of self-harm and impulsivity

Look for the features bipolar II simply does not carry. The **identity and self-harm** row is decisive because these features belong to borderline personality disorder and are not part of bipolar II at all. Identity disturbance, a markedly and persistently unstable self-image, and chronic emptiness, a persistent hollowness distinct from depressive sadness, are core borderline criteria

with no bipolar equivalent; a genuinely stable sense of self between episodes argues strongly against borderline. The *character* of the self-harm and impulsivity discriminates too. In borderline personality disorder self-harm is recurrent, interpersonally cued and typically functions to regulate unbearable affect or to end dissociation, and the impulsivity is a pervasive, lifelong trait present between crises. In bipolar II the risk-taking and impulsivity are state-bound, confined to the hypomanic phase and absent when euthymic, and the self-harm clusters within depressive episodes. So the same behaviour, cutting or reckless spending, discriminates by *when* it happens: pervasive and trigger-linked in borderline, phasic and episode-linked in bipolar.

PEARL

Impulsivity that is present *between* episodes is a personality trait; impulsivity that appears only *during* an elevated mood and vanishes when the mood settles is a state. Trait impulsivity, chronic emptiness and an unstable identity together pull hard toward borderline; state-bound impulsivity on a euthymic baseline pulls toward bipolar II. The discriminator is not the behaviour but its timing against the mood.

10.6 Family history, and the response to a mood stabiliser

Two corroborating discriminators, held as support rather than proof. The **family history** is a genuine pointer because bipolar disorder is among the most heritable of psychiatric conditions: a strong, well-documented bipolar loading in first-degree relatives raises the prior for bipolar II, whereas a family picture weighted toward trauma, cluster B traits, mood and substance problems fits borderline better. Treat it as corroboration, not verdict, since both loadings can coexist. The **response to a mood stabiliser** is the other corroborating discriminator, and it is where the error becomes consequential. In bipolar II a mood stabiliser (lithium, valproate, or lamotrigine (Lamitor, Lametec) for the depressive pole) is foundational and often clearly effective; the deep pharmacology sits in the Mood disorders: pharmacotherapy notes. In borderline personality disorder the same drugs have at best a modest, symptom-targeted effect and are never a substitute for structured psychotherapy, which is the primary treatment. A patient whose "mood swings" do not respond to an adequate mood-stabiliser trial was very likely never bipolar; the non-response is itself a discriminator.

GOOD TO REMEMBER

- **Borderline personality disorder:** a pervasive pattern of instability of relationships, self-image and affect with marked impulsivity, five or more of the nine criteria; the affect is rapidly reactive, interpersonally triggered and lasts hours, on a floor of chronic emptiness and an unstable identity. First discriminating step in this differential: read the tempo, the trigger and the baseline of the mood change.
- **Bipolar II disorder:** at least one hypomanic episode (elevated or irritable mood, at least four consecutive days) plus at least one major depressive episode (at least two weeks), with a euthymic baseline between discrete, largely autonomous episodes and no full manic episode. Discriminator: sustained, autonomous, days-to-weeks episodes, not minutes-to-hours interpersonal reactivity.
- **Dialectical behaviour therapy:** the structured psychotherapy the borderline side responds to; it targets emotion dysregulation and self-harm through four skills modules (mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness). Indication is recurrent self-harm and affective instability in borderline personality disorder, not the mood episodes of bipolar II. Caution: it treats the personality pathology, not a coexisting bipolar illness, which still needs its mood stabiliser.

10.7 The classic trap, and holding both diagnoses when they co-occur

The error and its correction. The classic trap is to hear reactive, hours-long, interpersonally driven lability, label it bipolar II, and start a mood stabiliser, medicalising a personality-based instability whose primary treatment is a structured psychotherapy. The drug then chases a misdiagnosis rather than an illness, the patient does not improve, and the failure is read as treatment resistance rather than as the wrong target. The correction is the grid: apply the discriminators before the label. Equally, the two are not mutually exclusive, and a comorbid bipolar II disorder is not rare in patients with borderline personality disorder; when a genuine, sustained, autonomous episode with a euthymic baseline is documented alongside the pervasive reactive pattern, both diagnoses stand and both treatments are needed, the mood stabiliser for the episodes and the structured psychotherapy for the personality pathology. The boundary with complex post-traumatic stress disorder, the other great mimic of borderline instability, is drawn in the Anxiety, OCD and trauma-related disorders notes.

TRAP **Labelling reactive instability "bipolar" and starting a mood stabiliser.** Reading minutes-to-hours, interpersonally cued lability as bipolar II and prescribing a mood stabiliser treats a personality-based instability with the wrong tool and delays the structured psychotherapy that is its actual primary treatment.

COMMON TRAP

Assuming the diagnosis is either-or. A strong bipolar family history or a documented autonomous episode does not exclude borderline personality disorder, and a clear borderline pattern does not exclude a genuine comorbid bipolar II. Diagnose each on its own evidence: the pervasive reactive pattern for borderline, a discrete sustained autonomous episode with a euthymic return for bipolar II. Where both are truly present, treat both.

10.8 The India lens: under-recognition, cultural expression, and access to therapy

The trap is amplified in Indian practice. Borderline personality disorder is markedly under-recognised in India: patients reach services through the overdose or the self-harm, which is coded as the act rather than the pattern, so the reactive lability underneath is repeatedly mislabelled as a mood disorder and medicated as bipolar. Two adaptations matter for this discrimination. First, cultural expression: affective display, transient dissociative or possession-trance presentations, and intense family-embedded reactions are normative idioms of distress in many Indian settings and must be judged against the person's own cultural and social norms before they are read as either borderline reactivity or a bipolar episode; personality pathology must not be read through a single culture's norms. Second, access: the structured psychotherapies the borderline side points to, dialectical behaviour therapy and schema therapy, are being delivered and culturally adapted at Indian tertiary and private centres rather than being widely available, so recognising that a patient needs psychotherapy rather than a mood stabiliser is only the first step, and a realistic plan must reckon with what the local service can actually deliver.

INDIA

Because borderline personality disorder is under-recognised in Indian practice, reactive interpersonal lability is disproportionately mislabelled bipolar and treated with a mood stabiliser, the exact trap of this topic. Judge every mood change against the patient's own cultural norms before scoring it, so that culturally sanctioned emotional expression and dissociative or possession-form idioms are not read as either a borderline criterion or a hypomanic episode. And recognise that catching the borderline diagnosis only helps if dialectical behaviour therapy or schema therapy is reachable; both are available and being adapted in the metros and academic centres but scarce elsewhere, which the plan must accommodate.

MNEMONIC

REACTIVE and RAPID versus AUTONOMOUS and SUSTAINED

The one-line split. Borderline instability is **REACTIVE** (interpersonally triggered) and **RAPID** (minutes to hours, on a floor of emptiness with an unstable identity); bipolar II mood is **AUTONOMOUS** (arises unprovoked) and **SUSTAINED** (days to weeks, with a euthymic baseline). Trigger and tempo first, then the corroborating family history and mood-stabiliser response.

HOLD THIS

Borderline affective instability is reactive, interpersonally triggered and lasts minutes to hours on a floor of chronic emptiness and unstable identity; bipolar II mood is autonomous and sustained over days to weeks (hypomania at least four consecutive days, depression at least two weeks) with a euthymic baseline; the mood stabiliser helps bipolar, while structured psychotherapy is primary for borderline, and mislabelling the first as the second is the classic, consequential error.

Aetiology, assessment and treatment

11 . Aetiology of personality disorders

Ask the question at three levels, then name one model. The **aetiology of personality disorders** is examined the same way every time: at the **genetic** level (what is heritable), the **neurobiological** level (the circuitry and neurochemistry that carry the trait), and the **developmental** level (attachment, trauma, temperament and the environment that shapes the trait into a disorder), all knitted together by a **gene-environment** transaction rather than a single cause. What is inherited is never a diagnostic category; it is a set of continuous personality trait dimensions whose extreme configurations, transacting with a formative environment, become the inflexible patterns the classification then labels.

This fragment walks the three levels in turn, states the integrating gene-environment principle, and then teaches the one disorder-specific aetiological model examiners expect by name, the Marsha Linehan biosocial theory of borderline personality disorder: a biologically heightened **emotional vulnerability** transacting reciprocally, across development, with a pervasively **invalidating environment**. The accompanying figure lays the transaction out schematically. The bipolar-II side of the affective-instability spectrum is cross-referenced to the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; the complex-PTSD boundary to the Anxiety, OCD and trauma-related disorders notes; the deep serotonergic and mood-stabiliser pharmacology to the Mood disorders: pharmacotherapy notes; and attachment-based technique to the Psychotherapies, clinical assessment, MSE and nosology notes.

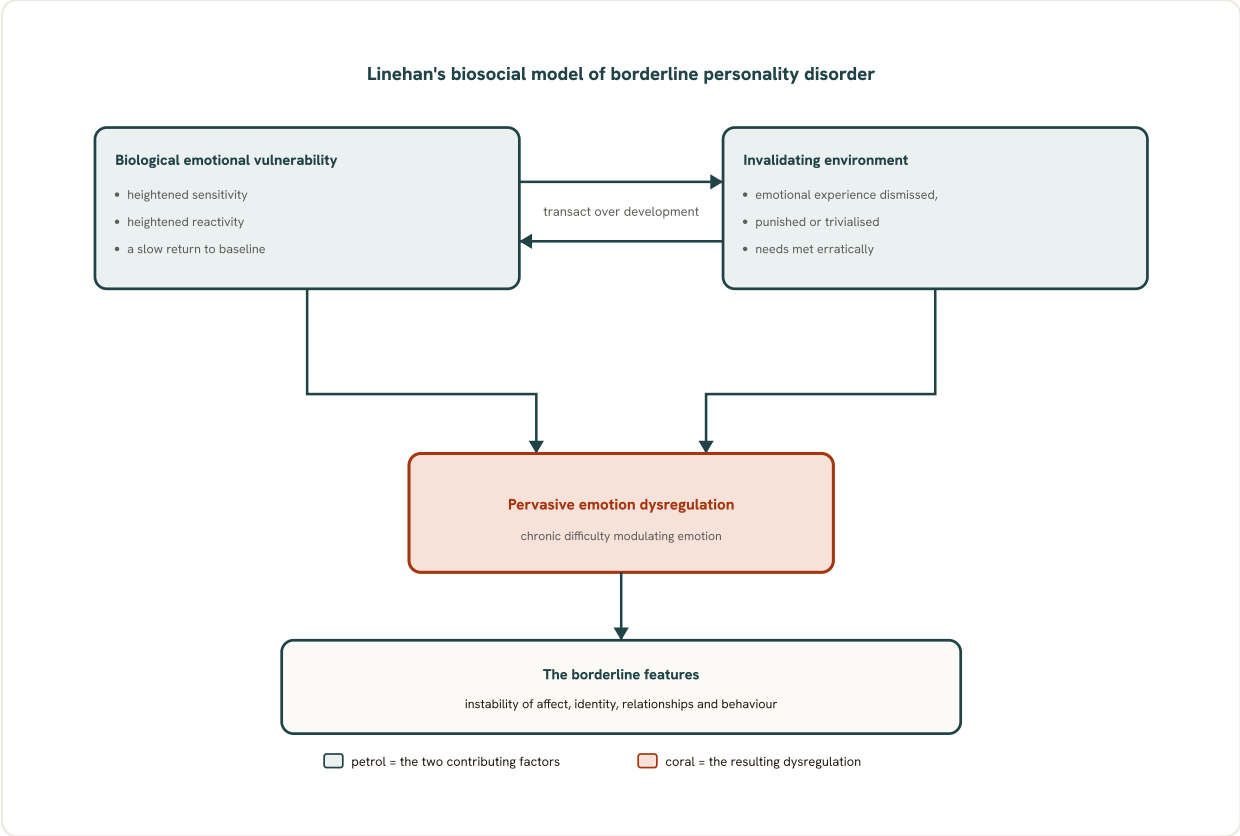


Fig 16.6 Linehan's biosocial model holds that a biological emotional vulnerability (heightened sensitivity and reactivity with a slow return to baseline) transacts reciprocally over development with a pervasively invalidating environment, and the transaction produces the pervasive emotion dysregulation that underlies the borderline features.

11.1 The three-level frame and the diathesis-stress spine

No personality disorder has a single cause. The stable finding across every type is that a heritable trait diathesis is necessary but not sufficient; the disorder emerges only when that diathesis meets a formative environment, and the two do not simply add but transact. Hold the three levels as a scaffold, the **genetic** (heritable trait dimensions), the **neurobiological** (the amygdala-prefrontal emotion circuitry and the serotonergic substrate of impulsive aggression) and the **developmental** (attachment disruption, childhood maltreatment, temperament), and read them not as competing explanations but as three windows on one process. This diathesis-stress spine, sharpened into a reciprocal transaction, is what the Linehan model makes concrete for borderline personality disorder, and it is the frame an examiner is testing when the question simply says "discuss the aetiology".

11.2 The genetic level: heritable dimensions, not heritable categories

Personality disorder is moderately heritable, and inherited as continuous traits. Twin, family and adoption studies agree that liability to personality pathology varies quantitatively and is moderately heritable, with estimates for normal and abnormal personality traits clustering in the roughly 40 to 60 per cent band. Crucially, personality disorders are not transmitted as discrete entities; what is inherited is a spread of trait dimensions, and the disorders are unusual configurations of the same traits that vary across the general population. The heritable loading is shared across spectra rather than tidy per-category packages: an **impulsivity and externalising** spectrum and an **affective-instability** spectrum load onto borderline and antisocial pathology

together, which is why comorbidity among the types is the rule. Most of the heritability sits in complex gene-gene interaction (epistasis) rather than in the average effect of single variants, so that individual common genes explain very little variance even in samples of tens of thousands, the so-called missing-heritability problem; the variants that are found tend to regulate neural development and neuroplasticity.

ENTITY	HERITABILITY ESTIMATE	WHAT IT TELLS YOU
Personality traits (normal + abnormal)	Moderate, roughly 40 to 60 per cent	Inherited as continuous dimensions, not discrete categories; mostly via epistasis (gene-gene interaction)
Any personality disorder	**Broad heritability about 44 per cent (Torgersen twins: MZ concordance 58, DZ 36 per cent)**	The anchor twin figure; DZ correlations well under half of MZ point to gene-environment interaction
Clusters A, B and C	Moderate, 40 to 60 per cent each	Separate heritable influences further differentiate the three clusters
Antisocial personality (symptom count)	The most heritable type, around 38 per cent	Best-studied; adoption and twin data converge; an unstable, hostile home acts synergistically
Paranoid personality (symptom count)	The least, around 28 per cent	Weak-to-moderate range across the ten categorical types

Heritability of personality pathology (Torgersen SCID-II twin data and DSM symptom-count studies). The highlighted any-disorder figure is the number to carry; the message is moderate, dimensional, and gene-environment dependent.

11.3 The neurobiological level: an amygdala-prefrontal imbalance and a serotonergic floor

Emotion dysregulation and impulsive aggression have a shared circuitry. At the **neurobiological** level the recurring finding is an imbalance in the **amygdala-prefrontal** emotion-regulation circuit: a hyperreactive amygdala that responds fast and hard to emotionally salient and socially threatening cues, paired with hypofunction of the prefrontal regions (orbitofrontal cortex and anterior cingulate) that would normally exert top-down inhibitory control. The net effect is intense, poorly braked affect, exactly the reactivity that shows up clinically as affective instability and as anger that outruns its trigger; imaging of individuals with impulsive aggression (Emil Coccaro and colleagues) shows just this exaggerated amygdala and blunted orbitofrontal response to social threat. Beneath the circuit sits a neurochemical dimension: reduced central **serotonergic** function correlates with **impulsive aggression** and with self-directed violence, the endophenotype Larry Siever placed at the centre of the borderline and antisocial impulsive-aggressive spectrum. That serotonergic floor is the rationale, cross-referenced to the Mood disorders: pharmacotherapy notes, for the symptom-targeted use of serotonin reuptake inhibitors against impulsive aggression, and it is a dimensional trait marker, not a disorder-specific lesion.

11.4 The developmental level: attachment, trauma and temperament

Early relationships and adversity shape the trait, but do not simply cause the disorder. Three **developmental** strands recur. First, **attachment disruption**: disorganised early attachment and a caregiving environment that fails to help the child read and regulate internal states leave a fragile capacity to mentalise (to hold minds in mind), which Peter Fonagy places at the heart of the borderline vulnerability. Second, **childhood trauma and maltreatment**: histories of sexual and physical abuse, neglect and pervasive family adversity are over-represented, and childhood sexual abuse is reported by a large minority to a majority of borderline patients (roughly 40 to 70 per cent). Third, **temperament**: early-emerging, procedurally learned dispositions (high negative emotionality, effortful-control deficits, novelty seeking) are the behavioural face of the heritable diathesis and are visible long before a disorder can be diagnosed. The developmental level is the environment that the genetic diathesis meets, and it is where the therapeutic leverage lies; the complex-PTSD-versus-borderline boundary that this trauma strand raises is developed in the Anxiety, OCD and trauma-related disorders notes.

TRAP **Reading childhood abuse as the cause of borderline personality disorder.** Childhood sexual abuse is reported by roughly 40 to 70 per cent of borderline patients, yet the association is only moderate (a meta-analytic effect size of about r = 0.28) and is neither necessary nor sufficient; trauma is a powerful risk factor that transacts with the diathesis, not the single cause.

11.5 The integrating principle: the gene-environment transaction

Diathesis and environment do not add, they transact. The three levels are bound by **gene-environment** interplay operating in both directions. Genes moderate how strongly a child reacts to adversity (gene-environment interaction), and a child's heritable temperament also shapes and selects the very environment it meets: an irritable, emotionally intense infant evokes harsher, more inconsistent caregiving (evocative gene-environment correlation) and later seeks out environments that amplify the trait (active correlation). The consequence is a feedback loop rather than a sum, in which a heritable diathesis and a formative environment escalate one another over years. This is precisely why the same adversity produces a personality disorder in one child and resilience in another, and why heritability estimates that ignore this transaction over-read the genetic share. The transactional reading is the modern successor to plain diathesis-stress, and it is the exact logic the Linehan model applies to borderline personality disorder.

RULE **A heritable trait becomes a disorder only in transaction with development.** Inherited trait dimensions set the diathesis; the disorder emerges through their reciprocal gene-environment transaction with attachment, trauma and the family environment, never from heredity or adversity alone.

11.6 The Linehan biosocial model: the disorder-specific synthesis

Borderline personality disorder is fundamentally a disorder of the emotion-regulation system. The Linehan **biosocial model** is the aetiological theory to name for borderline personality disorder, and it is simply the gene-environment transaction made concrete. In the **Linehan biosocial** account, the pervasive emotion dysregulation that underlies the borderline features results from continuous, reciprocal transactions among three components: a biological

emotional vulnerability, a pervasively **invalidating environment**, and the emotion dysregulation the two of them generate. None of the three is the cause on its own; the causal force is the transaction between them, running back and forth across development, and the figure alongside sets out that reciprocal loop. Because the model locates borderline pathology in emotion regulation rather than in character or manipulation, it is also non-pejorative and directly treatment-guiding, which is why it, and not the older object-relations account alone, is the model expected in an examination answer.

3	3	5	44
COMPONENTS OF THE LINEHAN BIOSOCIAL TRANSACTION	FEATURES OF THE EMOTIONAL VULNERABILITY	ICD-11 DIMENSIONAL TRAIT DOMAINS	BROAD HERITABILITY OF ANY PERSONALITY DISORDER, PER CENT (TORGERSEN TWINS)

11.7 The biological emotional vulnerability

Fast up, hard hit, slow down. The first arm of the model is a biologically mediated **emotional vulnerability**: a predisposition to affective instability arising from genetic, intrauterine and temperamental factors, and defined by three properties. The person is emotionally over-sensitive (a low threshold, so a wide range of ordinary stimuli triggers a response), over-reactive (a high magnitude of physiological arousal once triggered), and slow to return to baseline. The third property is the engine of the disorder: because arousal decays slowly, each subsequent event lands on top of incompletely settled arousal, making extreme responses ever more likely, the emotional equivalent of a burn victim feeling the wind. This vulnerability is the biological diathesis of the transaction, and it is what a treatment such as dialectical behaviour therapy targets with emotion-regulation and distress-tolerance skills.

Heightened sensitivity

A low threshold for emotional response; a wide range of everyday cues sets emotion off.

Heightened reactivity

A high magnitude of physiological arousal once a response is triggered.

Slow return to baseline

Arousal decays slowly, so successive events compound and escalate; the property that drives the instability.

11.8 The pervasively invalidating environment

An environment that teaches the child not to trust its own experience. The second arm is the **invalidating environment**: one that pervasively criticises, minimises, trivialises, punishes or only erratically reinforces the communication of internal experience, and that over-simplifies how easy problems are to solve ("you're not really upset", "you don't know what you want"). Two consequences follow. The child learns that its own thoughts and feelings are wrong, unimportant or shameful, and so comes to rely excessively on the social surround for cues on how to feel, producing the interpersonal hypersensitivity that marks the disorder. And because ordinary emotional displays are dismissed while extreme ones are intermittently attended to, the environment shapes escalation: the child who is ignored until it threatens self-harm, and then receives soothing, is taught that only extreme distress works. Childhood sexual and physical

abuse are the prototypical severe instances, but the invalidation need not be abusive; a well-meaning but poorly matched caregiver of a highly vulnerable child can invalidate inadvertently.

PEARL

The most examinable mechanism inside the invalidating environment is *intermittent reinforcement of extreme emotional displays*. When calm requests are ignored and only crisis behaviour (self-harm, threats) draws a caring response, the environment inadvertently trains the very high-amplitude behaviour it then finds intolerable. Naming this loop explains why borderline self-harm is so resistant to simple reassurance and why dialectical behaviour therapy works to break the contingency rather than to scold the behaviour.

11.9 The transaction, its product, and the treatment it points to

The two arms amplify each other; emotion dysregulation is the product. The force of the model is reciprocal. A highly emotionally vulnerable child is harder to soothe and so makes an environment more invalidating, even when caregivers mean well; and a more invalidating environment, by punishing and confusing emotional learning, further worsens the vulnerability. Round the loop turns, and its cumulative product is a pervasive **emotion dysregulation** that expresses itself across the borderline domains, the unstable relationships, the identity disturbance, the reactive affect, the impulsivity and the self-harm, all of them re-read as failures of emotion regulation rather than as separate symptoms. Because the model names a mechanism, it names a treatment: dialectical behaviour therapy was built directly on it to teach the emotion-regulation skills the transaction never allowed to develop, and schema therapy targets the same developmental deficits through the maladaptive schema modes; both are developed on their own topics in this chapter.

INDIA

Three India-specific points are genuine here. First, under-recognition: personality disorders are markedly under-diagnosed in Indian practice because patients reach services through the self-harm, the overdose or a comorbid depression, which is coded as the event rather than the enduring pattern, so the aetiological formulation is rarely made. Second, cultural expression: judge every trait and every "invalidation" against the person's own cultural and family norms, because collectivist family interdependence must not be misread as pathological dependence or as an invalidating environment, and possession-trance and dissociative idioms are normative in many settings. Third, access and forensic framing: dialectical behaviour therapy and schema therapy are being delivered and culturally adapted at Indian tertiary and private centres rather than being widely available, and antisocial personality disorder in particular carries a medico-legal frame (offender assessment, court reports) developed in the Mental health legislation and forensic psychiatry notes.

GOOD TO REMEMBER

- **Borderline personality disorder (aetiology):** the model to name is the Linehan biosocial theory, a biologically heightened emotional vulnerability (heightened sensitivity, heightened reactivity, slow return to baseline) transacting reciprocally over development with a pervasively invalidating environment, the transaction producing the pervasive emotion dysregulation that underlies the borderline features. Discriminator from a purely genetic or purely trauma account: the cause is the reciprocal transaction, not either arm alone. The diagnosis still rests on five or more of the nine criteria, developed on its own topic; the first aetiological step is to think transaction, not single cause.

GOOD TO REMEMBER

- **Dialectical behaviour therapy (from the model):** mechanism is to correct the emotion dysregulation the biosocial model places at the core, teaching skills across mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness, delivered through its four treatment modes (individual therapy, the skills group, intersession phone coaching, and the therapist consultation team). Indication is borderline personality disorder, especially where reducing recurrent self-harm is the priority (NICE, Indian Psychiatric Society). Signature caution: it is a comprehensive structured programme, not a brief "DBT-informed" add-on, and delivering truncated fragments is not delivering dialectical behaviour therapy.

HOLD THIS

Borderline personality disorder is neither purely inborn temperament nor purely childhood damage: it is the product of a biologically heightened emotional vulnerability transacting reciprocally, across development, with a pervasively invalidating environment, and it is that gene-environment transaction, not either half alone, that generates the pervasive emotion dysregulation underlying the borderline features.

12 · Assessment of personality

Why this matters. The **assessment of personality** is the step that turns a clinical impression into a defensible diagnosis, and it is examined as a set of named instruments plus two governing principles. The instruments split cleanly into two families: clinician-administered **structured interviews** that confirm a diagnosis against the general criteria, and self-report questionnaires that screen for it. The two principles are the ones a stem is built to catch: a self-report screen identifies, an interview confirms, and personality is a trait, not a state, so it must never be diagnosed from the affect of an acute episode. Learn the instruments as their structure, not their item wording, and hold the two principles as the reasoning frame.

This note typesets the working toolkit: the International Personality Disorder Examination (IPDE) and the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) as the categorical confirming interviews; the Personality Inventory for DSM-5 (PID-5) as the dimensional self-report of the trait model; the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) as a symptom-severity and change measure; and the **ICD-11 severity anchors** as the graded frame that a modern, severity-led assessment records first. The general diagnostic criteria that open the chapter are assumed here; this note owns the measurement, the screen-then-confirm logic, and the state-versus-trait caution. The wider technique of clinical

assessment and the mental state examination belong to the Psychotherapies, clinical assessment, MSE and nosology notes.

12.1 Two families of instrument: interviews that confirm, questionnaires that screen

Map the toolkit before the details. Every personality instrument is either an interview or a self-report, and either categorical (does the patient meet the criteria of a named type) or dimensional (how severe and along which trait continua). The four workhorses populate the grid: the IPDE and the SCID-5-PD are clinician interviews that yield categorical diagnoses; the PID-5 is a self-report that yields a dimensional trait profile; the ZAN-BPD is a clinician scale that quantifies borderline severity for tracking change. Sitting over all of them is the ICD-11 severity judgement, which is not a questionnaire at all but a clinical grading of impairment recorded first. Fix that two-by-two picture and each instrument slots into place.

The prior gate still governs. No instrument replaces the general threshold: an enduring, pervasive, inflexible, culturally deviant pattern with onset by adolescence and clinically significant impairment, not better explained by another disorder. The instruments operationalise that judgement; they do not bypass it. A structured interview is, in effect, the general criteria and the type criteria administered as a disciplined, replicable schedule.

12.2 Self-report versus interview: screen wide, confirm narrow

The single most testable design principle. The **self-report versus interview** distinction is the logic that ties the instruments together. Self-report questionnaires (the IPDE screening questionnaire, the SCID-5 Personality Questionnaire, the PID-5) are quick, patient-completed and deliberately over-inclusive: they are sensitive but not specific, so they *screen* and over-identify. The clinician-administered **structured interview** (the IPDE, the SCID-5-PD) then probes only what screened positive and *confirms* the diagnosis, distinguishing a genuine enduring trait from an endorsed item. A positive screen is a prompt to interview, never a diagnosis in itself. This screen-then-confirm architecture is why the interview instruments each ship with a matched self-report front end.

RULE **Screen wide, confirm narrow.** A self-report questionnaire (the IPDE-SQ, the 106-item SCID-5-SPQ, the PID-5) screens and over-identifies; the structured interview (the IPDE, the SCID-5-PD) confirms against the criteria. A screen that is positive earns an interview; it does not earn a label.

PEARL

Read the self-report and interview as a sensitivity-then-specificity pair. The questionnaire is tuned to miss few cases (high sensitivity, low specificity), so its job is to decide which criteria are worth a clinician's time; the interview is tuned to confirm (specificity), so its job is to decide whether the endorsed pattern is real, enduring and impairing. Getting the order wrong, confirming from a questionnaire, is the commonest measurement error in the personality field.

12.3 The instruments, typeset

The object to hold cold. The instruments are learned as their structure and scoring with a citation, not as their items. The table gathers the four workhorse instruments and their matched

screeners; the highlighted cells are the structural facts an examiner reaches for.

INSTRUMENT	ADMINISTRATION	STRUCTURE AND COVERAGE	SCORING	SOURCE
IPDE	Clinician semi-structured interview	**Two modules, an ICD-10 and a DSM-IV module, usable alone or together; questions grouped by six life areas (work; self; interpersonal relationships; affects; reality testing; impulse control), not by disorder**	Each relevant criterion rated 0 absent, 1 subthreshold, 2 criterion level; trait present at least the past five years, one criterion before the age of twenty-five; output both dimensional and categorical (definite or probable)	Loranger, Janca, Sartorius; WHO / Cambridge UP (Loranger et al. 1994)
IPDE-SQ	Self-report screener (true or false)	First-pass filter flagging which disorders to probe in the full interview	A positive screen prompts the interview; not diagnostic	IPDE screening questionnaire
SCID-5-PD	Clinician structured interview	Covers the ten DSM-5 (Section II) personality disorders plus other-specified personality disorder; the DSM-5 successor to the SCID-II	**Each criterion rated 1 absent, 2 subthreshold, 3 threshold; the DSM-5 required criterion counts then decide each diagnosis**	First, Williams, Benjamin, Spitzer 2016 (APPI)
SCID-5-SPQ	Self-report screener (yes or no)	A 106-item questionnaire the patient completes first, so the interview probes only criteria that screened positive	Screening only; not itself diagnostic	SCID-5 Personality Questionnaire
PID-5 (and PID-5-BF)	Self-report dimensional trait measure	**Five higher-order trait domains over twenty-five lower-order facets; full form 220 items, Brief Form 25 items (domain level); operationalises the DSM-5 Section III alternative model Criterion B**	Items scored 0 to 3; domain and facet scores as item means (higher is more maladaptive); no single categorical cut-off	Krueger, Derringer, Markon, Watson, Skodol 2012 (APA)

INSTRUMENT	ADMINISTRATION	STRUCTURE AND COVERAGE	SCORING	SOURCE
ZAN-BPD	Clinician-rated severity and change scale	Nine items, one per DSM borderline criterion, spanning the affective, cognitive, impulsive and interpersonal domains; rated over the prior week	**Each item 0 to 4; total on the 0 to 36 scale; higher is greater severity; tracks change, not a diagnostic cut-off**	Zanarini et al. 2003

The four workhorse personality instruments and their matched self-report screeners, typeset as structure and scoring with a citation; the highlighted cells mark the single fact most often tested for each. Item wording is not reproduced.

GOOD TO REMEMBER

- **IPDE:** a WHO semi-structured interview in two modules (ICD-10 and DSM-IV) organised by six life areas, criteria scored 0, 1 or 2, giving both a dimensional and a categorical output, paired with the IPDE-SQ self-report screener.
- **SCID-5-PD:** the DSM-5 structured interview over the ten Section II personality disorders, criteria rated 1, 2 or 3, fronted by the 106-item SCID-5-SPQ self-report screener; the successor to the SCID-II.
- **PID-5:** the self-report dimensional measure of the five trait domains and twenty-five facets (220-item full form, 25-item brief), the alternative-model Criterion B instrument, with no categorical cut-off.
- **ZAN-BPD:** nine clinician-rated items, one per borderline criterion, each 0 to 4 for a total on the 0 to 36 scale; a severity and change measure, not a diagnostic test.
- **ICD-11 severity anchors:** personality difficulty, mild, moderate and severe on a harm gradient; severity is graded first, before any trait qualifier.

12.4 The categorical confirming interviews: IPDE and SCID-5-PD

Two interviews, one job: confirm a named type against the criteria. The IPDE, developed by Armand Loranger out of the earlier Personality Disorder Examination and adopted under the WHO joint programme, is the international standard. Its distinctive move is to organise questions by life area rather than by disorder, walking the patient through work, self, interpersonal relationships, affects, reality testing and impulse control, so the clinician rates the underlying criteria as they surface across the whole life rather than interrogating one type at a time. Each criterion is scored 0, 1 or 2, and the IPDE builds in a temporal guard against late-onset mimics: a criterion counts only if the trait has run for at least the past five years, with at least one criterion satisfied before the age of twenty-five. It returns both a dimensional score per disorder and a categorical verdict (definite, or probable when one criterion short).

The SCID-5-PD is the DSM-native equivalent. The SCID-5-PD covers the ten DSM-5 Section II personality disorders and rates each criterion on the standard SCID convention of 1 (absent), 2 (subthreshold) or 3 (threshold), with the DSM-5 criterion counts then deciding each diagnosis. Its 106-item self-report questionnaire, the SCID-5-SPQ, is completed first so the interview need only probe the criteria that screened positive, the screen-then-confirm logic in a single package.

Both instruments are copyright and are learned as structure and scoring, not as reproduced items.

GOOD TO REMEMBER

- **IPDE (the discriminator):** the interview organised by six life areas, not by disorder; criteria scored 0, 1 or 2 with the five-year and pre-age-twenty-five temporal guard, yielding a dimensional plus categorical result.
- **SCID-5-PD (the discriminator):** the DSM-5 structured interview over the ten Section II types, criteria rated 1, 2 or 3 to the DSM criterion counts, with the 106-item SCID-5-SPQ as its screen.

12.5 The PID-5 and the dimensional trait map

The self-report that measures the trait model directly. The PID-5 is the self-report operationalisation of the DSM-5 Section III alternative model of personality disorders, specifically its Criterion B maladaptive-trait model. It measures five higher-order trait domains, negative affectivity, detachment, antagonism, disinhibition and psychoticism, resolved into twenty-five lower-order facets. The full form is 220 items on a four-point scale from 0 to 3, scored at domain and facet level; the 25-item Brief Form (PID-5-BF), five items per domain, gives a domain-level profile only. Being dimensional, it has no categorical cut-off: an elevated domain or facet mean flags maladaptive trait expression, to be read alongside the Criterion A judgement of how impaired personality functioning is.

The trait domains almost, but not exactly, match ICD-11. The high-yield trap is that the two dimensional systems share four domains and differ on the fifth. Read the table across: the DSM-5 alternative model and ICD-11 both carry negative affectivity, detachment, a callous-antagonistic domain and disinhibition, but ICD-11's fifth domain is anankastia (rigid over-control), whereas the alternative model's fifth is psychoticism (odd, eccentric cognition). ICD-11 also names its antagonistic domain dissociality and adds a borderline pattern qualifier.

TRAIT-DOMAIN THEME	ICD-11 QUALIFIER	DSM-5 ALTERNATIVE MODEL / PID-5 DOMAIN
Negative emotionality	Negative affectivity	Negative affectivity
Social withdrawal	Detachment	Detachment
Callous, antagonistic	Dissociality	Antagonism
Under-control, impulsivity	Disinhibition	Disinhibition
The differing fifth domain	**Anankastia (rigid over-control)**	**Psychoticism (odd, eccentric)**
Optional pattern specifier	Borderline pattern qualifier	A borderline type is reconstructed from the traits

The two dimensional trait systems share four domains; the fifth differs, ICD-11 adding anankastia while the DSM-5 alternative model adds psychoticism. Cross from one to the other by swapping anankastia for psychoticism (and dissociality for antagonism).

MNEMONIC

Three D's, plus N and A

The five ICD-11 trait domains: the three D's, **D**etachment, **D**issociality and **D**isinhibition, plus **N**egative affectivity and **A**nankastia. To convert to the DSM-5 alternative model, keep negative affectivity, detachment and disinhibition, rename dissociality as antagonism, and swap anankastia for psychoticism.

COMMON TRAP

Reading a high PID-5 domain score as a diagnosis. The PID-5 is dimensional and has no categorical cut-off; an elevated negative-affectivity or detachment mean describes trait expression, it does not by itself declare a personality disorder. The diagnosis still needs the level-of-functioning judgement (Criterion A) and the general threshold. A trait score is a profile, not a verdict.

12.6 The ICD-11 severity anchors

Severity is graded first, and it leads the diagnosis. The **ICD-11 severity anchors** are the frame a modern assessment records before anything else: rather than matching a type, the clinician grades how impaired personality functioning is, on a continuum from personality difficulty through mild, moderate and severe. The judgement rests on impairment of the *self* (identity, self-worth, self-direction) and of *interpersonal* functioning (relationships and roles), together with the risk of harm to self or others. There is no numeric cut-off; the harm gradient is the quick discriminator, running from typically none in mild, through sometimes in moderate, to often in severe.

SEVERITY LEVEL (CODE)	SELF AND INTERPERSONAL FUNCTIONING	HARM TO SELF OR OTHERS
Personality difficulty (QE50.7)	Longstanding pronounced traits shown only intermittently (for example under stress) or at low intensity; some but not notable disruption; a health-status factor, not a mental disorder	Minimal
Mild (6D10.0)	Some areas of self-functioning affected, or all areas mildly; problems in many relationships and roles, but some are maintained	Typically none
Moderate (6D10.1)	Multiple areas of self-functioning affected at moderate severity; marked problems in most relationships and most roles compromised; may show mild dissociative or psychotic-like states under stress	**Sometimes**
Severe (6D10.2)	Severe disturbance in the sense of self; virtually all relationships affected and role performance severely compromised or absent; impairment across nearly all of life	**Often**

The ICD-11 severity anchors, graded on self and interpersonal impairment plus harm risk; the harm gradient (minimal, typically none, sometimes, often) is the quick discriminator, and personality difficulty is a health-status factor rather than a disorder. Trait-domain qualifiers may be added at any severity level.

12.7 The ZAN-BPD: a measure of change, not a diagnostic test

Quantify severity, then track it. The ZAN-BPD, derived by Mary Zanarini from the borderline criteria and the revised diagnostic interview for borderlines, is a nine-item clinician-rated scale in which each item maps onto one of the nine DSM borderline criteria, from frantic efforts to avoid abandonment through to transient stress-related paranoia or dissociation. Each item is rated 0 to 4 over the prior week, for a total on the 0 to 36 scale, with higher scores meaning greater severity. Its purpose is to be sensitive to change: it is the instrument used to measure whether borderline symptoms are responding in a treatment trial or over follow-up, not to make the diagnosis. That confirming diagnosis is the job of the general criteria and a structured interview; the ZAN-BPD then meters the severity over time.

GOOD TO REMEMBER

- **ZAN-BPD (the discriminator):** nine clinician-rated items, one per borderline criterion, each 0 to 4 for a 0 to 36 total; a severity and change measure sensitive to treatment response, explicitly not a diagnostic instrument.

12.8 State versus trait: assess personality at baseline, not mid-storm

The caution that governs the whole assessment. The **state versus trait** rule is the reason a personality diagnosis is timed as much as it is measured: a personality disorder is an enduring, pervasive pattern, so it must not be diagnosed from the affect, impulsivity or relational chaos of an acute episode of another disorder. The lability of a mood episode, the disinhibition of intoxication and the reactivity of a fresh crisis all mimic personality pathology while they last. The safeguards are to assess when the patient is at baseline rather than in the acute state, to require that the same pattern predates and outlasts the episode, and to lean on collateral and longitudinal history rather than a single cross-sectional interview. Situational affective lability without the identity disturbance and abandonment fear is not borderline personality; and the reactive, hours-long mood swings of borderline must be separated from the sustained, autonomous episodes drawn out in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

TRAP **Diagnosing a personality disorder mid-episode.** Affective instability, impulsivity and stormy relationships during an acute mood episode, an intoxication or a fresh crisis are state, not trait. Diagnose personality at baseline, against a pattern that is enduring, pervasive and pre-existing, or you will pin a lifelong label on a passing storm.

WORKED EXAMPLE

A woman in her twenties is admitted after self-harm during a depressive relapse, floridly labile and rejecting. The temptation is to record borderline personality disorder from the presentation. The disciplined route is the reverse: quantify the acute picture (a ZAN-BPD can meter current borderline symptoms, but does not diagnose), treat the mood episode, and defer the personality assessment. Reassessed at baseline some weeks later with collateral, a structured interview (the SCID-5-PD or the IPDE) then establishes whether an enduring, pervasive pattern truly predated the episode. Screen if useful, confirm by interview, and grade ICD-11 severity, but do it when the storm has passed.

12.9 The India lens and the cultural frame

Under-recognition makes systematic assessment worth more, not less. Personality disorders are substantially under-recognised in routine Indian practice, surfacing through comorbid mood, substance, anxiety or self-harm presentations rather than as a personality diagnosis, and often left uncoded for fear of stigma. A brief self-report screen embedded in a busy clinic is exactly the low-cost step that raises detection of the mixed and subthreshold cases that a purely impressionistic assessment misses, provided a structured interview then confirms. A severity-led ICD-11 reading, which begins with a graded judgement of dysfunction rather than a full type match, suits this reality well.

Read pathology against the patient's own culture, not a single norm. Every instrument still requires deviation from what the person's *own* culture expects, so joint-family interdependence, deference and religiously framed experience must not be scored as dependent, avoidant or odd pathology; personality must not be read through one culture's norms. On the treatment side, the

structured psychotherapies a severity rating points toward, dialectical behaviour therapy and schema therapy, are available and being culturally adapted at Indian tertiary and private centres but scarce elsewhere, so a severe rating can outrun what a service can deliver; the wider technique of these therapies belongs to the Psychotherapies, clinical assessment, MSE and nosology notes. Antisocial personality disorder carries the sharpest medico-legal weight in the Indian context, where the structured assessment feeds offender and court framing, cross-referenced to the Mental health legislation and forensic psychiatry notes.

INDIA

Personality disorders are under-recognised in Indian practice and present through their comorbidities, so a brief self-report screen followed by a confirming structured interview genuinely raises detection of the subthreshold and mixed cases. Judge deviation against the patient's own cultural norms, so collectivist family-embeddedness is not miscoded as dependency and religiously framed experience not as schizotypal oddness. The structured psychotherapies that a severity rating points to, dialectical behaviour therapy and schema therapy, are available and being culturally adapted in the metros and academic centres but unevenly accessible elsewhere; and antisocial personality disorder carries the medico-legal weight, where the assessment feeds the forensic notes.

5 ICD-11 AND ALTERNATIVE-MODEL TRAIT DOMAINS	**25** PID-5 LOWER-ORDER TRAIT FACETS (220-ITEM FULL FORM)	**0 to 36** ZAN-BPD TOTAL SCORE RANGE (NINE ITEMS)	**4** ICD-11 SEVERITY ANCHORS (DIFFICULTY TO SEVERE)

HOLD THIS

Assessment of personality runs screen-then-confirm: self-report questionnaires (the IPDE-SQ, the 106-item SCID-5-SPQ, the PID-5) screen and over-identify, and a structured interview (the IPDE, organised by six life areas; the SCID-5-PD, over the ten DSM-5 types) confirms against the criteria; grade the ICD-11 severity anchors first (difficulty, mild, moderate, severe on a harm gradient), map the five trait domains and twenty-five PID-5 facets, meter borderline change with the ZAN-BPD, and never fix the diagnosis during an acute episode, because personality is a trait, not a state.

13 . Dialectical behaviour therapy for borderline personality disorder

The first treatment that worked, and the template for all the rest. Dialectical behaviour therapy (DBT) is the psychotherapy that changed the outlook for borderline personality disorder: developed by Marsha Linehan out of failed attempts to treat chronically suicidal women with standard behaviour therapy, it was the first treatment of any kind shown in a randomised trial to reduce self-harm in a group that clinicians had come to regard as untreatable. Examiners return to it because it is comprehensive and highly structured, so it can be dismantled into named parts: a theory of the disorder, an organising philosophy, four skills modules, four treatment modes, a hierarchy of what to treat first, and staged goals across the whole arc of recovery. Learn those parts as a scaffold and the topic answers itself.

This fragment builds DBT from its foundations upward. It sets out the **biosocial theory** that DBT rests on, the central **dialectic** of acceptance and change from which the treatment takes its name, the four skills modules with **mindfulness** as their core, the four modes that together make a comprehensive programme, the target hierarchy that decides what is worked on in any given session, the stages of treatment, and the evidence for the reduction in self-harm and hospitalisation that earned DBT its place at the front of the guidelines. The disorder itself is taught on its own topic; here the pharmacology stays deliberately light and adjunctive, and the deep drug detail is cross-referenced to the Mood disorders: pharmacotherapy notes.

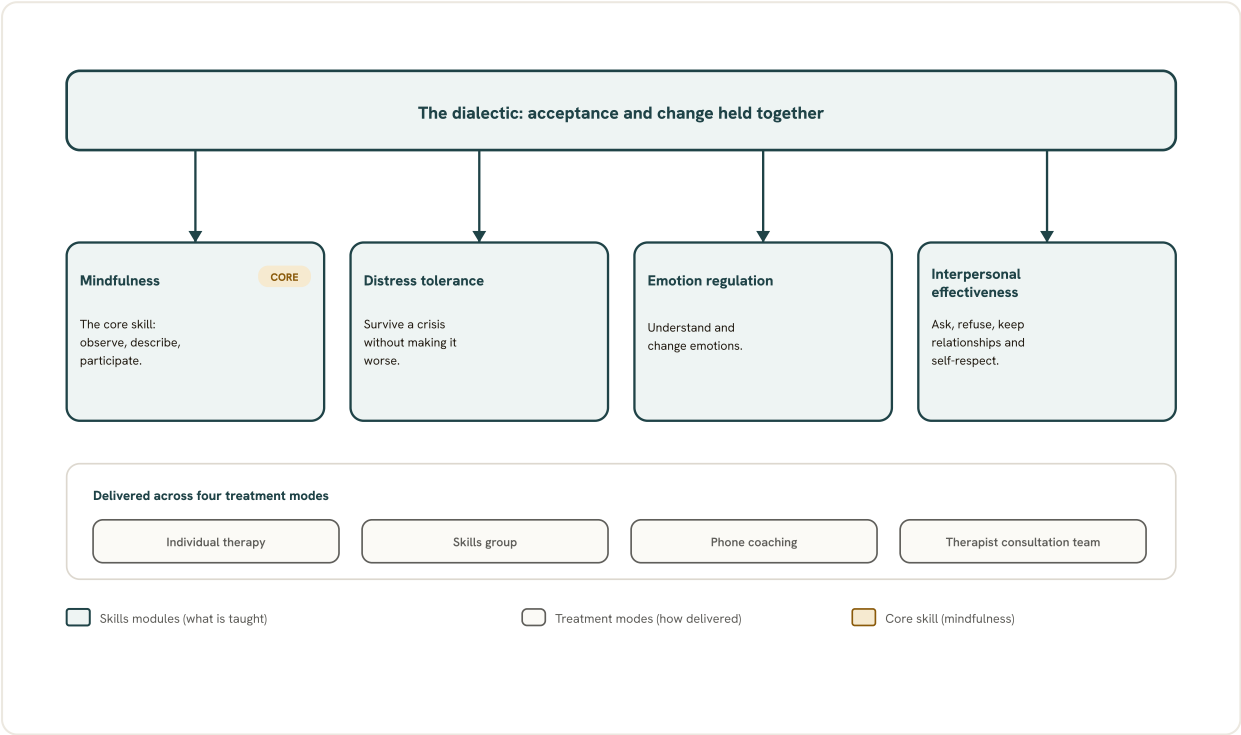


Fig 16.7 Dialectical behaviour therapy holds acceptance and change in dialectic and teaches four skills modules, mindfulness at the core, distress tolerance, emotion regulation and interpersonal effectiveness, delivered across four modes: individual therapy, the skills group, phone coaching and the therapist consultation team.

13.1 Origins and the core proposition

A behaviour therapy rebuilt around emotion dysregulation. Dialectical behaviour therapy grew in the early nineteen-eighties from work on repetitive suicidal and self-harm behaviour. Standard cognitive and behavioural change strategies, applied to chronically suicidal borderline patients, met a wall: pushing for change alone was experienced as invalidating, provoked drop-out and sometimes worsened the very behaviours being targeted. Linehan's solution was to place emotion dysregulation, rather than any single symptom, at the centre of the disorder, and to hold change strategies in constant balance with an equally strong stance of acceptance. The first controlled trial (Linehan and colleagues, published in the Archives of General Psychiatry) tested the new treatment in chronically parasuicidal women and made DBT the first psychotherapy to demonstrate efficacy in borderline personality disorder, opening the era of therapeutic optimism from which schema therapy, mentalisation-based treatment and transference-focused psychotherapy all followed.

4	4	3
SKILLS TRAINING MODULES	TREATMENT MODES IN COMPREHENSIVE DBT	STAGE-ONE TARGET TIERS (LIFE-THREATENING FIRST)

13.2 The biosocial theory of emotion dysregulation

Biology transacting with an invalidating environment. The biosocial theory is DBT's model of how borderline personality disorder arises, and it is the mechanism the whole treatment is built to address. A biological **emotional vulnerability**, meaning heightened sensitivity to emotional stimuli, greater intensity of response, and a slow return to baseline, transacts over development with a pervasively **invalidating environment**, one that dismisses, punishes or responds erratically to the child's inner experience. The transaction is reciprocal: the environment's invalidating responses amplify the biological sensitivity, and the resulting dysregulated behaviour draws further invalidation. The end state is pervasive **emotion dysregulation**, and DBT reads the criterion behaviours of the disorder, self-harm, impulsivity, stormy relationships and identity disturbance, as either the direct consequence of that dysregulation or the person's own attempts to re-regulate an unbearable affective state. Framing self-harm as attempted problem-solving, rather than manipulation, is what makes the theory both compassionate and clinically directive.

PEARL

The biosocial theory is why DBT never treats self-harm as a thing to be simply forbidden. If the behaviour is an attempt to solve the problem of unbearable emotion, then removing it without teaching a replacement skill leaves the person defenceless. Every act on the target list is therefore met with a behavioural chain analysis (what preceded it, what it achieved) and a substitute skill, not merely a safety contract.

13.3 The central dialectic: acceptance and change

Two technologies held in tension. The name of the treatment comes from **dialectics**: the philosophical stance that every position (thesis) calls up its opposite (antithesis) and that truth is found by synthesising the valid kernel of each. The single overarching dialectic in DBT is **acceptance and change**. The therapist must simultaneously accept the patient exactly as they are and relentlessly push for the changes that will build a life worth living, moving fluidly between the two poles rather than settling at either. This resolves the impasse that defeated ordinary behaviour therapy. Practically, DBT fuses two technologies: **behaviourism**, the technology of change (chain analysis, contingency management, skills training, exposure), and mindfulness derived from Zen, the technology of acceptance (validation, and ultimately radical acceptance of reality as it is). The constant motion between accepting and pushing is what gives DBT its characteristic speed and flow, and failures of the treatment are typically dialectical failures, a therapist stuck rigidly at one pole.

RULE **Structured psychotherapy is primary; DBT is the best-evidenced option for self-harm.** In borderline personality disorder the primary treatment is a structured, theory-based psychological therapy, and DBT is the intervention guidelines name first where reducing recurrent self-harm is the priority (NICE 2009, IPS 2023); medication is only adjunctive, symptom-targeted and time-limited.

13.4 The four skills modules, and mindfulness as the core

Four modules, built around a mindfulness centre. DBT teaches concrete behavioural skills in four modules, and Kaplan and Sadock name them exactly: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Mindfulness is the *core*: it is not one module among equals but the foundation, taught first and re-taught recurrently at the start of each of the other three modules. Its skills are the observing, describing and participating "what" skills, and the non-judgmental, one-mindful and effective "how" skills, converging on *wise mind*, the synthesis of emotion mind and reasonable mind. An elegant way to hold the set, shown in the accompanying figure, is that two modules serve *acceptance* (mindfulness and distress tolerance) and two serve *change* (emotion regulation and interpersonal effectiveness), so the four modules themselves mirror the central acceptance-change dialectic. A wrong module is the classic slip; verify the four against this list.

MODULE	POLE	WHAT IT TRAINS	SIGNATURE SKILLS
Mindfulness	**Acceptance (the CORE, re-taught before each module)**	Present-moment, non-judgmental awareness; the ground for all other skills	Observe, describe, participate; non-judgmentally, one-mindfully, effectively; wise mind
Distress tolerance	Acceptance	Surviving a crisis without making it worse; accepting what cannot be changed now	TIP, distraction (ACCEPTS), self-soothe, IMPROVE the moment, radical acceptance
Emotion regulation	Change	Understanding, naming and reducing the intensity of emotions; lowering vulnerability	Check the facts, opposite action, PLEASE (reduce vulnerability), accumulate positives
Interpersonal effectiveness	Change	Asking, refusing and keeping relationships and self-respect intact	DEAR MAN (objectives), GIVE (relationship), FAST (self-respect)

The four DBT skills modules; mindfulness is the core set, taught first and revisited before each of the other three. Two modules serve acceptance, two serve change.

MNEMONIC

DEAR MAN

The interpersonal-effectiveness skill for getting an objective met: **D**escribe the situation, **E**xpress feelings, **A**ssert the ask or the no, **R**einforce (name the benefit to the other), stay **M**indful (broken-record, ignore attacks), **A**ppear confident, **N**egotiate. Its two companions are GIVE (Gentle, Interested, Validate, Easy manner) for keeping the relationship, and FAST (Fair, no Apologies, Stick to values, Truthful) for keeping self-respect.

13.5 Distress tolerance, emotion regulation and interpersonal effectiveness

The three modules that complete the set. **Distress tolerance** is the acceptance-side crisis kit: skills to get through an urge to self-harm or an overwhelming affect without acting on it, from physiological down-regulation (the TIP skills) to distraction, self-soothing and, at its deepest, radical acceptance of a painful reality that cannot be changed in the moment. **Emotion regulation** is the change-side workhorse: it teaches the person to identify and label emotions, to check whether an emotion fits the facts, to act opposite to an unjustified emotion's urge, and to reduce baseline vulnerability by attending to sleep, eating, exercise and mastery. **Interpersonal effectiveness** supplies scripts for asking effectively, refusing without rupture, and preserving both the relationship and self-respect, which directly targets the abandonment sensitivity and the idealisation-devaluation swings of the disorder. The three change-and-tolerance modules are where the biosocial deficits are actively repaired.

TRAP **Calling a stand-alone skills class "DBT".** A weekly skills group on its own is skills training, not comprehensive DBT; the full treatment requires all four modes working together (individual therapy, skills group, phone coaching and a consultation team). Over-relying on distress tolerance while neglecting emotion regulation is the parallel error, since it teaches survival without teaching change.

13.6 The four treatment modes

Four modes, five functions. Comprehensive DBT is delivered through four **modes**, each serving a treatment function. The two that carry the standard trial format are **individual therapy plus skills group**: weekly **individual therapy** (which enhances motivation, uses the diary card and chain analysis, and where the individual therapist bears ultimate responsibility for the target behaviours) and the weekly **skills training group** (which enhances capabilities by teaching the four modules in a psychoeducational, class-like format). Alongside them run between-session phone coaching (which ensures the generalisation of skills into real life, coaching the patient through a crisis in the moment rather than in the next session) and the therapist consultation team (the "therapy for the therapists", which enhances the clinicians' own capability and motivation, guards treatment fidelity, and protects against burnout and dialectical failure). Between them these modes deliver DBT's five functions: enhance capabilities, improve motivation, ensure generalisation, structure the environment, and enhance the therapist. A programme missing any mode is not comprehensive DBT.

MODE	FUNCTION IT SERVES	WHAT HAPPENS IN IT
Individual therapy (weekly)	Improve motivation	One-to-one; diary card review and behavioural chain analysis; the individual therapist holds ultimate responsibility for the targets
Skills training group (weekly)	Enhance capabilities	Class-format teaching of the four modules with homework; a leader and co-leader; opens with a mindfulness exercise
Phone coaching (between sessions)	Ensure generalisation	Brief in-the-moment coaching to apply a skill during a crisis; commonly structured by a rule limiting calls after self-harm
Consultation team	**Enhance the therapist (fidelity and morale)**	Weekly clinician meeting; "therapy for the therapists"; sustains adherence and prevents dialectical failure and burnout

The four modes of comprehensive DBT and the functions they serve. The consultation team, exported into the treatment itself from the trials that use teams to control adherence, is the uniquely DBT mode examiners test.

13.7 The hierarchy of treatment targets

What gets worked on first is fixed, not chosen ad hoc. Because borderline patients typically present with many simultaneous problems, DBT imposes a strict order on what any given individual session addresses. Within the first stage of treatment the targets are ranked: **life-threatening behaviours** first (suicidal and self-harm acts, and credible threats), then **therapy-interfering behaviours** (of the patient or the therapist, such as missing sessions, arriving intoxicated, or a therapist's own drift), and finally **quality-of-life-interfering behaviours** (the substance use, disordered eating, unemployment and relational chaos that seriously destabilise a life). Only once those are in hand does the work turn to increasing behavioural skills. The diary card is scanned against this hierarchy at the top of every session, so a fresh episode of self-harm always pulls the agenda upward regardless of what patient or therapist would rather discuss. This ordering is one of the most reliably examined facts of the topic.

WORKED EXAMPLE

A young woman in comprehensive DBT arrives wanting to talk about a job interview. Her diary card, however, shows a cutting episode three evenings earlier. The target hierarchy decides the agenda: the therapist addresses the life-threatening behaviour first, running a chain analysis of the cutting and rehearsing the distress-tolerance skill that could have replaced it, before any time goes to the interview (a quality-of-life target). The ordering is not coldness; it is the treatment refusing to let the highest-risk behaviour be talked past.

13.8 The DBT stages of treatment

Staged goals across the whole arc of recovery. The **DBT stages** organise the treatment over time, beginning with a distinct pre-treatment phase of orientation and commitment, in which

patient and therapist agree the goals, the mode structure and the working agreements before therapy proper starts. The staged plan then runs from severe behavioural dyscontrol toward a full life, and the target hierarchy above sits inside the first stage.

STAGE	PRESENTING LEVEL	GOAL OF THE STAGE
Pre-treatment	Not yet committed or oriented	Orientation, commitment, agreeing goals, modes and working agreements
Stage one	Severe behavioural dyscontrol	**Behavioural control and stability (the life-threatening, therapy-interfering, quality-of-life target hierarchy)**
Stage two	Quiet desperation; controlled behaviour but emotional suffering	Non-anguished emotional experiencing; processing the past, including trauma and post-traumatic stress
Stage three	Problems in living	Ordinary happiness and unhappiness; self-respect and individual life goals
Stage four	Sense of incompleteness	Capacity for sustained joy, freedom and connection

Pre-treatment plus the four DBT stages. Most suicidal borderline patients enter at stage one, where behavioural control is the priority; trauma processing waits for stage two, after stability is achieved.

13.9 The evidence base: self-harm and hospitalisation

The reductions that earned it the guidelines. The foundational trial (Linehan and colleagues, in chronically parasuicidal women with borderline personality disorder) showed that, compared with treatment as usual, DBT reduced the frequency and medical severity of self-harm, produced fewer psychiatric hospitalisation days, and markedly improved treatment retention by lowering drop-out, even where it did not initially separate on depression or hopelessness. Those two signals, less **self-harm** and less **hospitalisation**, have been the durable core of the DBT evidence base ever since, replicated across later trials and reviews, and DBT remains the most extensively researched and evaluated of all treatments for the disorder (the basis for its Cochrane and guideline standing). Both NICE and the Indian Psychiatric Society recommend DBT specifically to reduce recurrent self-harm and emotion dysregulation, which is exactly the outcome the original trial demonstrated.

13.10 Place among the borderline psychotherapies, and the guideline anchor

One of several structured therapies, first among equals for self-harm. DBT sits alongside schema therapy, mentalisation-based treatment and transference-focused psychotherapy as the evidence-based structured psychotherapies for borderline personality disorder, each with its own mechanism and their own topics in this chapter; DBT is distinguished by its behavioural roots, its skills curriculum, and the strongest evidence base for reducing self-harm. The guideline position is consistent and worth carrying cleanly: structured psychological therapy is the primary treatment, DBT (or an equally comprehensive programme) is offered where recurrent self-harm is

the priority, and pharmacotherapy is not a treatment for the disorder itself but a symptom-targeted, time-limited adjunct for a comorbidity or a crisis. A programme is only DBT if it keeps the biosocial theory, the acceptance-change dialectic, all four modes and the target hierarchy; strip those out and what remains is skills training under a borrowed name. The wider technique of the structured psychotherapies is developed in the Psychotherapies, clinical assessment, MSE and nosology notes.

INDIA

Personality disorders are markedly under-recognised in Indian practice, so the borderline patient usually reaches services coded by the self-harm episode rather than by the pattern, and the structured therapy that would help is rarely offered. Two things temper a realistic plan. First, availability: dialectical behaviour therapy and schema therapy are being delivered and culturally adapted at Indian tertiary and private centres rather than being widely accessible, and few settings can staff a full four-mode programme with a trained consultation team, so pragmatic, skills-focused adaptations are common. Second, cultural fit: the mindfulness and acceptance core of DBT sits naturally with Indian contemplative traditions, an asset when framed in the patient's own idiom, while the interpersonal-effectiveness scripts must be calibrated to family interdependence rather than imported wholesale, since assertiveness norms and the very expression of personality pathology differ by culture and must not be read through a single culture's lens.

GOOD TO REMEMBER

- **Dialectical behaviour therapy (DBT):** core mechanism is the biosocial theory, an emotional vulnerability transacting with an invalidating environment to produce pervasive emotion dysregulation, treated by fusing behavioural change with mindfulness-based acceptance (the acceptance-change dialectic). Structure: four skills modules (mindfulness as the core, plus distress tolerance, emotion regulation and interpersonal effectiveness) delivered through four modes (individual therapy, skills group, phone coaching and consultation team), with a target hierarchy of life-threatening, then therapy-interfering, then quality-of-life-interfering behaviours across staged treatment. Indication: borderline personality disorder with recurrent self-harm, suicidality and chronic emotion dysregulation; it is the first-line structured psychotherapy for self-harm (NICE, IPS). Signature caution: it must be comprehensive and delivered with fidelity, it is resource-intensive, and trauma processing waits for stage two, only after stage-one behavioural control.

HOLD THIS

DBT rests on the biosocial theory of emotion dysregulation and the acceptance-change dialectic, and is delivered as four skills modules (mindfulness at the core, with distress tolerance, emotion regulation and interpersonal effectiveness) through four modes (individual therapy, skills group, phone coaching, consultation team), targeting life-threatening before therapy-interfering before quality-of-life behaviours; its landmark evidence is the reduction in self-harm and hospitalisation.

14 . Schema therapy for personality disorders

The integrative psychotherapy built for the difficult patient. Schema therapy is Jeffrey Young's integrative model, weaving cognitive-behavioural technique together with attachment theory, object relations and the experiential (gestalt) tradition, and designed expressly for the chronic, characterological presentations on which ordinary short-term cognitive-behavioural therapy

stalls. It matters in the examination because it is one of the small handful of structured psychotherapies with a genuine borderline personality disorder evidence base, and because its vocabulary, **early maladaptive schemas**, coping styles, **schema modes** and **limited reparenting**, is asked directly. Learn it as a four-part architecture: the schemas (the enduring self-defeating patterns), the domains that group them, the coping styles that keep them alive, and the modes framework that carries the work with the labile borderline patient.

This fragment teaches the model forward: what a **schema** is and where it comes from, the **five schema domains** holding the **eighteen early maladaptive schemas**, the **three coping styles** (surrender, avoidance, overcompensation), and the mode map that reduces the borderline patient's shifting states to a workable set of parts. It then teaches the two signature techniques, limited reparenting and experiential **mode work**, and closes on the trial evidence and the Indian picture. The wider landscape of psychotherapy models and technique sits in the Psychotherapies, clinical assessment, MSE and nosology notes; the borderline construct itself, and the sibling therapies dialectical behaviour therapy and mentalisation-based treatment, are developed on their own topics in this chapter.

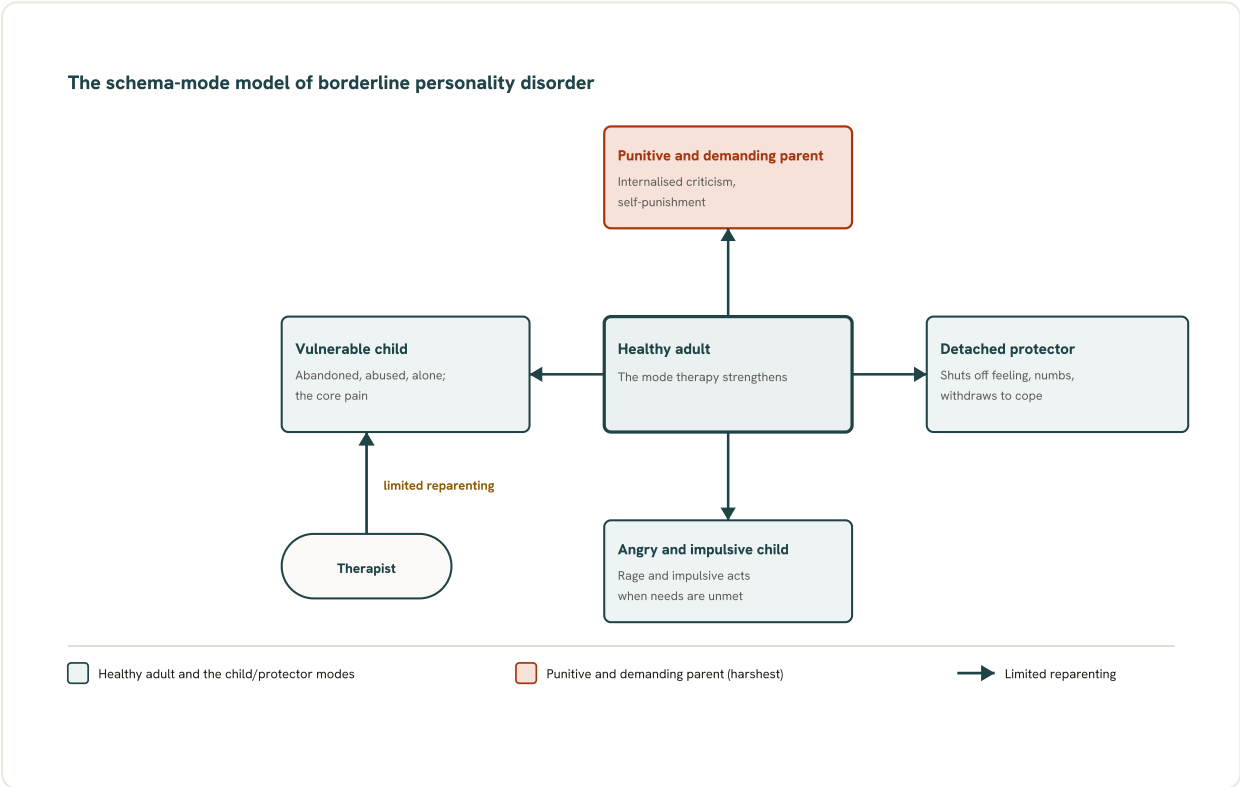


Fig 16.8 Schema therapy formulates borderline personality disorder as shifts between modes, the vulnerable child, the angry and impulsive child, the detached protector and the punitive and demanding parent, and uses limited reparenting to meet the vulnerable child's needs and build up the healthy adult mode.

14.1 What schema therapy is, and who it is for

An integrative model for ego-syntonic, characterological pathology. Standard cognitive-behavioural therapy assumes a patient who forms an alliance quickly, has a stable identity and clear goals, can access and verbalise affect, and can change through logic and homework. The personality-disordered patient breaks every one of those assumptions: the pathology is rigid, ego-syntonic and interpersonal, and it defeats a symptom-focused approach. Schema therapy was

constructed by Young for exactly this population. Its organising idea is that maladaptive personality patterns grow from **unmet core emotional needs** in childhood, five of them, secure attachment, autonomy and competence and a sense of identity, freedom to express valid needs and emotions, spontaneity and play, and realistic limits and self-control. Where these needs go unmet, through aversive experience interacting with temperament, the child lays down self-defeating patterns that harden into personality. The therapy aims to meet those needs, in a bounded therapeutic form, and so to heal the patterns rather than merely manage the symptoms.

14.2 Early maladaptive schemas: the enduring self-defeating pattern

Broad, pervasive, self-perpetuating themes about self and relationships. An early maladaptive schema is a broad, pervasive theme about oneself and one's relationships, comprising memories, emotions, cognitions and bodily sensations, laid down in childhood or adolescence and elaborated across the lifespan, dysfunctional to a significant degree. The examples make it concrete: abandonment, mistrust and abuse, emotional deprivation, defectiveness and shame. A schema begins as a reasonably accurate reading of a harmful early environment and becomes inaccurate as the person grows, yet it fights for survival: the patient assimilates new experience to fit the schema and discounts what would disconfirm it, which is schema perpetuation. This is what makes personality pathology so treatment-resistant, and it is why the schema, not the presenting symptom, is the unit of the work. Schemas are traits: present as a vulnerability, they may or may not be activated at a given moment, and when a schema is triggered the person is flooded with the original affect.

18	5	3	4
EARLY MALADAPTIVE SCHEMAS (YOUNG)	SCHEMA DOMAINS GROUPING THEM	MALADAPTIVE COPING STYLES	DYSFUNCTIONAL BORDERLINE MODES

14.3 The five schema domains and the eighteen schemas

Each domain answers one thwarted childhood need. The **eighteen early maladaptive schemas** are grouped into **five schema domains**, and the domain is the more examinable unit because each maps cleanly onto one of the unmet core emotional needs. Hold the five domains and one or two schemas under each, rather than reciting all eighteen; the domain structure is what the questions test.

DOMAIN	THWARTED CORE NEED	REPRESENTATIVE SCHEMAS WITHIN IT
Disconnection and Rejection	**Secure attachment: safety, stability, nurturance, acceptance**	**Abandonment/Instability; Mistrust/Abuse; Emotional Deprivation; Defectiveness/Shame; Social Isolation**
Impaired Autonomy and Performance	Autonomy, competence, a sense of identity	Dependence/Incompetence; Vulnerability to Harm; Enmeshment/Undeveloped Self; Failure
Impaired Limits	Realistic limits and self-control	Entitlement/Grandiosity; Insufficient Self-Control/Self-Discipline
Other-Directedness	Freedom to express valid needs and emotions	Subjugation; Self-Sacrifice; Approval/Recognition-Seeking
Overvigilance and Inhibition	Spontaneity and play	Negativity/Pessimism; Emotional Inhibition; Unrelenting Standards; Punitiveness

The five schema domains, each anchored to the childhood emotional need it reflects; the highlighted Disconnection and Rejection domain is the one most central to borderline pathology and the main target of limited reparenting.

14.4 The three maladaptive coping styles: surrender, avoidance, overcompensation

How the patient responds when a schema is triggered. A schema is the wound; the coping style is what the person does when it is touched. Young identifies **three coping styles**, and they map onto the innate threat responses. In surrender, the patient yields to the schema, accepts it as true and lives it out, choosing partners and situations that confirm it. In avoidance, the patient arranges life so the schema is never activated, blocking the thoughts and numbing the affect, often through detachment, substance use or workaholism. In overcompensation, the patient fights the schema by acting as though its opposite were true, so a defectiveness schema can drive grandiose perfectionism. All three are adaptive survival responses in childhood that become maladaptive later, because each perpetuates the very schema it was meant to escape.

COPING STYLE	INNATE ANALOGUE	WHAT THE PATIENT DOES
Surrender	Freeze	Yields to the schema, accepts it as true, repeats the schema-driven pattern and confirms it
Avoidance	Flight	Keeps the schema from firing at all: blocks thought and affect, withdraws, self-medicates, disengages from therapy
Overcompensation	**Fight**	**Behaves as though the opposite of the schema were true; counter-attacks, and overshoots into grandiosity or control**

The three maladaptive coping styles and their fight, flight, freeze analogues; a single patient uses different styles with different schemas and at different times.

MNEMONIC

FIGHT, FLIGHT, FREEZE

The three coping styles as the three threat responses: **Fight** is overcompensation (act as if the opposite is true), **Flight** is avoidance (keep the schema from firing), **Freeze** is surrender (yield to it and live it out). Three responses, three coping styles, one schema underneath.

14.5 The schema modes framework: from traits to states

Modes are the workhorse for the labile borderline patient. The original schema model is a trait model, and it fits the more stable personality disorders. It struggles with borderline personality disorder, where patients score high on almost every schema at once and flip between extreme states within minutes, angry, then terrified, then detached, then self-hating. Young answered this with the schema modes concept: a mode is the moment-to-moment state, the cluster of schemas and coping responses that is active right now, in contrast to the schema, which is the enduring trait. Reframing a chaotic patient as a small set of parts that alternate, rather than dozens of simultaneously active schemas, is what makes borderline pathology workable in the room, and it is why the modes framework, not the schema list, is the tool used with these patients. The mode map is shown in the accompanying figure.

RULE **Trait for the stable, state for the labile.** Use the schema (trait) model for the more stable personality disorders and the schema modes (state) model for the borderline patient who shifts between extreme states, because that patient has too many schemas active at once to work with one at a time.

14.6 The borderline modes: the four that shift, and the one that heals

Four dysfunctional modes, alternating around an underdeveloped Healthy Adult. The borderline patient characteristically moves between **four dysfunctional modes**. The **vulnerable child** (the Abandoned Child) carries the raw pain of the schemas, fragile, frightened, alone; the Angry and Impulsive Child erupts in rage or acts out impulsively when needs go unmet; the

detached protector is a coping mode of avoidance, shutting off all feeling and connection to keep the pain out; and the **punitive parent** (the internalised critical, sometimes demanding, parent) attacks the child with self-hatred and punishment, and drives much of the self-harm. Against these stands the fifth mode, the Healthy Adult, which in the borderline patient is weak and which the therapy exists to strengthen: the goal of treatment is to build a Healthy Adult that can nurture the vulnerable child, set limits on the angry child, bypass the detached protector and banish the punitive parent.

WORKED EXAMPLE

A woman in her twenties arrives numb and monosyllabic, saying she feels nothing (the detached protector is in charge). As the therapist gently makes contact, she begins to cry about being unlovable and terrified of being left (the vulnerable child breaks through). Asked about the previous night's cutting, she says flatly that she deserved it and is disgusting (the punitive parent speaks). Minutes later she is furious that the session must end (the angry child). The formulation is not "unstable and manipulative" but a rapid cycling through four modes, each of which is addressed differently: soothe the child, validate but contain the anger, get past the protector, and fight the punitive parent.

14.7 Limited reparenting: the relational engine

The therapist partially meets the unmet childhood needs, within bounds. Limited reparenting is the central relational stance of the therapy and its main active ingredient. Within the ethical and professional limits of the therapeutic frame, the therapist deliberately provides an approximation of the emotional experiences the patient missed in childhood, warmth, stability, containment and, where needed, firm limit-setting, so as to directly address the core emotional needs behind the schemas, above all those in the Disconnection and Rejection domain. It is *limited* precisely because the therapist does not become the parent and does not regress the patient into dependency; the more severe the early deprivation, and the more childlike the borderline patient's needs, the more central this reparenting becomes. It runs alongside empathic confrontation, in which the therapist holds warmth and honest challenge together, confronting the schema-driven behaviour while staying firmly on the patient's side.

PEARL

Limited reparenting is what most sharply distinguishes schema therapy from ordinary cognitive-behavioural therapy, in which the relationship is a vehicle for technique rather than an active ingredient. Here the relationship *is* a treatment: the therapist is a stable, caring figure who models the Healthy Adult the patient will internalise. The word "limited" is load-bearing, and marks the difference between therapeutic reparenting and a boundary violation.

14.8 Experiential mode work: imagery rescripting and chair work

Change is driven at the level of affect, not just cognition. Schema therapy works across four channels, cognitive (testing and reframing the schema), behavioural (pattern-breaking, replacing the coping responses), the therapy relationship (limited reparenting and empathic confrontation), and, most distinctively, the experiential. Experiential **mode work** engages the modes emotionally

rather than by argument. In imagery rescripting, the patient re-enters a painful childhood image; the therapist, and later the patient's own Healthy Adult, enters the scene to protect and comfort the vulnerable child and to confront the offending figure, so the memory is re-scripted with the need met. In chair work, the modes are externalised onto chairs and put into dialogue, so the Healthy Adult can, for instance, be given a voice to answer and expel the punitive parent. These techniques are the engine of schema change, and treating the therapy as cognitive disputation alone forfeits them.

TRAP **Running schema therapy as ordinary CBT.** Reducing it to cognitive disputation and homework, skipping the limited reparenting and the experiential imagery and chair work, strips out its two signature ingredients and leaves the schemas, which are held in affect and memory, untouched.

14.9 The evidence, in borderline and other personality disorders

A real trial base, strongest in borderline personality disorder. The landmark trial is Giesen-Bloo and colleagues' multicentre randomised study in the Netherlands (2006), which ran schema therapy against transference-focused psychotherapy over roughly three years in borderline personality disorder and found schema therapy superior, with a higher recovery rate (about double) and notably lower attrition. Farrell and colleagues (2009) showed a large added benefit from a group form of schema therapy, and Bamelis and colleagues (2014) extended the evidence beyond borderline, with a randomised trial supporting schema therapy across a range of personality disorders (including avoidant, dependent, obsessive-compulsive, paranoid, histrionic and narcissistic types), for which specific mode models have since been mapped. On this base, schema therapy sits, with dialectical behaviour therapy and mentalisation-based treatment, among the structured psychological therapies that are the primary treatment for borderline personality disorder; drug treatment is not first-line, and the deep pharmacology is cross-referenced to the Mood disorders: pharmacotherapy notes.

14.10 Place in management, and the Indian picture

A structured, longer-term psychotherapy delivered by trained, supervised therapists. Schema therapy is a structured, theory-based, longer-term treatment, typically delivered over a couple of years, moving from assessment and schema education, through the experiential and cognitive change work built on the reparenting relationship, to behavioural pattern-breaking and relapse prevention. It is not a brief intervention and, like the other borderline-specific therapies, it should not be delivered outside a supervised, structured service. Where availability is thin, its ideas, the mode formulation and limited reparenting, still usefully inform a general management plan even when the full protocol is out of reach.

INDIA

Personality disorders are markedly under-recognised in Indian practice, so the patients who would benefit from schema therapy are often reached only through a self-harm presentation and never formulated. Access is the second constraint: schema therapy, like dialectical behaviour therapy, is being delivered and adapted at a small number of Indian tertiary and private centres rather than being widely available, and trained, supervised schema therapists are scarce. Cultural calibration matters throughout, both because the schema content is read against family and cultural norms (interdependence and duty to family are not, in themselves, a Subjugation or Self-Sacrifice schema) and because the reparenting relationship must respect local expectations of the therapeutic bond; personality pathology must never be judged through a single culture's norms.

GOOD TO REMEMBER

- **Schema therapy (Young):** mechanism is healing early maladaptive schemas, the enduring self-defeating patterns laid down by unmet core emotional needs, through limited reparenting (the therapist partially and within bounds meets the missed needs) plus experiential mode work (imagery rescripting, chair work) alongside cognitive and behavioural change; the eighteen schemas sit in five domains, the three coping styles are surrender, avoidance and overcompensation, and the borderline patient is worked through the schema modes (vulnerable child, angry and impulsive child, detached protector, punitive parent) toward a strengthened Healthy Adult. Indication is chronic, characterological personality pathology, with the strongest evidence in borderline personality disorder (Giesen-Bloo 2006, superior to transference-focused psychotherapy) and support across other personality disorders (Bamelis 2014). Signature caution: it is a structured, longer-term therapy needing trained, supervised delivery, and stripping out the reparenting and the experiential work turns it into ordinary CBT that leaves the schemas untouched.

HOLD THIS

Schema therapy heals early maladaptive schemas through limited reparenting and experiential mode work; for the borderline patient the workhorse is the schema modes map, four dysfunctional modes (vulnerable child, angry and impulsive child, detached protector, punitive parent) cycling around a Healthy Adult that the therapy exists to strengthen.

15 . Mentalisation-based therapy and transference-focused psychotherapy

Two more borderline-specific therapies, two different engines. Alongside dialectical behaviour therapy and schema therapy, the borderline literature carries two further structured, manualised, evidence-based models, and the examiner wants the *mechanism* of each, not a vague label. Mentalisation-based therapy (**MBT**, also called mentalisation-based treatment, developed by Bateman and Fonagy) reads borderline pathology as a collapse of mentalising, the capacity to understand behaviour in terms of underlying mental states, that occurs under attachment stress; its whole technique is to restore that capacity through a particular therapeutic posture. Transference-focused psychotherapy (**TFP**, developed by Clarkin and Kernberg) reads the same pathology through object relations theory as a set of split, unintegrated internal representations of self and other, and works to integrate them in the live, here-and-now transference.

The high-yield frame is the contrast: both work in the here and now and both use the therapeutic relationship as the instrument, but MBT deliberately does *not* interpret the unconscious (it takes a curious, not-knowing **mentalising stance** to get the patient thinking about minds again), whereas TFP *does* interpret, using the sequence of clarification, confrontation and interpretation to fuse the idealised and persecutory images the patient cannot hold together. This fragment teaches each engine, its indications and its evidence, and closes by placing both alongside dialectical behaviour therapy and schema therapy; those two are taught on their own topics in this chapter, and the wider psychodynamic and general models are cross-referenced to the Psychotherapies, clinical assessment, MSE and nosology notes.

15.1 Mentalising: holding mind in mind

Mentalising is reading behaviour, one's own and others', in terms of mental states.

Mentalising is the social-cognitive ability to make sense of actions, of the self and of other people, in terms of the mental states behind them, thoughts, feelings, wishes, beliefs and desires; in plain language, it is attentiveness to thinking and feeling in oneself and in others. It is an ordinary human capability that underpins everyday interaction, and it runs across four dimensions that can each become unbalanced: automatic versus controlled, self versus other, cognitive versus affective, and internal versus external. In personality disorder these capacities are reduced, and reduced most sharply at moments of interpersonal stress, which is exactly when they are most needed. Bateman and Fonagy argue that many borderline symptoms emerge from this distortion or loss of mentalising: the person loses the felt distinction between their own perspective and external reality, cannot easily coordinate their mind with another's, and is left isolated, since the joining of minds (the so-called we-mode) is the ingredient of ordinary connection that the loss of mentalising obstructs.

15.2 The collapse under attachment stress, and the nonmentalising modes

Rising arousal switches mentalising off, and older, prementalising modes reappear.

Mentalising develops within attachment relationships and is vulnerable within them: high arousal, generated by attachment hyperactivation and disorganised attachment strategies, disrupts the less well-practised, higher cognitive capacity to reflect. As the accompanying figure shows, when interpersonal arousal climbs past a threshold, balanced mentalising drops away and three developmentally earlier, nonmentalising modes take over. The examinable point is that borderline phenomena are not random: each mode is what you get when one dimension of mentalising dominates and the others fail.

NONMENTALISING MODE	EXPERIENCE OF THE MIND	CLINICAL FACE
Psychic equivalence	**Inner states are felt as literally, unquestionably real; thought equals reality, so no alternative perspective is possible ("concreteness of thought")**	Overwhelming certainty ("the therapist hates me", "I am wicked"), the drama and terror that make self-harm feel comprehensible
Teleological	Mental states are believed only if their outcome is physically observable; affection is real only with a touch, care real only with an action	Demands for concrete proof of caring; self-harm or action as the only "real" expression of a state; the automatic pole dominates
Pretend mode	Thoughts and feelings become severed from reality; much is said about mental states with little genuine connection to them	Hypermentalising or pseudo-mentalising, long inconsequential talk about feelings; taken to an extreme, derealisation and dissociation

The three nonmentalising (prementalising) modes that reappear when mentalising collapses under arousal; the highlighted psychic-equivalence cell is the one that makes borderline self-harm and quasi-psychotic certainty intelligible.

MNEMONIC

TOO REAL · ONLY IF SEEN · NOT REAL AT ALL

The three nonmentalising modes in three tags. **Too real** = psychic equivalence (thought is experienced as reality). **Only if seen** = teleological (a state counts only if physically demonstrated). **Not real at all** = pretend mode (talk about feelings cut loose from any real feeling; hypermentalising).

15.3 The mentalising stance: curious, not-knowing, restoring the capacity to think

The stance is the treatment: inquisitive, not-knowing, aimed at reviving mentalising rather than delivering insight. The bedrock clinical principle of MBT is an authentic **mentalising stance**, an inquisitive, "not-knowing" posture that respects the opacity of minds: minds can never be truly known, so the clinician's task is to inquire, to be genuinely curious, and to be willing to be surprised by the patient's answer, with the aim of raising the patient's own awareness of their internal states through a shared process. The work is in the here and now and stays close to preconscious, working-memory experience rather than pursuing unconscious meaning through free association; a session typically settles onto a single focus within the first ten to fifteen minutes and then works around it. Crucially, MBT does not push interpretation while the patient is non-mentalising and highly aroused; the first job is to lower arousal and re-open thinking, because interpreting a mind that has collapsed into psychic equivalence only confirms the concreteness. The secure-base relationship to the therapist is what makes it safe to explore one's own mind and find it reflected in another's.

WORKED EXAMPLE

A patient arrives certain that "you were going to cancel on me, I could tell". A not-knowing MBT response is not a reassurance and not an interpretation of transference; it is a curious inquiry: "I did not know that was in your mind, help me understand what told you that, and what it was like to sit with it." The clinician marks their own not-knowing, slows the moment, and invites the patient back into thinking about the mental states involved, theirs and the clinician's, rather than settling the "fact". The same opening moment in TFP would be handled differently (see below), and that difference is the whole point of the topic.

RULE **Structured, borderline-specific psychotherapy is the treatment; the model is chosen by fit, not by a proven winner.** MBT, TFP, dialectical behaviour therapy and schema therapy are all evidence-based for borderline personality disorder, and head-to-head trials show no single model is reliably superior; choose by patient fit, therapist training and local availability, and deliver it as a structured programme, not as eclectic support.

15.4 MBT: structure, indications and evidence

A structured, time-limited programme of individual plus group work, first proven in a partial-hospitalisation trial. MBT is delivered as a combination of individual and group sessions within a structured, time-limited programme (the original model ran in a day-hospital and partial-hospitalisation setting, with later intensive-outpatient versions), all built around the mentalising stance. Its indications have widened from borderline personality disorder (the primary and best-evidenced target) to antisocial personality disorder (MBT-ASPD), to adolescents with emerging borderline features and self-harm (MBT-A), and to other conditions marked by mentalising failure. The founding evidence is Bateman and Fonagy's randomised trial of partial-hospitalisation MBT against treatment as usual: the MBT group showed significant reductions in depressive symptoms, in suicidal and self-injurious behaviour and in inpatient days, with better social and interpersonal functioning; the gains began to appear after about six months and were maintained after treatment ended, with long-term follow-up showing durable benefit. That "benefit emerges over months, then holds" shape is itself examinable.

PEARL

MBT reframes what a borderline crisis *is*: not primarily a behaviour to be managed but a moment when mentalising has gone offline. This is why the intervention is a stance rather than a technique menu, and why "the therapist not knowing what to say" is treated as useful data, an accurate read of the patient's own collapsed mentalising, rather than a therapist failure.

GOOD TO REMEMBER

- **Mentalisation-based therapy (MBT), Bateman and Fonagy:** mechanism, borderline symptoms arise from a loss of mentalising (understanding behaviour in terms of mental states) under attachment-stress arousal, so the therapy restores mentalising through a curious, not-knowing mentalising stance in the here and now, working close to conscious experience rather than interpreting the unconscious. Indication, borderline personality disorder first-line among structured therapies, extended to antisocial personality disorder and to adolescents; evidence from a partial-hospitalisation RCT versus treatment as usual with gains maintained after termination. Signature caution, do not push interpretation while the patient is non-mentalising and highly aroused, lower arousal and re-open thinking first.

15.5 TFP and the object-relations frame: split, unintegrated representations of self and other

The borderline mind is built of split object dyads that idealise and persecute but never integrate. Transference-focused psychotherapy rests on an ego-psychological and **object relations** framework derived from Melanie Klein and elaborated by Otto Kernberg. Its unit of analysis is the internal *object dyad*: a single mental representation of the self linked to a representation of another person by an affect (for example, a weak, needy self bound to an exploitative but needed other by fear). In health these representations integrate into whole, ambivalent images; in borderline personality organisation (BPO) they do not. Instead the patient relies on splitting, keeping idealised and persecutory representations apart so that the same person is experienced as all-good or all-bad and flips between the two. TFP therefore diagnoses along a *level of personality organisation* axis rather than by categorical criteria, assessing the interrelated domains of identity, object relations, primitive defences, reality testing, aggression and moral values in a structural interview, which the Structured Interview of Personality Organization (STIPO-R) helps to operationalise. The core therapeutic target is **identity diffusion**, the lack of an integrated sense of self, and the goal is identity consolidation.

COMMON TRAP

Reading TFP as "diagnose the DSM type, then treat it". TFP works on borderline personality organisation, a broader structural construct than DSM borderline personality disorder that cuts across many categorical personality diagnoses and also covers narcissistic pathology. Two patients with different DSM labels can share the same borderline-level organisation and the same split object relations, which is exactly what TFP targets; the categorical label is not the treatment axis.

15.6 The TFP technique: integrating the dyads in the here-and-now transference

Contract first, then channel the split into the transference and interpret it into integration. TFP is an individual therapy, tested as a twice-weekly treatment of at least one to two years' duration, and it begins with explicit contracting, goal-setting and limit-setting. The wager is that the patient's split, unintegrated representations of self and other will inevitably be enacted in the relationship with the therapist, the *transference*, where they become available in the room in the here and now rather than only in history. Work follows a priority hierarchy (suicidal and self-destructive behaviour first, then threats to the continuity of the treatment, then the dominant transference theme) and a technical sequence of clarification, then confrontation of contradictions, then interpretation. By naming, for example, that the patient is treating the

therapist as the persecutor of the moment while a needy, idealising self is split off, TFP brings the two poles into contact so they can begin to integrate; as the split dyads fuse into whole-object relations, identity consolidates. Reflective functioning and integration, not symptom management alone, are the intended fruits.

TRAP **Deep transference interpretation into a mind that has already collapsed.** Interpretation only works on a patient who can still mentalise; delivering a Kernberg-style transference interpretation while the patient is in psychic equivalence and high arousal tends to confirm the concreteness and destabilise, which is precisely the failure MBT was built to avoid. Restore mentalising and lower arousal first; interpret when there is a mind available to think with.

3	4	6	2
MBT NONMENTALISING MODES (PSYCHIC EQUIVALENCE, TELEOLOGICAL, PRETEND)	DIMENSIONS OF MENTALISING IN MBT	TFP STRUCTURAL-INTERVIEW DOMAINS OF PERSONALITY ORGANISATION	TFP SESSIONS A WEEK (TWICE WEEKLY, OVER ONE TO TWO YEARS)

15.7 TFP indications and evidence

For borderline and narcissistic pathology in a patient who can tolerate interpretation, with a solid RCT base. TFP is indicated for borderline and narcissistic personality disorders and, more broadly, for patients at a borderline level of organisation who can commit to a long, twice-weekly, interpretation-based treatment and tolerate the affect it raises; the containing contract and limit-setting are what make it usable in a high-risk population. The evidence base is genuinely randomised. Clarkin and colleagues' three-arm trial compared TFP, dialectical behaviour therapy and supportive psychodynamic therapy and found all three efficacious, with TFP producing broad change across domains; Doering and colleagues found TFP superior to treatment by experienced community psychotherapists on borderline symptoms, suicide attempts and dropout; and the Giesen-Bloo multicentre trial comparing schema therapy and TFP showed both producing significant improvement, with schema therapy holding an advantage on recovery and retention. Mechanism-consistent findings (Levy and colleagues) show TFP increasing reflective functioning and shifting attachment toward security, which is the change the object-relations model predicts.

GOOD TO REMEMBER

- **Transference-focused psychotherapy (TFP), Clarkin and Kernberg:** mechanism, an object-relations therapy that treats borderline pathology as split, unintegrated internal representations of self and other (object dyads) held apart by splitting, and integrates them by working the here-and-now transference through clarification, confrontation and interpretation, with identity diffusion as the core target and identity consolidation the goal. Indication, borderline and narcissistic personality disorders (borderline personality organisation) in a patient able to tolerate a long, twice-weekly, interpretive treatment; evidence from several RCTs. Signature caution, it is interpretation-heavy, so it needs a mind that can still mentalise and a firm contract, or the interpretation destabilises.

15.8 Where MBT and TFP sit alongside dialectical behaviour therapy and schema therapy

Four structured models, four different theories of the same disorder. The four borderline-specific psychotherapies are best held as one grid: each names a different core mechanism and a

different signature technique, and no head-to-head trial has crowned one as reliably best, which is why the selection RULE above governs. The two owned on their own topics in this chapter (dialectical behaviour therapy and schema therapy) are set here beside MBT and TFP so the discriminators are visible at a glance.

THERAPY	THEORETICAL MODEL	CORE MECHANISM / TARGET	SIGNATURE TECHNIQUE
Dialectical behaviour therapy (Linehan)	Biosocial: emotional vulnerability plus an invalidating environment	Emotion dysregulation and behavioural dyscontrol	Skills training (mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness) held in dialectic of acceptance and change
Mentalisation-based therapy (Bateman and Fonagy)	Attachment and mentalising deficit	Loss of mentalising under arousal	**Curious, not-knowing mentalising stance that restores thinking about mental states in the here and now**
Transference-focused psychotherapy (Clarkin and Kernberg)	Ego-psychology and object relations (Klein, Kernberg)	Identity diffusion; split, unintegrated self and other representations	**Here-and-now transference interpretation (clarification, confrontation, interpretation) to integrate the split dyads**
Schema therapy (Young)	Early maladaptive schemas and schema modes	Maladaptive schema modes (vulnerable child, detached protector, punitive parent)	Limited reparenting and mode work

The four structured, evidence-based borderline psychotherapies; the two highlighted cells are the discriminator of this topic, MBT restores mentalising through a stance while TFP interprets the transference to integrate split object relations.

INDIA

Personality disorders are markedly under-recognised in Indian practice, and the specialist psychotherapies are scarcer still. Dialectical behaviour therapy has the widest, if uneven, adaptation and delivery at Indian tertiary and private centres; mentalisation-based therapy and transference-focused psychotherapy are far less available, concentrated in a few academic and psychodynamically trained settings, and the binding constraint is the training and supervision pipeline rather than patient demand. Two cautions travel with the models. First, mentalising norms are cultural: the we-mode, joint attention and the expression of affect are read differently across Indian family systems, and interdependence must not be mistaken for a mentalising failure. Second, the object-relations reading of a case must be held against the patient's own cultural idiom, so that a culturally normative deference or a shared family self is not over-interpreted as split or diffuse identity. Judge the mind against its own context, not a single culture's template.

HOLD THIS

MBT (Bateman and Fonagy) restores lost mentalising through a curious, not-knowing stance and does not interpret; TFP (Clarkin and Kernberg) integrates split object-relations dyads by interpreting the here-and-now transference, and does; both work in the present through the therapeutic relationship, and both sit as evidence-based options beside dialectical behaviour therapy and schema therapy.

16 . Pharmacotherapy in personality disorders

The most trapped question on the day: which drug? The examinable truth about **pharmacotherapy in personality disorders** is almost entirely a truth about restraint. There is no medication registered to treat any personality disorder, structured psychological therapy is the primary treatment, and every drug that is used is used **symptom-targeted** and adjunctive, aimed at a defined target symptom or a comorbidity, never at the disorder itself. The single fact worth more than any dose is the NICE position on borderline personality disorder: drug treatment is not first-line, and the candidate who reaches for a mood stabiliser or an antipsychotic as the answer has walked into the classic trap.

This fragment leads with the guideline law, states the NICE rule as both a rule and a trap, then reconciles it with what the wider bodies (the Indian Psychiatric Society CPG and WFSBP) permit at symptom-domain level. It teaches the three psychobiological symptom domains and the agent class attached to each, keeps the pharmacology deliberately light, and cross-references the deep drug detail to the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes. The bipolar-II differential that so often triggers a wrong prescription sits in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and the forensic frame for antisocial personality disorder in the Mental health legislation and forensic psychiatry notes.

16.1 The governing principle: adjunctive, symptom-targeted, never disorder-specific

No drug licensed. The organising principle of **pharmacotherapy in personality disorders** is that it is never a disorder-specific registered treatment. **No drug licensed** for any personality disorder exists in any major formulary, and every guideline body, however permissive, agrees that psychotherapy is primary and medication is at most an adjunct. What medication can legitimately do is act on a discrete **symptom-targeted** problem, an aggressive outburst, a run of cognitive-perceptual disturbance, a depressive or anxious swing, or a comorbid Axis-I disorder sitting alongside the personality pathology. It follows that a drug is prescribed against a named, measurable target with a defined review point, and is stopped if that target does not move. The diagnosis itself must be secure before any of this begins: an enduring, pervasive, inflexible pattern with onset by adolescence, not a situational state, and for borderline personality disorder that means the full pattern (five or more of the nine criteria), not a single stormy fortnight.

PEARL

Read every personality-disorder drug question as a question about a target symptom, not about the disorder. "What is the drug treatment for borderline personality disorder?" has no correct drug answer, the correct answer is that structured psychological therapy is the treatment and medication is only a time-limited, symptom-targeted adjunct. Reframing the question this way is what protects you from the trap the stem is usually setting.

16.2 The NICE rule: drug not first-line for borderline

The most tested management fact of the day. NICE (2009, CG78) states that drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms and behaviours associated with it (repeated self-harm, marked emotional instability, risk-taking, transient psychotic symptoms). Structured psychological therapy is primary. Medication is legitimate in only two situations: to treat a diagnosed comorbid condition, or short-term during a crisis (a sedative, usually for no longer than one week). NICE guidance is explicit that antipsychotic drugs should not be used for the medium- and long-term treatment of the disorder. This is the highest-yield line of the topic, and a mis-statement of it is a critical error.

RULE **Drug not first-line for borderline.** In borderline personality disorder, structured psychological therapy is primary; any medication is symptom-targeted, adjunctive and time-limited, for a comorbidity or a crisis only, and antipsychotics are not for medium- or long-term use (NICE 2009).

TRAP **Reaching for a drug first.** Starting a mood stabiliser or antipsychotic as the primary treatment for borderline personality disorder, or for its self-harm and lability directly, is the classic error and contradicts NICE outright; there is no licensed disorder-specific drug to reach for.

0	3	1
DRUGS LICENSED FOR BORDERLINE PERSONALITY DISORDER	SYMPTOM-TARGET DOMAINS FOR ADJUNCTIVE DRUGS	WEEK, USUAL MAXIMUM FOR CRISIS SEDATION (NICE)

16.3 Reconciling the guidelines: NICE, the Indian Psychiatric Society, WFSBP

Same primacy of psychotherapy, differing latitude on adjuncts. The bodies agree that psychological therapy is the primary treatment and that no drug is a registered disorder-specific treatment; they differ in how much symptom-targeted prescribing they permit. NICE is the most restrictive (no drug for the disorder or its symptoms; a crisis sedative or comorbidity treatment only). The Indian Psychiatric Society CPG (IPS 2023) makes psychotherapy central but allows that, in some patients, antipsychotics may reduce hostility, suspiciousness, affect dysregulation and cognitive-perceptual distortions, and that mood stabilisers may reduce impulsivity and aggressiveness. WFSBP (2007) supplies the fullest symptom-domain framework for adjunctive agents. Hold NICE as the safe default answer and the domain framework as the "where is there any evidence" detail.

GUIDELINE (YEAR)	POSITION ON DRUG TREATMENT	WHAT IT PERMITS
NICE, CG78 (2009)	**Do NOT use drugs specifically for borderline personality disorder or its symptoms; no antipsychotic for medium- or long-term use**	Treat a comorbidity; a crisis sedative for usually no longer than one week; review and deprescribe
NICE, personality disorders (2015)	No drug for the personality itself; structured clinical assessment to diagnose	Antipsychotic or sedative only for short-term crisis or a comorbid condition; group cognitive-behavioural therapy for antisocial personality disorder
the Indian Psychiatric Society CPG (2023)	Psychotherapy is central; DBT recommended early	Symptom-targeted antipsychotics and mood stabilisers in some patients; avoid benzodiazepines
WFSBP (2007)	Adjunctive, symptom-targeted only, not a registered treatment	Agent chosen by symptom domain; trial for at least three months against defined targets
APA (2024)	Structured psychotherapy primary; medication adjunctive	Time-limited, single measurable target symptom; reconcile and review medications at least every six months

The guideline hierarchy for these notes: NICE leads and is the safest default, the Indian Psychiatric Society and WFSBP add the symptom-domain latitude, APA supplies the core prescribing principles.

16.4 The three symptom domains and the agent attached to each

The Soloff-style psychobiological domains organise all adjunctive prescribing. When medication is used at all, it is targeted at one of three symptom domains rather than at the disorder, a framework running from Soloff's psychobiological model through the APA and WFSBP schemes. The **cognitive-perceptual** domain (suspiciousness, ideas of reference, transient quasi-psychotic or dissociative experiences) attracts a low-dose antipsychotic; the **impulsive-behavioural dyscontrol** domain (impulsive aggression, self-damaging impulsivity, anger) attracts a mood stabiliser, with a low-dose antipsychotic as an alternative where aggression dominates; and the **affective instability domain** (affective dysregulation, depressive mood swings, anxiety) attracts an SSRI. The mapping is the examinable core, shown in the accompanying figure.

SYMPTOM DOMAIN	TARGET FEATURES	AGENT CLASS WITH ADJUNCTIVE EVIDENCE
Cognitive-perceptual	Suspiciousness, ideas of reference, transient quasi-psychotic and dissociative symptoms	**Low-dose antipsychotic (second-generation)**
Impulsive-behavioural dyscontrol	Impulsive aggression, self-damaging impulsivity, anger and behavioural discontrol	**Mood stabiliser (a low-dose antipsychotic where aggression dominates)**
Affective instability and anxiety	Affective dysregulation, depressive mood swings, rejection sensitivity, anxiety	**SSRI**

The three psychobiological symptom domains and the drug class attached to each; this is the framework the wider guidelines use, always as an adjunct to primary psychotherapy, never as a treatment for the disorder.

16.5 Low-dose antipsychotics: cognitive-perceptual and impulsive domains

Low, short, and for a named target only. A **low-dose antipsychotic**, a second-generation agent such as quetiapine (Qutipin, Seroquel), olanzapine (Oleanz, Zyprexa) or aripiprazole (Arip, Abilify), carries moderate adjunctive evidence in the **cognitive-perceptual** domain and, where impulsivity and aggression dominate, in **impulsive-behavioural dyscontrol** (WFSBP 2007; IPS 2023). The doses used are low and the course is meant to be short and target-defined; the deep pharmacology, receptor profiles and adverse effects belong to the Schizophrenia: management, antipsychotics and adverse effects notes and are not re-taught here. The overriding constraint is the NICE one: an antipsychotic is legitimate short-term, but must not be continued for the medium- and long-term treatment of borderline personality disorder, so a crisis prescription is reviewed and stopped once the crisis resolves.

16.6 Mood stabilisers: impulsive aggression

For impulsive aggression, not for a personality-based "mood swing". A **mood stabiliser**, valproate or divalproex (Valprol, Encorate), lamotrigine (Lamitor, Lametec) or topiramate, has adjunctive evidence for reducing impulsivity and impulsive aggression that antipsychotics have not settled (IPS 2023; WFSBP 2007). The trap this sets is the borderline-versus-bipolar-II confusion: the rapid, reactive affective instability of borderline personality disorder, minutes to hours and triggered by interpersonal events, is not the sustained syndromic mood episode of bipolar II, and starting a mood stabiliser for personality-based lability, mislabelled as bipolarity, is a common and consequential error. That differential is developed in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and the deep drug detail in the Mood disorders: pharmacotherapy notes; here the mood stabiliser stays a targeted adjunct for impulsive aggression.

TRAP **Treating borderline lability as bipolar II.** Rapid, reactive, interpersonally cued affective instability is a borderline feature, not a bipolar mood episode; reflexively starting a mood stabiliser for it medicalises a personality target and misses the primary psychotherapy.

16.7 SSRIs: the affective instability and anxiety domain

Best-shown class for affective dysregulation and anxiety, still adjunctive. Of the drug classes, the SSRI has the clearest evidence for the **affective instability domain**, the depressive mood, mood swings and anxiety of the disorder (WFSBP 2007), and an SSRI such as fluoxetine (Fludac, Prozac) or sertraline (Serlift, Zoloft) is a reasonable adjunct where that domain predominates or where a comorbid depressive or anxiety disorder is present. It also carries the practical advantage of relative safety in overdose, which matters in a population with recurrent self-harm. As always, this is symptom-targeted and adjunctive to psychotherapy, and where an SSRI is used for a comorbidity it is that comorbidity, not the personality disorder, that is being treated; the deep detail sits in the Mood disorders: pharmacotherapy notes.

16.8 The cautions: avoid polypharmacy, deprescribe, and what never to use

The prohibitions are as examinable as the indications. Several cautions run across the guidelines. Avoid benzodiazepines: the Indian Psychiatric Society CPG advises against them in borderline personality disorder because of dependence risk and disinhibition that can worsen impulsive behaviour. Avoid drugs dangerous in overdose: WFSBP counsels against irreversible MAOIs and lithium despite some efficacy, precisely because these patients need agents safe in parasuicidal acts. Above all, **avoid polypharmacy** and long-term prescribing without a clear indication: NICE guidance is to review repeat prescriptions regularly, to discourage polypharmacy, and to withdraw drugs started in a crisis once it resolves, aiming to reduce and stop unnecessary treatment. The maintenance rule that antipsychotics are not for medium- or long-term use in borderline personality disorder belongs here too.

> **COMMON TRAP**
>
> A borderline patient accumulates a low-dose antipsychotic, a mood stabiliser, an SSRI and a "when required" benzodiazepine over successive crises, none reviewed. This is exactly the polypharmacy NICE tells you to unwind: benzodiazepines should be off entirely, the crisis-era drugs deprescribed once the crisis has passed, and the whole regimen reconciled against a single measurable target. Deprescribing is an active clinical act, not neglect.

16.9 Crisis, comorbidity, and antisocial personality disorder

Where a drug is genuinely indicated, and where none is. Two legitimate windows remain. In a crisis, short-term cautious sedation (an antihistamine such as promethazine, or a low-dose antipsychotic) may be considered as part of an overall plan, usually for no longer than one week, alongside risk assessment and a collaborative crisis plan (NICE 2009). For a diagnosed comorbid depression, post-traumatic stress or anxiety disorder, that comorbidity is treated on its own terms within the structured programme. Antisocial personality disorder is the instructive contrast: there is no drug treatment for the antisocial personality itself, the mainstay is a group cognitive-behavioural intervention (often in criminal-justice or health settings), and pharmacotherapy is reserved strictly for a comorbid mental disorder (NICE 2015). The offender-assessment and court-report frame is cross-referenced to the Mental health legislation and forensic psychiatry notes.

WORKED EXAMPLE

A woman in her twenties with borderline personality disorder presents in crisis after an argument, with rising urges to self-harm and transient paranoid ideas. The correct plan is not to "start" a drug for the disorder: assess risk, enhance coping and reflective capacity, agree a crisis plan, and, if sedation is needed, offer it cautiously and briefly (usually no longer than one week), reviewing to stop it as the crisis settles. The definitive treatment is referral to a structured psychological therapy such as dialectical behaviour therapy; any antipsychotic used for the cognitive-perceptual symptoms is short-term and target-defined, never a maintenance prescription.

16.10 Place in the plan, and the Indian picture

Medication sits inside a psychotherapy-led, stepped plan. The management spine holds: outpatient care by default with admission avoided and, when unavoidable, brief and purposeful; short-term focus on crisis and safety, mid-term on the core features through structured psychological therapy, long-term on function and relationships. Within that, pharmacotherapy is a symptom-targeted, time-limited adjunct, layered onto (never in place of) dialectical behaviour therapy, schema therapy, mentalisation-based treatment or transference-focused psychotherapy by availability and fit. The candidate who leads with a drug has inverted the plan.

INDIA

Personality disorders are markedly under-recognised in Indian practice, so many patients reach services only through a self-harm or crisis presentation and are prescribed a symptom drug without ever being formulated or offered the structured therapy that is the actual treatment. Two realities shape a sensible plan. Access: dialectical behaviour therapy and schema therapy are being delivered and culturally adapted at a small number of Indian tertiary and private centres rather than being widely available, so the psychotherapy-first rule can be hard to enact and makes disciplined, minimal prescribing (and active deprescribing) all the more important. Culture: personality pathology must never be read through a single culture's norms, its expression, and the antisocial and medico-legal framing in particular, differs by setting, and the forensic use of an antisocial diagnosis carries weight that belongs with the forensic notes, not with a prescription pad.

GOOD TO REMEMBER

- **Pharmacotherapy overall:** mechanism is symptom-targeted and adjunctive (never disorder-specific; no drug licensed); indication is a defined target symptom, a comorbidity, or short-term crisis sedation; signature caution is that it is not first-line for borderline personality disorder, psychotherapy is primary, and antipsychotics are not for medium- or long-term use (NICE 2009).
- **Low-dose antipsychotic:** targets the cognitive-perceptual domain (and impulsive aggression where it dominates); short-term and low-dose; caution is no medium- or long-term use in borderline personality disorder.
- **Mood stabiliser:** targets impulsive-behavioural dyscontrol and impulsive aggression; caution is not to mistake reactive borderline lability for bipolar II and medicalise a personality target.
- **SSRI:** targets the affective instability and anxiety domain and any comorbid depression or anxiety; advantage is relative safety in overdose; caution is it treats the symptom or comorbidity, not the disorder.
- **Never:** avoid benzodiazepines (dependence, disinhibition), avoid drugs dangerous in overdose (irreversible MAOIs, lithium), and avoid polypharmacy; review and deprescribe.

HOLD THIS

No drug is licensed for a personality disorder; structured psychological therapy is primary and NICE says drug treatment is not first-line for borderline personality disorder, so all pharmacotherapy is symptom-targeted and adjunctive, a low-dose antipsychotic for the cognitive-perceptual domain, a mood stabiliser for impulsive-behavioural dyscontrol, an SSRI for the affective instability and anxiety domain, for a comorbidity or a crisis only, while you avoid benzodiazepines, avoid polypharmacy, and deprescribe.

17 . The integrated management of borderline personality disorder

The treatment block, assembled into one plan. The separate topics teach the disorder and each therapy on its own; this one is the synthesis, the single algorithm an examiner wants when the question is simply "how would you manage this patient". The integrated management of borderline personality disorder is *integrated* in two senses: it braids the strands of care (crisis work, structured psychotherapy, selective medication, care planning and psychoeducation) into one coherent plan, and it reconciles the guideline bodies (NICE, the Indian Psychiatric Society and WFSBP) into one defensible line. The plan is built on a three-part spine, **LOCUS** (where care happens), **FOCUS** (what is targeted, and when) and **MODUS** (by what means), and it is anchored, above everything, on one rule that examiners test relentlessly: a drug is not the first-line treatment for this disorder.

This fragment walks the spine end to end. It fixes the **locus** of care as outpatient and community by default, sets the **focus** by phase from short-term crisis and risk through the mid-term core-feature work to long-term function and remission, and lays out the **modus**, with structured psychological therapy as the primary mode and medication kept symptom-targeted, time-limited and adjunctive. Throughout, the guideline order is NICE first (CG78), then the Indian Psychiatric Society CPG and WFSBP, and the pharmacology stays deliberately light, with the deep drug detail cross-referenced to the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes. The integrated algorithm is drawn in the accompanying figure.

4	0	1 wk
STRUCTURED PSYCHOTHERAPIES FOR THE DISORDER (DBT, SCHEMA, MBT, TFP)	DRUGS LICENSED FOR BORDERLINE PERSONALITY DISORDER (NICE)	USUAL CEILING FOR A CRISIS SEDATIVE (NICE)

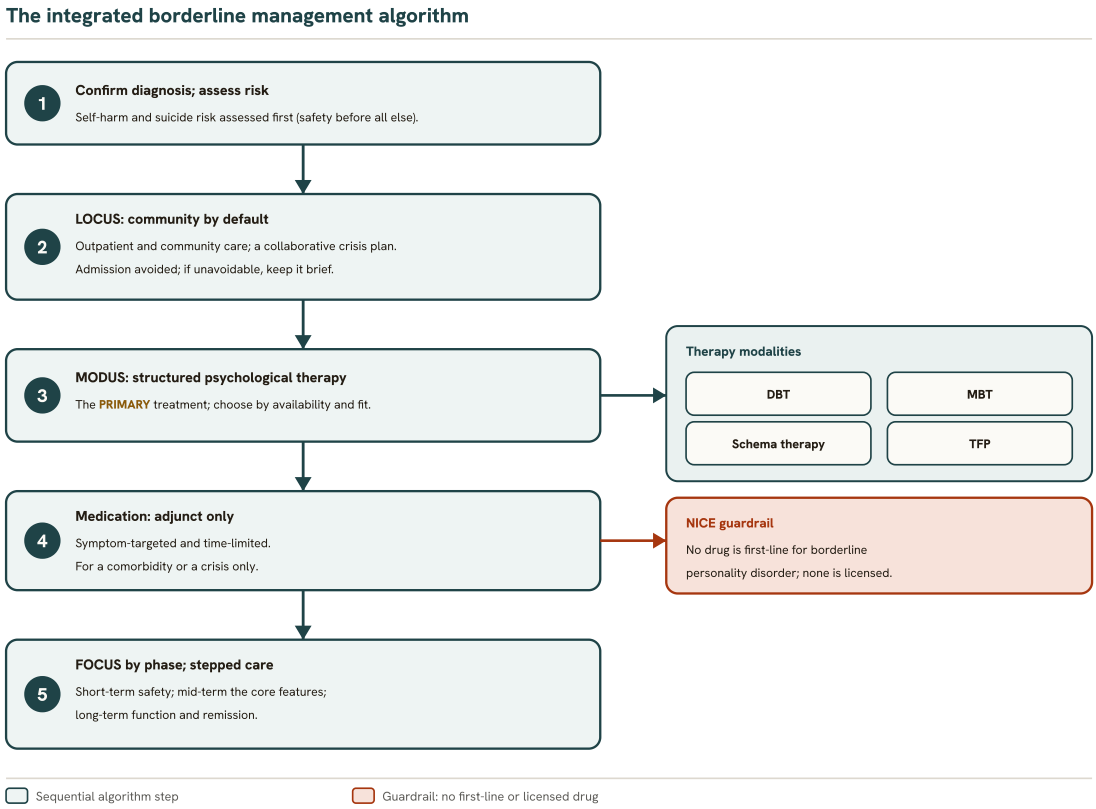


Fig 16.9 The integrated plan treats borderline personality disorder mostly in the community with a crisis plan, makes structured psychological therapy (dialectical behaviour therapy, mentalisation-based therapy, schema therapy or transference-focused psychotherapy) the primary treatment, and uses medication only, symptom-targeted and time-limited, for a comorbidity or a crisis, because no drug is first-line or licensed for the disorder.

17.1 The integrated frame, and the one rule that governs it

One plan, one governing rule. Before the spine, fix the principle that shapes every branch of it. NICE (2009, CG78) states that drug treatment should not be used specifically for borderline personality disorder or for its individual symptoms (repeated self-harm, marked emotional instability, risk-taking, transient psychotic symptoms), that no drug is licensed for the disorder, and that structured psychological therapy is the primary treatment; medication is reserved for a comorbid condition or short-term use in a crisis. The Indian Psychiatric Society (IPS 2023) agrees, making psychotherapeutic methods the central treatment and permitting only symptom-targeted adjuncts; WFSBP (2007) frames any drug as adjunctive and symptom-domain-targeted rather than disorder-specific. The three bodies differ only in how much room they leave for adjunctive medication, NICE the most restrictive, IPS and WFSBP allowing symptom-targeted agents, and they are unanimous that psychotherapy is primary. The whole integrated plan is therefore a psychotherapy-led plan into which crisis care, selective medication and care planning are fitted.

RULE **Structured psychological therapy is primary; any medication is adjunctive.** In borderline personality disorder the first-line treatment is a comprehensive, structured, theory-based psychotherapy delivered by trained supervised practitioners; medication is only ever symptom-targeted, time-limited and reserved for a comorbidity or a crisis (NICE 2009, IPS 2023, WFSBP 2007).

TRAP **Reaching for a drug first-line for the disorder itself.** Starting an antipsychotic or a mood stabiliser as the primary treatment for borderline instability, or continuing antipsychotics for medium- and long-term management, runs directly against NICE (which recommends no drug for the disorder and no antipsychotic for its longer-term treatment). A wrong first-line for borderline personality disorder is a critical error.

17.2 LOCUS, where the care happens

Outpatient and community by default; admission avoided, and when unavoidable, brief and purposeful. The **locus** of care is the community. Borderline personality disorder is managed in outpatient and community settings within a stepped care framework, matching intensity to need and stepping up only as required. Inpatient admission is actively avoided, because prolonged admission tends to entrench regression, reinforce crisis behaviour and disrupt the very relationships and roles that recovery depends on; NICE is explicit that admission should be avoided unless there is a serious risk to self or others that cannot be managed any other way, and that when it does happen it should be brief and for an agreed, specific purpose (typically the containment of acute risk), not open-ended asylum. The **service frame** matters as much as the setting: people with the disorder must not be excluded from any health or social care service because of the diagnosis or because they have self-harmed, and any planned change or withdrawal of a service is agreed with the person through a structured, phased plan rather than an abrupt discharge. Community continuity, not the ward, is the therapeutic base.

COMMON TRAP

Admitting the recurrently self-harming borderline patient to a general ward for safety, and keeping them. Beyond the brief, purposeful containment of an unmanageable acute risk, prolonged admission is not protective; it interrupts the outpatient therapy that actually reduces self-harm, models the crisis as the route to care, and is where iatrogenic regression sets in. The default is to manage the crisis in the community and return the person to their structured programme.

17.3 FOCUS, the target shifts by phase

Three phases, three different jobs. The **focus** of the work is not static; it moves as the patient stabilises. In the *short term* the target is safety, the job is crisis management and **risk** (containing self-harm and suicidality, and building a collaboratively agreed crisis plan). In the *mid term* the target is the core disorder itself, the emotion dysregulation, identity disturbance, abandonment sensitivity and unstable relationships, addressed through a sustained course of structured psychological therapy. In the *long term* the target is life beyond symptoms, function, relationships, work or study, and consolidated remission, which for many patients is a realistic goal given that borderline personality disorder has a substantially remitting long-term course. Sequencing

matters: trauma processing and deep character work wait until behavioural safety is established, so a plan that opens with intensive trauma exposure while the patient is still cutting weekly has the phases in the wrong order.

PHASE	PRIMARY TARGET (THE FOCUS)	THE MAIN WORK
Short-term	**Safety, risk and the acute crisis**	Risk assessment, crisis management, a collaboratively agreed crisis plan with identified triggers; brief, purposeful containment only if risk is otherwise unmanageable
Mid-term	The core disorder features	A sustained course of structured psychological therapy (the emotion dysregulation, identity, abandonment and relational instability)
Long-term	Function, relationships and remission	Rehabilitation into role and relationship, relapse prevention, and consolidation of gains toward remission

The focus of the integrated plan shifts by phase; safety is secured before core-feature therapy, and function follows.

17.4 The short-term focus, crisis management, risk and self-harm

Assess the risk, hold the person, agree a plan, avoid the ward. When a patient presents in crisis, the sequence is concrete. Assess the current **risk** to self and others; ask what has happened before and what helped then; help the person manage the surge of anxiety by enhancing coping and reflective capacity rather than simply removing them from their life; and avoid hospital admission unless there is a serious risk that cannot be managed otherwise (NICE 2009). The durable output of a crisis contact is a crisis plan, agreed collaboratively and documented, that names the person's individual triggers, the early-warning signs, the self-management steps and skills to use first, and exactly whom to contact and how, so that the next crisis has a rehearsed pathway that is not the emergency department by default (IPS 2023 makes the collaboratively agreed crisis plan central to reducing hospitalisation in acutely suicidal patients). Self-harm is managed within, not outside, this frame: it is understood, taught and responded to inside the structured therapy, and the person is never excluded from care because of it. Where a sedative is genuinely needed to get through an acute crisis, its use is short-term and time-limited (see the medication topic below), and benzodiazepines are avoided.

WORKED EXAMPLE

A woman known to the community team presents at night after superficial cutting following a relationship rupture, distressed but not acutely suicidal on assessment. The integrated response is not admission. The clinician assesses current risk, reviews what helped in previous episodes, helps her down-regulate the immediate arousal, and works with her on the crisis plan, updating the trigger list, rehearsing the distress-tolerance skill to use first, and confirming the daytime contact route back into her structured therapy. If night-time distress is extreme, a short-term sedative for a few days may be considered as part of the plan, not a new standing prescription, and she returns to her outpatient programme rather than to a ward.

17.5 MODUS, structured psychological therapy as the primary mode

The primary means is a structured, theory-based psychotherapy, delivered whole. The **modus** of the plan is led by structured psychological therapy. The question is rarely whether to offer psychotherapy but *which structured psychotherapy*, chosen by availability, patient fit and the dominant problem: dialectical behaviour therapy (DBT, Marsha Linehan), the best-evidenced option where reducing recurrent self-harm is the priority; schema therapy (Jeffrey Young), where enduring maladaptive patterns and identity are central; mentalisation-based treatment (MBT, Bateman and Fonagy), where the loss of mentalising under attachment stress dominates; and transference-focused psychotherapy (TFP, Clarkin and Kernberg), an object-relations treatment for the patient who can tolerate a long interpretive therapy. What matters more than the brand is that whichever is chosen is comprehensive, theory-based, of adequate duration and delivered by trained, supervised practitioners; NICE warns specifically against brief psychological interventions of less than three months offered outside a structured, supervised service. Each modality has its own topic; the wider models and technique are developed in the Psychotherapies, clinical assessment, MSE and nosology notes.

STRUCTURED THERAPY	CORE MECHANISM (WHAT IT TARGETS)	BEST-FIT INDICATION
Dialectical behaviour therapy (DBT)	**Emotion dysregulation from a biosocial deficit; skills plus acceptance-change balance**	Recurrent self-harm and suicidality the priority (the first-line, best-evidenced choice for self-harm)
Schema therapy	Early maladaptive schemas and schema modes; limited reparenting	Pervasive lifelong patterns and identity work; where relational-pattern change is central
Mentalisation-based treatment (MBT)	Restoring mentalising that collapses under attachment-stress arousal	Marked mentalising failures and attachment-driven relational storms
Transference-focused psychotherapy (TFP)	Integrating split self-other representations through the here-and-now transference	Identity diffusion in a patient able to tolerate a long, interpretive treatment

The four structured psychotherapies of the modus; the choice is by availability and fit, and all four have randomised support. Delivery must be comprehensive and of adequate duration.

MNEMONIC

LOCUS, FOCUS, MODUS

The integrated plan on one spine. **LOCUS**, where: outpatient and community, stepped care, admission avoided (and brief and purposeful if unavoidable). **FOCUS**, what and when: short-term safety and risk, mid-term the core disorder via structured therapy, long-term function and remission. **MODUS**, by what means: structured psychological therapy primary, medication symptom-targeted and time-limited, plus multidisciplinary care planning and psychoeducation. The three read as a single sentence, care in the community, targeted by phase, delivered chiefly by psychotherapy.

17.6 Schema therapy done properly, the mode framework

The therapy that reads the disorder as shifting modes, and reparents them. Because it is the lens many Indian trainees will use, schema therapy deserves its structure stated cleanly. It understands borderline personality disorder not as one steady state but as rapid flips between *schema modes*, moment-to-moment states each schema activates. In the borderline patient the recurring modes are the **vulnerable child** (the abandoned, abused, frightened core the whole treatment aims to protect and heal), the **angry and impulsive child** (raw rage and impulsive self-harm when needs go unmet), the **detached protector** (the numbing, dissociative, disconnected withdrawal that shields the child from feeling), the **punitive and demanding parent** (the internalised critical voice that attacks the self and drives self-harm and guilt), and the **healthy adult** (the mode the therapy builds up to meet needs adaptively). The signature mechanism is *limited reparenting*: within professional bounds the therapist provides, in a corrective form, the safety, validation and limits the patient's developmental environment failed to supply, and through mode work (including chair work) weakens the maladaptive modes and strengthens the healthy adult. It is delivered as a longer-term treatment, and its randomised evidence in borderline personality disorder is a genuine strength.

GOOD TO REMEMBER

- **Structured psychological therapy (the primary mode):** mechanism, whichever of DBT (biosocial emotion dysregulation, skills plus the acceptance-change dialectic), schema therapy (schema modes healed by limited reparenting), MBT (restoring mentalising under attachment stress) or TFP (integrating split object representations in the transference) fits; all four are comprehensive, theory-based and of adequate duration. Indication, borderline personality disorder as the first-line treatment; the choice is by availability and fit, with DBT the best-evidenced where recurrent self-harm is the priority. Signature caution, a brief or fragmentary intervention of less than three months outside a structured supervised service is not adequate treatment, and behavioural safety precedes deep trauma or character work.

17.7 MODUS, the place of medication, symptom-targeted and time-limited

Not for the disorder; for a comorbidity or a crisis, by symptom domain. Medication is the adjunctive, not the primary, arm of the modus, and its rules follow the guideline order. NICE (2009) is the most restrictive: no drug for the disorder or its symptoms, no antipsychotics for medium- and long-term treatment, and any drug started in a crisis reviewed and stopped once

the crisis resolves, with regular review of repeat prescriptions and active discouragement of polypharmacy. Two legitimate windows remain. The first is **medication for comorbidity**: a co-occurring depressive, anxiety, post-traumatic or other disorder is treated on its own merits, within the structured borderline programme. The second is the short-term crisis: a sedative (for example a sedating antihistamine, or a low-dose antipsychotic) may be used cautiously as part of the plan, usually for no longer than one week. Where IPS and WFSBP permit symptom-targeted adjuncts, they are matched to the dominant symptom domain, and Indian brand names are given first with the pharmacology kept light and cross-referenced. Two agents to avoid: benzodiazepines (dependence and disinhibition, IPS), and drugs unsafe in overdose such as irreversible MAOIs and lithium as a first choice (WFSBP), because these patients must be given drugs safe in parasuicidal acts.

SYMPTOM DOMAIN	ADJUNCTIVE CLASS (INDIAN BRAND FIRST; LIGHT)	GUIDELINE NOTE
Cognitive-perceptual (suspiciousness, transient quasi-psychotic symptoms)	**Low-dose atypical antipsychotic, quetiapine (Qutipin) or olanzapine (Oleanz)**	WFSBP first among drugs here; NICE forbids medium- and long-term antipsychotic use, so short, targeted only
Affective dysregulation (depressed mood, anxiety, mood swings)	SSRI, sertraline (Serlift) or fluoxetine (Fludac)	WFSBP best-shown class for this domain; treat true comorbid depression or anxiety on its merits
Impulsive-behavioural dyscontrol and aggression	Low-dose atypical antipsychotic; mood stabiliser, valproate or divalproex (Valprol, Encorate), if antipsychotic insufficient	IPS and WFSBP symptom-targeted option; not a disorder-specific treatment
Acute crisis (short-term only)	A sedative, a sedating antihistamine or low-dose antipsychotic	NICE, cautious, part of the plan, usually no longer than one week; review and stop

Adjunctive medication is symptom-domain-matched, time-limited and reserved for a comorbidity or a crisis; the deep dosing sits in the pharmacotherapy notes. Doses are not re-taught here.

PEARL

The most useful prescribing question in a borderline patient already on three or four psychotropics is not "what to add" but "what to stop". NICE asks you to review people prescribed drugs without a diagnosed comorbidity, aim to reduce and discontinue treatments started in past crises, and discourage polypharmacy. A careful deprescribing review is often the single most guideline-concordant medication act you can perform, and it protects a group who are, by the nature of the disorder, at high overdose risk.

17.8 Multidisciplinary care planning, psychoeducation and the service frame

The connective tissue that holds the plan together. Around the therapy and the selective medication sit the elements that make the plan durable. A comprehensive **multidisciplinary care plan** is developed with the person (and carers where appropriate), documenting the agreed goals, the roles of each team member, the crisis plan with its identified triggers, and the long-term aims for education and employment; it names who does what and is the reference point every

team member works from, which is also how a patient prone to splitting is held by a consistent, communicating team rather than played between its members. **Psychoeducation** is therapeutic in its own right: a collaborative, de-stigmatising explanation of the condition, its typically remitting long-term course, and the rationale for a psychotherapy-led plan improves engagement and reduces the hopelessness the diagnosis can carry. The **service frame** closes the loop, no exclusion from services because of the diagnosis or self-harm, agreed supervision for the staff who do this demanding work, and a structured, phased handover whenever care is transferred, so that the person never falls through the gap between services.

17.9 The guideline synthesis, NICE then IPS and WFSBP reconciled

One line the three bodies will all sign. The examiner-safe synthesis is easy to hold once the hierarchy is clear. All three agree that structured psychotherapy is primary and that no drug is a registered treatment for the disorder; they differ only in how much adjunctive medication they permit. NICE (CG78, 2009) leads and is the most restrictive, no drug for the disorder, no long-term antipsychotic, drugs only for a comorbidity or briefly in a crisis. The Indian Psychiatric Society (IPS 2023) makes psychotherapy central, names DBT for the early reduction of emotion dysregulation and self-harm, builds the plan around a collaboratively agreed crisis plan, and permits symptom-targeted antipsychotics or mood stabilisers in some patients while forbidding benzodiazepines. WFSBP (2007) supplies the symptom-domain map for those adjuncts and insists any drug be trialled against clear targets for at least three months and stopped if it does not help. Read together (the guideline stack, nice ips wfsbp), the message is one: lead with structured psychological therapy, use medication sparingly and by symptom, and review it to stop.

GUIDELINE	POSITION ON PSYCHOTHERAPY	POSITION ON MEDICATION
NICE 2009 (CG78), the home guideline	**Structured, theory-based psychotherapy is primary; DBT or MBT where self-harm reduction is the priority**	No drug for the disorder; no medium- or long-term antipsychotic; only for a comorbidity or short-term in a crisis (a sedative, usually up to one week)
Indian Psychiatric Society 2023	Psychotherapy central; DBT early for emotion dysregulation and self-harm; a collaboratively agreed crisis plan	Symptom-targeted antipsychotics or mood stabilisers in some patients; benzodiazepines avoided
WFSBP 2007	Psychotherapy primary; pharmacotherapy adjunctive only	Symptom-domain-matched (antipsychotic for cognitive-perceptual and impulsive, SSRI for affective); avoid MAOIs and lithium first; trial at least three months

The three guideline bodies reconciled; they converge on psychotherapy-primary and diverge only on the room left for symptom-targeted adjuncts, NICE most restrictive.

17.10 The integrated plan in Indian practice

Where the algorithm meets the ground here. The integrated plan is drawn as an algorithm in the accompanying figure; four India realities shape how it runs. First, *under-recognition*,

personality disorders are markedly under-recognised in routine Indian practice, and borderline patients often reach services labelled only by their crises, self-harm, an overdose, a mood or substance comorbidity, so the disorder is captured, and the psychotherapy-led plan started, only when it is actively looked for. Second, *availability and cultural adaptation*, the structured psychotherapies the plan depends on are concentrated in a few tertiary and metropolitan centres; DBT and schema therapy are being trained and culturally adapted in India (attending to family involvement, idioms of distress and the collectivist framing of autonomy and relationship), but access is uneven, and a realistic plan often blends available structured elements with skilled generic clinical management rather than assuming a full programme. Third, the *medico-legal frame*, most forcefully around antisocial rather than borderline personality disorder, is where the diagnosis carries legal weight, and offender assessment, court reports and the prediction of dangerousness are developed in the Mental health legislation and forensic psychiatry notes. Fourth, the *cultural expression of personality pathology*, deviation is judged against the person's own cultural, social and economic milieu, so that culturally sanctioned dependence, help-seeking idioms or situational distress are not misread as trait pathology, and the disorder is not read through a single culture's norms.

INDIA

A pragmatic Indian version of the integrated plan holds the spine and adapts the resourcing. The locus stays outpatient (admission is even less desirable where beds are scarce and asylum-style regression easy to induce), and the crisis plan is built around the family and, for many patients, WhatsApp-reachable daytime contact rather than a formal crisis line. The modus leads with whatever structured therapy is genuinely available, DBT-informed skills work most often, with schema therapy where a trained therapist exists, delivered with cultural adaptation; medication stays symptom-targeted and minimal, with Indian brands (quetiapine as Qutipin, sertraline as Serlift) named first but kept light and, crucially, reviewed to stop. The single most common local error is the mirror image of the guideline: a borderline patient carried for years on rotating polypharmacy with no structured psychotherapy ever started. Distinguishing borderline instability from bipolar II before reaching for a mood stabiliser is developed in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes, and the complex-PTSD boundary in the Anxiety, OCD and trauma-related disorders notes.

GOOD TO REMEMBER

- **Borderline personality disorder (the disorder being managed):** defining criterion set, a pervasive pattern of instability of affect, self-image and relationships with marked impulsivity, diagnosed on five or more of the nine DSM-5-TR criteria (and captured as the borderline pattern qualifier on the ICD-11 dimensional model). First management step, establish safety and a collaboratively agreed crisis plan, then start structured psychological therapy as the primary treatment. The discriminator that changes management, it is an enduring, pervasive, inflexible pattern with onset by adolescence, not a situational affective lability and not bipolar II, so the answer is a psychotherapy-led plan, not a mood stabiliser started first-line.

HOLD THIS

Borderline personality disorder is managed community-first on the LOCUS, FOCUS, MODUS spine, with structured psychological therapy as the primary treatment and medication only symptom-targeted, time-limited and for a comorbidity or a crisis: NICE says no drug is first-line for the disorder, and starting one is the trap.

Apply and consolidate

18 . Worked cases

The arc closer, where the chapter is put to work. A personality-disorders question is rarely won on the criteria list alone; it is won on the **formulation**, the reasoning that carries a presentation through the general criteria, to a named diagnosis, past its mimics, into a model of why the person is the way they are, and out to a defensible first-line plan. Long cases and vivas test exactly this movement, so this fragment reasons four worked cases end to end rather than restating the facts the earlier topics have already fixed. Each case is a **worked example** in the strict sense: the presentation is given, and then the discriminators, the model and the management are argued out loud.

The four are chosen to exercise the four highest-yield skills of the chapter. The first is a borderline personality disorder case formulated on both the Linehan biosocial and the schema-modes models and treated with structured psychotherapy, with medication kept symptom-targeted; the second works the borderline-versus-bipolar-II discrimination through the discriminator grid to the correct diagnosis and the correct first-line treatment; the third is an antisocial forensic vignette, with its conduct-disorder history, its structured risk assessment and its medico-legal frame; and the fourth is a cluster-C (anankastic) case. Read across them and one spine repeats, laid out in the figure alongside: clear the general criteria, count and type, discriminate from the mimic, formulate, and treat with psychotherapy first.

3	5	9	4
DSM-5 CLUSTERS (A, B AND C)	ICD-11 TRAIT DOMAINS	BORDERLINE CRITERIA, THRESHOLD FIVE	DBT SKILLS MODULES

18.1 Working a personality-disorder case: the shared spine

Every case runs the same five-step spine. Before any single case, hold the sequence that all four share, because a case answer that jumps straight to a label has skipped the marks. First, clear the **general personality-disorder criteria**: an enduring, pervasive, inflexible and maladaptive pattern of inner experience and behaviour, deviating from the person's cultural expectation, stable and of long duration with onset traceable to adolescence or early adulthood, causing distress or impairment, and not better explained by another mental disorder, a substance or a medical condition. Second, **count and type** against the criteria of the suspected disorder. Third, **discriminate** from the presentations that mimic it, above all the borderline-versus-bipolar-II line. Fourth, **formulate**, on a disorder-specific model where one exists. Fifth, **treat**, with structured psychotherapy primary and any drug symptom-targeted, adjunctive and time-limited.

The spine is the same whether the type survives as a DSM-5-TR category or is re-expressed as an ICD-11 severity level with trait qualifiers; the categorical name is a shorthand for a point on that dimensional map.

RULE **Formulate before you medicate.** Clear the general criteria, count and type, discriminate from the mimic, build the formulation, and only then treat, with structured psychotherapy primary and any drug symptom-targeted, adjunctive and time-limited; the label is the start of the reasoning, not the end of it.

18.2 case: the borderline patient, presentation and the general criteria

case: A woman in her early twenties is referred after an overdose that followed a break-up. On history she describes a terror of being left that predates this relationship, a lifelong pattern of relationships that swing from "he is perfect" to "he is cruel" within a single afternoon, a persistent sense of never knowing who she really is, recurrent cutting between crises, moods that flip within a couple of hours when a text goes unanswered, a background hollow emptiness, and disproportionate anger she cannot hold down. The presentation is dramatic, but the discipline is to work the spine, not to pattern-match. The general criteria are cleared first: this is an enduring, pervasive pattern present across relationships and settings, traceable to her adolescence, ego-syntonic and inflexible, not confined to the current crisis, and not better explained by a primary mood disorder or a substance. Only now is the count taken, and it is comfortably met: abandonment fear, unstable idealising-devaluing relationships, identity disturbance, recurrent self-harm, reactive affective instability, chronic emptiness and inappropriate anger give **five or more of the nine criteria** with room to spare. The diagnosis is defensible because the criteria can be named and shown to be trait, not a fresh state.

18.3 case: the borderline patient, the dual formulation

Two models, read together, not as rivals. The formulation borrows from both disorder-specific frameworks, because each answers a different question. Marsha Linehan's biosocial model answers *why*: a constitutional **emotional vulnerability**, heightened sensitivity, intense responses and a slow return to baseline, has transacted over her development with a pervasively **invalidating environment** that dismissed or punished her inner experience, and the two have amplified one another into a pervasive **emotion dysregulation**; her overdose and her cutting are read as attempts to solve the problem of unbearable affect, not as manipulation. Jeffrey Young's schema therapy answers *what is in the room*: because she scores high on almost every early maladaptive schema at once and flips between extreme states within minutes, she is formulated not as a list of schemas but through the **schema modes**, the small set of parts that alternate, cycling through the vulnerable (abandoned) child, the angry and impulsive child, the detached protector and the punitive parent, around a Healthy Adult that is weak and must be strengthened. The dual formulation is drawn in the accompanying figure, the biosocial pathway feeding the mode map.

PEARL

The two models are complementary, not competing. The Linehan biosocial theory gives the *mechanism* (emotion dysregulation) and the technology of change (concrete skills); the schema-modes map gives the *parts* (which mode is speaking now) and the relational and experiential engine (limited reparenting, chair work). A single clinician can formulate one patient on both, which is exactly why dialectical behaviour therapy and schema therapy are best held as siblings in one evidence-based family rather than as a forced choice.

WORKED EXAMPLE

Re-expressing the same patient in the ICD-11 dimensional system, forward-taught on the framework topics, gives a formulation of the form "moderate personality disorder, with prominent negative affectivity and disinhibition and some dissociality, plus the borderline pattern qualifier": the severity level is rated first and leads, the trait domains qualify it, and the borderline pattern is appended last. The categorical name "borderline personality disorder" and this dimensional string describe the same woman; the ICD-11 borderline pattern qualifier was retained precisely to flag the patients who respond to the borderline-specific psychotherapies, which is what makes both worth carrying.

18.4 case: the borderline patient, the structured-therapy plan

Structured psychotherapy is primary; the drug is a time-limited adjunct. The plan follows the formulation and the guidelines exactly. Structured psychological therapy is the primary treatment (NICE 2009, IPS 2023): where reducing recurrent self-harm is the priority, comprehensive dialectical behaviour therapy is the option named first, delivering its **four skills modules** (mindfulness at the core, with distress tolerance, emotion regulation and interpersonal effectiveness) through its four modes, with the target hierarchy putting the life-threatening behaviours ahead of everything else. The schema layer runs alongside or in sequence: limited reparenting and experiential mode work address the parts the skills alone do not reach, and the two layers map neatly onto her modes, as below. Medication stays symptom-targeted, adjunctive and time-limited: no drug is licensed for the disorder, so a short course of a sedative or a low-dose antipsychotic such as quetiapine (Qutipin, Seroquel) may be considered cautiously in a crisis, usually for no longer than a week, and a serotonin reuptake inhibitor such as fluoxetine (Fludac, Prozac) is added only if a comorbid depressive disorder is present, with the dosing carried in the Mood disorders: pharmacotherapy notes rather than re-taught here. The complex-PTSD boundary, which her trauma history raises, is drawn in the Anxiety, OCD and trauma-related disorders notes.

BORDERLINE MODE	HOW IT PRESENTS IN THE ROOM	THE MATCHED MOVE (DBT AND SCHEMA)
Vulnerable (abandoned) child	Raw terror of being left; fragile, frightened, alone	**Limited reparenting and validation; soothe and meet the need within bounds**
Angry and impulsive child	Rage or impulsive acting-out when a need goes unmet	Validate the feeling and contain the behaviour; distress-tolerance and emotion-regulation skills
Detached protector	Numbness, "I feel nothing", connection shut off	Gently bypass it to reach the child; empathic confrontation of the avoidance
Punitive parent	Self-hatred, "I deserved it", driving the self-harm	Fight and expel it through chair work; build the Healthy Adult and self-compassion

The four borderline schema modes matched to the therapeutic move, showing how the DBT skills (distress tolerance, emotion regulation) and the schema-therapy engines (limited reparenting, chair work) act on different modes of the same patient.

GOOD TO REMEMBER

- **Borderline personality disorder:** defining requirement is a pervasive pattern of instability of relationships, self-image and affect with marked impulsivity, meeting five or more of the nine criteria, on a base already cleared against the general personality-disorder criteria. First diagnostic step in the case: clear the general criteria, then count the nine; the affect is rapidly reactive and interpersonally cued and lasts hours, which is what separates it from bipolar II.
- **Dialectical behaviour therapy:** mechanism is the biosocial theory (emotional vulnerability transacting with an invalidating environment to give emotion dysregulation), treated by fusing behavioural change with mindfulness-based acceptance across four skills modules and four modes with a life-threatening-first target hierarchy; indication is borderline personality disorder with recurrent self-harm, the first-line structured therapy for self-harm (NICE, IPS); caution is that it must be comprehensive and delivered with fidelity, and trauma work waits for stage two.
- **Schema therapy:** mechanism is healing early maladaptive schemas through limited reparenting plus experiential mode work (imagery rescripting, chair work), with the labile borderline patient worked through the schema modes toward a strengthened Healthy Adult; indication is chronic characterological pathology, strongest-evidenced in borderline personality disorder; caution is that stripping out the reparenting and the experiential work leaves it as ordinary CBT that never touches the schemas.

18.5 case: borderline versus bipolar II, working the grid to the diagnosis and the treatment

case: A woman in her mid-twenties is referred as "query bipolar II disorder, mood swings, please start a mood stabiliser". The temptation is to hear "unstable mood" and reach for the drug, so the whole task is to read the mood rather than name it, working one discriminator at a time. On history the swings last two to three hours, always follow a fight with her partner or a fear that he is pulling away, and lift the moment he reassures her; between them she sits not on a settled euthymic baseline but on a floor of chronic emptiness; she describes never knowing who she is; and she cuts when the distress peaks. Read across the discriminator grid, the tempo is minutes to hours rather than the sustained days-to-weeks of a bipolar episode; the trigger is reactive and interpersonal rather than autonomous; the baseline is chronic dysphoria rather than a euthymic

return; and identity disturbance, chronic emptiness and affect-regulating self-harm are present, none of which belongs to bipolar II. Nothing here is a distinct hypomanic period of **at least four consecutive days** or a major depressive episode of **at least two weeks**. The diagnosis is borderline personality disorder, not bipolar II, and the first-line treatment follows the diagnosis: a structured psychotherapy, not a mood stabiliser prescribed for a bipolarity she does not have. The bipolar-II syndromes themselves are developed in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes.

TRAP **Reaching for a drug first, on a pattern-matched label.** Reading reactive, hours-long, interpersonally cued lability as bipolar II and starting a mood stabiliser first-line, or drugging borderline personality disorder itself against NICE, treats a personality-based instability with the wrong tool and delays the structured psychotherapy that is its actual primary treatment.

GOOD TO REMEMBER

- **Bipolar II disorder:** defining requirement is at least one hypomanic episode (elevated or irritable mood lasting at least four consecutive days, with change in sleep, energy and goal-directed activity) plus at least one major depressive episode (at least two weeks), with a euthymic baseline between discrete, largely autonomous episodes and no full manic episode. Discriminator from borderline: the mood runs sustained, autonomous and days-to-weeks long, not the minutes-to-hours interpersonal reactivity of the personality disorder; the mood stabiliser is foundational here, whereas in borderline it is at best a symptom-targeted adjunct. When a genuine autonomous episode is documented alongside the pervasive reactive pattern, both diagnoses stand and both treatments are needed.

18.6 case: the antisocial forensic vignette, the history and the risk assessment

case: A man in his thirties is remanded after a violent robbery and referred for a court report with a request to "diagnose psychopathy". The vignette turns on the developmental gate and on the structure of the risk estimate. Collateral and documentary sources, which the manual insists on because deceit is central and the account cannot be taken on his word, show truanting, cruelty to animals and theft from well before the age of twelve, expulsions, a chaotic work record, unpaid debts, repeated adult convictions, and a flat indifference to the people he has hurt. The conduct disorder before fifteen and the age of at least eighteen are both satisfied, and he meets **three or more of the seven** adult criteria comfortably, so the diagnosis is antisocial personality disorder. The demand for a "diagnosis of psychopathy" is answered carefully: psychopathy is the narrower affective-interpersonal construct measured on the Hare Psychopathy Checklist-Revised, and it is not asserted without a rated instrument. The risk of future violence is then estimated by **structured professional judgement**, not by clinical impression and not by a raw checklist total: empirically derived factors are rated systematically, for instance on the HCR-20 across its historical, clinical and risk-management scales, and then weighed for this individual to a reasoned low, moderate or high rating.

RULE **No conduct disorder before fifteen, no antisocial personality disorder; and structure the risk estimate, do not total it.** The antisocial diagnosis is developmental and needs a documented childhood conduct disorder, and dangerousness is judged by structured professional judgement, factors rated systematically and then weighed for the case, never by the raw count on a checklist.

18.7 case: the antisocial forensic vignette, the medico-legal frame and the mainstay

The report claims only what it can defend, and the treatment is psychological. The medico-legal frame is where the diagnosis carries its weight, and its central caution is that antisocial personality disorder is a matter of disposal, not of exculpation. The insanity defence turns on an unsoundness of mind such that the accused did not know the nature of the act or that it was wrong, and a stable trait pattern rarely meets that legal test; the report therefore states three things and no more, that the diagnosis is antisocial personality disorder (not, on this assessment, formally psychopathy, which would need the rated instrument), that the disorder does not amount to the unsoundness of mind that founds an insanity defence and so does not reduce his responsibility, and that his risk of future violence, structured and then judged, is high and should guide disposal. The value of the report lies as much in what it declines to claim as in what it asserts, and the statutes, the fitness assessment and the disposal pathways sit in the Mental health legislation and forensic psychiatry notes. Management is modest and psychological-first: NICE recommends group-based cognitive and behavioural interventions, with the person sharing the choice of duration and intensity (NICE 2015), delivered where relevant in criminal-justice settings; no drug treats the personality, and where impulsive aggression is a target it is addressed adjunctively and off-licence, for example with divalproex (Valprol, Encorate), the detail cross-referenced to the Mood disorders: pharmacotherapy notes. Mentalisation-based treatment adapted for the disorder is an emerging structured option under trial.

GOOD TO REMEMBER

- **Antisocial personality disorder:** defining requirement is a pervasive pattern of disregard for and violation of the rights of others since fifteen, three or more of the seven criteria, gated by documented conduct disorder before fifteen and an age of at least eighteen, and not confined to schizophrenia or a bipolar illness. Discriminator: it is a trait pattern with a childhood conduct-disorder precursor, not a synonym for a criminal record or for the narrower affective-interpersonal construct of psychopathy; its forensic weight is in the structured assessment of dangerousness and the court report, not in the insanity defence.
- **Group cognitive-behavioural therapy (for antisocial personality disorder):** mechanism is a structured, skills-based group intervention targeting the cognitions and behaviours that drive offending, delivered with firm limits and shared choice of intensity; indication is antisocial personality disorder, especially with an offending history, and it is the NICE-recommended mainstay (NICE 2015); signature caution is that no drug is recommended for the personality itself (medication only for a comorbidity or, adjunctively and off-licence, for impulsive aggression) and that poor engagement and manipulation of the therapeutic frame are the rule, since the condition is ego-syntonic.

18.8 case: the cluster-C (anankastic) patient, formulation and management

case: An accountant in his forties is referred as "OCD, please treat". He is a relentless perfectionist who cannot discard years of worn-out paperwork, refuses to delegate unless colleagues submit to

exactly his method, and misses deadlines because he re-checks his work endlessly; he regards all of this as ordinary diligence and is untroubled by it, though his family and his team are worn down. Crucially, he describes no intrusive unwanted thoughts and performs no rituals to neutralise anxiety. The spine settles the diagnosis: the general criteria are cleared (an enduring, pervasive, ego-syntonic pattern from early adulthood, causing impairment and not better explained otherwise), and he meets **four or more of the eight** features of obsessive-compulsive personality disorder, the anankastic type, a preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness and efficiency. The single discriminator that decides the case is the absence of true obsessions and compulsions and the ego-syntonic tone: this is character, not the ego-dystonic, resisted symptom pattern of obsessive-compulsive disorder, whose side is developed in the Anxiety, OCD and trauma-related disorders notes. In the ICD-11 dimensional system the phenotype is captured by prominent **anankastia**, the fifth trait domain. Management is psychological-first: structured cognitive-behavioural therapy working on the rigidity and the need for control, with the schema-mode formulation informing the work where a full protocol is out of reach; medication is reserved for a comorbidity only, never for the personality, and had he also described genuine resisted obsessions and washing rituals, both diagnoses would stand together.

GOOD TO REMEMBER

- **Obsessive-compulsive (anankastic) personality disorder:** defining requirement is a pervasive, ego-syntonic preoccupation with orderliness, perfectionism and mental and interpersonal control at the expense of flexibility, openness and efficiency, four or more of the eight features, from early adulthood. First diagnostic step in the case: clear the general criteria, confirm the perfectionism and control are ego-syntonic trait, then search for true obsessions and compulsions; their absence, not the shared name, discriminates it from obsessive-compulsive disorder.
- **Cognitive-behavioural therapy (for cluster C):** mechanism is graded exposure to the avoided or feared situation plus cognitive restructuring of the core belief (the need for control in anankastic, inadequacy in avoidant, helplessness in dependent), with work on rigidity, assertiveness and autonomy; indication is all three cluster-C types, engaging fastest where the anxious behaviour distresses the person; signature caution is the alliance and pace (the anankastic patient resists surrendering control), and medication is for a comorbidity only, never disorder-specific.

18.9 The thread through the four cases, and the India lens

One method, four applications. Laid side by side, the four cases show the same reasoning applied to different pathology, and the grid below is the object to carry into the hall: in every row the diagnosis is reached by clearing the general criteria and then discriminating from a mimic, and in every row the first-line treatment is a structured psychotherapy, with medication either symptom-targeted and time-limited, reserved for a comorbidity, or absent altogether. The synthesis map alongside arranges the same four against the decision points of the chapter. The wider technique of the psychotherapies, beyond the disorder-specific models owned here, sits in the Psychotherapies, clinical assessment, MSE and nosology notes; the schizotypal-versus-schizophrenia boundary that a cluster-A case would raise is in the Schizophrenia: aetiology, phenomenology, classification and course notes.

WORKED CASE	THE DECISIVE FEATURE(S)	DIAGNOSIS	FIRST-LINE TREATMENT	MEDICATION
The self-harming young woman	Five or more of the nine; reactive hours-long affect on a floor of emptiness and unstable identity	**Borderline personality disorder**	Structured psychotherapy (DBT skills plus schema mode work)	Symptom-targeted, time-limited, adjunctive
"Query bipolar II, mood swings"	Hours-long, interpersonally cued lability; no autonomous days-long episode; identity disturbance and emptiness	**Borderline personality disorder (not bipolar II)**	Structured psychotherapy, not a mood stabiliser	Only for a genuine comorbidity
The remanded violent offender	Three or more of the seven; conduct disorder before fifteen; remorseless	**Antisocial personality disorder**	Group cognitive-behavioural therapy; structured risk assessment	None for the personality; adjunct for impulsive aggression only
The perfectionist "referred as OCD"	Ego-syntonic perfectionism and control; no true obsessions or compulsions	**Obsessive-compulsive (anankastic) personality disorder**	Structured CBT on rigidity and control	For a comorbidity only

The four worked cases mapped to their decisive feature, diagnosis, first-line treatment and medication role; the shared conclusion is that structured psychotherapy is primary across all four and the drug is never the treatment for the personality itself.

INDIA

Four genuine India angles converge on these cases. First, under-recognition: personality disorders are markedly under-recognised in Indian practice, so all four patients typically reach services through something else, the overdose, the "mood swings" referral, the legal remand, the burnout, and the underlying pattern is captured only when a corroborated developmental history is deliberately taken. Second, access: the structured psychotherapies the borderline and cluster-C cases need, dialectical behaviour therapy and schema therapy, are being delivered and culturally adapted at Indian tertiary and private centres rather than being widely available, so recognising that a patient needs psychotherapy rather than a mood stabiliser is only the first step; the mindfulness core of DBT sits naturally with Indian contemplative traditions, while its interpersonal-effectiveness scripts must be calibrated to family interdependence rather than imported wholesale. Third, the medico-legal frame of the antisocial case: the insanity defence rests on the unsoundness-of-mind test carried into the Indian Penal Code, which antisocial personality disorder rarely satisfies, and the dedicated forensic infrastructure to support the risk assessment is thin. Fourth, cultural expression: every criterion is judged against the person's own cultural, social and economic milieu, so that normative family interdependence is not scored as dependence, culturally sanctioned emotional or dissociative-trance display is not over-read as borderline reactivity, and survival-driven or subcultural offending is not read as trait antisociality; personality pathology must never be read through a single culture's norms.

HOLD THIS

Every personality-disorder case runs one spine: clear the general criteria, count and type, discriminate from the mimic (above all borderline from bipolar II), formulate on the biosocial and schema-mode models, and treat with structured psychotherapy first, the drug being only ever a symptom-targeted, time-limited adjunct for a comorbidity or a crisis, and never the first-line treatment for the personality itself.

19 · Consolidation

The last step is not new material, it is retrieval. This closing topic turns a chapter you have *read* into one you can *reproduce* under exam pressure. The single most examinable idea of the personality-disorders chapter, that the **general criteria** are a gate and that ICD-11 rates **severity first** before any trait, is learned not by rereading it but by forcing it out of memory. The evidence is one-directional: testing yourself on half-learned material, **retrieval practice**, fixes it far more durably than reading it again, and the efficient way to study is to **cover the answer** and pull each fact out before checking it. Everything below is built for that, a **mnemonic** that reassembles the whole chapter from one line, answer-free **retrieval prompt** lists, two answer vaults to check against, and a whole-chapter **synthesis map** to reproduce.

Use it actively, not by rereading. Say the master mnemonic once, then close the notes and work the retrieval prompts with the vaults covered; only then uncover the Good-to-remember vaults and mark what you missed. Finish by reproducing the synthesis map on a blank sheet. Do those three things and the chapter is consolidated, and the gaps you find are exactly where to go back. The wider technique of **active recall** and spaced retrieval sits alongside the clinical material, and

the general models and technique of the psychological therapies are developed in the Psychotherapies, clinical assessment, MSE and nosology notes.

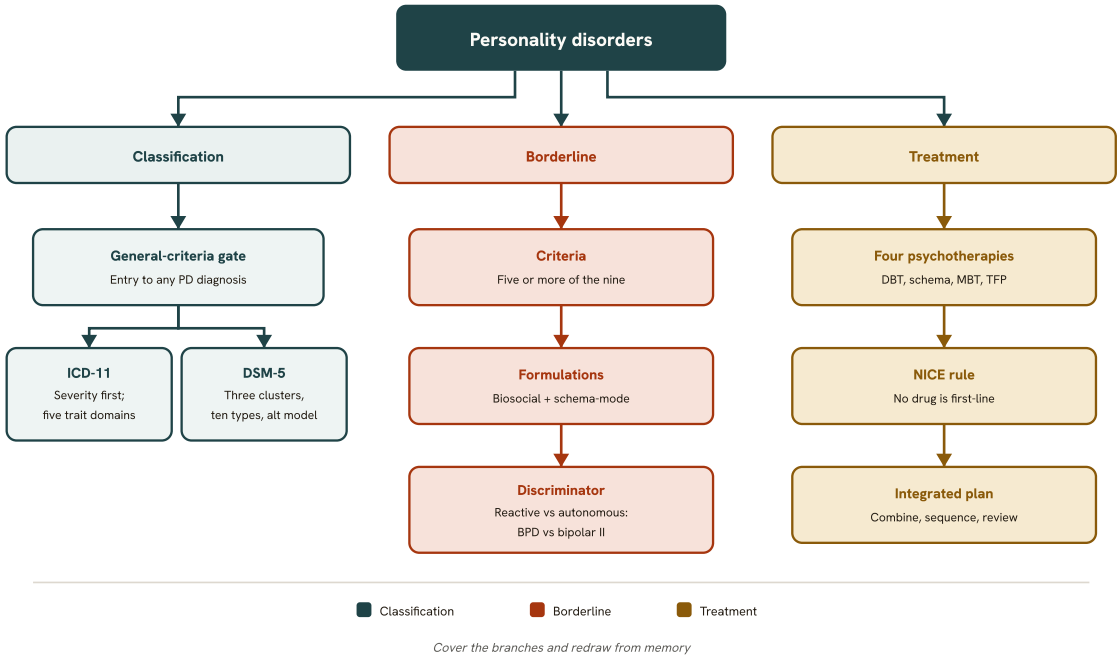


Fig 16.10 The chapter in one map: the general-criteria gate opening onto the ICD-11 dimensional and DSM-5 categorical classifications; borderline personality disorder with its criteria, its biosocial and schema-mode formulations and the bipolar-II discriminator; and the treatment branch of four structured psychotherapies with the rule that no drug is first-line. Cover the branches and redraw from memory.

19.1 The master mnemonic, paid off

One line rebuilds the whole chapter. The chapter opened by seeding a single **mnemonic**, and this is where it is redeemed. Its four beats are the four countable skeletons of the day, the clusters and types, the ICD-11 trait domains, the borderline criterion count, and the core skills therapy, and saying the line should make the branches beneath each beat unfold. If the line is solid, the whole family, however you later classify it, is recoverable from it.

MNEMONIC

MAD BAD SAD, FIVE DOMAINS, NINE-FOR-FIVE, FOUR TO COPE

MAD BAD SAD are the three DSM-5-TR clusters holding the ten categorical types: *mad* is Cluster A, odd or eccentric (Paranoid, Schizoid, Schizotypal); *bad* is Cluster B, dramatic or erratic (Antisocial, Borderline, Histrionic, Narcissistic); *sad* is Cluster C, anxious or fearful (Avoidant, Dependent, Anankastic). **FIVE DOMAINS** are the ICD-11 trait qualifiers, hooked as *New Dogs Do Dig Antiques*: Negative affectivity, Detachment, Dissociality, Disinhibition, Anankastia, plus the optional borderline pattern qualifier that sits apart. **NINE-FOR-FIVE** is borderline personality disorder, defined by **five or more of the nine** criteria. **FOUR TO COPE** is dialectical behaviour therapy and its four skills modules (mindfulness at the core, plus distress tolerance, emotion regulation and interpersonal effectiveness). Four numbers, and the chapter rebuilds from one line.

3	10	5	4
DSM-5-TR CLUSTERS	CATEGORICAL PERSONALITY TYPES	ICD-11 TRAIT DOMAINS	DBT SKILLS MODULES

19.2 How to run the recall

Cover, retrieve, check, redraw. The mechanics of **active recall** for this chapter are fixed and worth stating so the rest of the topic is usable. First, **cover the answer**, keeping the two Good-to-remember vaults below hidden. Second, work each **retrieval prompt** out loud or on paper from memory. Third, uncover the vault and mark every miss. Fourth, close on the **synthesis map** and **redraw from memory** on a blank sheet. The order matters, because the effortful pull of retrieval is what lays down the memory, so a prompt you struggle with and then check is worth more than a paragraph reread. That is why the prompt lists below are deliberately answer-free.

RULE **Two anchors hold the chapter.** The general criteria are a gate that must clear before any type is named, and ICD-11 rates severity *first* (personality difficulty, then mild, moderate, severe) before adding the five trait domains; and in borderline personality disorder structured psychotherapy is primary while a drug is never a first-line treatment for the disorder. Recover those and the detail hangs off them.

19.3 Retrieval prompts: the general criteria, the clusters and the ICD-11 model

Cover the vaults below and answer from memory. Each prompt targets the single point the examiner tests, not a general description. Work them as **retrieval practice**, then check against the criterion vault.

1. State the six-part general personality-disorder gate (Criteria A to F), and why no specific type is named until every part is cleared.
2. Which two or more of the four channels (cognition, affectivity, interpersonal functioning, impulse control) must Criterion A involve, and what age of onset does Criterion D require?
3. What separates a personality *disorder* from a personality *style*, and how does ICD-11 code the style that falls short of the threshold?
4. Name the three DSM-5-TR clusters and the ten categorical types under them, and give each cluster's descriptor.
5. What did ICD-11 abolish, what did it put in its place, and in what order are the three moves made?
6. Name the five ICD-11 trait domains, and say which one is ICD-11-only and which AMPD domain has no ICD-11 counterpart.
7. Where does the borderline pattern qualifier sit in the ICD-11 model, and why was it the one pattern retained?
8. What did ICD-10 keep that ICD-11 removed, and why do the categorical names still get tested?

19.4 Retrieval prompts: the borderline criteria and the bipolar-II discriminator

Still covered. This is the highest-yield discrimination of the chapter, so retrieve it cleanly and check against the criterion vault.

1. Reproduce the nine DSM-5-TR borderline criteria and state the threshold; which four strands do they unpack into?
2. Which single criterion (its reactivity clause) is the pivot of the bipolar-II discrimination, and what does it specify about duration?
3. Read the borderline-versus-bipolar-II differential on tempo, trigger and baseline: which pattern points to each side?
4. Which features belong to borderline personality disorder and have no bipolar-II equivalent at all?
5. How long must a hypomanic episode and a major depressive episode last, and where does the bipolar mood return to between episodes?
6. When do borderline personality disorder and bipolar II both stand, and what does each then need?

GOOD TO REMEMBER

- **Personality disorder (general):** an enduring pattern of inner experience and behaviour, pervasive and inflexible, deviating markedly from cultural expectation in two or more of cognition, affectivity, interpersonal functioning and impulse control, with onset by adolescence, causing impairment or distress, and not better explained by another disorder, a substance or a medical condition. Discriminator from a personality *style*: the impairment or distress (Criterion C); ICD-11 codes the style short of this as personality difficulty. First step: clear all the general criteria before naming any type.
- **ICD-11 dimensional classification:** no types; rate severity *first* (personality difficulty, then mild, moderate, severe by self-and-interpersonal dysfunction and risk of harm), then add any of the five trait domains (negative affectivity, detachment, dissociality, disinhibition, anankastia), then the borderline pattern qualifier if present. Discriminator from DSM-5-TR: DSM keeps the categorical clusters in its main text (with the Section III AMPD hybrid alongside), so read fluently in both.
- **Borderline personality disorder:** a pervasive pattern of instability of relationships, self-image and affect with marked impulsivity, meeting **five or more of the nine** criteria. Discriminator: the affect is rapidly reactive, interpersonally triggered and lasts hours, versus the sustained autonomous episodes of bipolar II. First step: clear the general criteria, then count the nine. ICD-11 keeps the construct as the optional borderline pattern qualifier.
- **Bipolar II disorder (the discriminator):** at least one hypomanic episode (elevated or irritable mood, at least four consecutive days) plus at least one major depressive episode (at least two weeks), with a euthymic baseline between discrete, largely autonomous episodes. Discriminator: sustained, autonomous, days-to-weeks episodes, not minutes-to-hours interpersonal reactivity; the mood stabiliser helps here, not in personality-based instability.
- **The three classic boundary traps:** schizotypal is placed on the schizophrenia spectrum but is a personality disorder marked by enduring cognitive-perceptual oddness without sustained psychosis (the schizophrenia boundary sits in the aetiology-and-phenomenology notes); anankastic personality is an ego-syntonic *trait* of rigid perfectionism, not the ego-dystonic obsessions and compulsions of OCD; and antisocial personality disorder, never diagnosed before adulthood, carries the medico-legal weight of the chapter and is worked in the forensic notes.

19.5 Retrieval prompts: the psychotherapies and their mechanisms

Cover the therapy vault below. Each prompt asks for the *mechanism* and the signature technique, which is what the examiner rewards, not a bare name.

1. State the biosocial theory and the acceptance-change dialectic of dialectical behaviour therapy, and name its four skills modules and four treatment modes.
2. Which behaviours does the DBT target hierarchy address first, second and third within its first stage?
3. Define an early maladaptive schema and name the four borderline schema modes; what is limited reparenting?
4. How does mentalisation-based therapy read borderline pathology, and what is the mentalising stance it uses instead of interpretation?
5. How does transference-focused psychotherapy read the disorder, and by what sequence does it integrate the split object dyads?
6. Which of the four structured therapies is best-evidenced where recurrent self-harm is the priority, and does any head-to-head trial crown one overall?

19.6 Retrieval prompts: the NICE rule and the integrated plan

Still covered. These are the single most examinable management statements of the material; retrieve them and check against the therapy vault.

1. State the NICE (2009, CG78) rule on drug treatment in borderline personality disorder: is any drug licensed, and what are the only two windows for medication?
2. What does NICE say specifically about antipsychotics for the medium- and long-term treatment of the disorder?
3. Lay out the LOCUS, FOCUS, MODUS spine: where care happens, how the target shifts by phase, and by what primary means.
4. Where NICE, the Indian Psychiatric Society and WFSBP differ, what is the one line all three will sign, and which is most restrictive?
5. Which two agents do the guidelines steer away from, and why (dependence, and safety in overdose)?

GOOD TO REMEMBER

- **Dialectical behaviour therapy (Marsha Linehan):** mechanism is the biosocial theory (emotional vulnerability transacting with an invalidating environment to produce pervasive emotion dysregulation), treated by fusing behavioural change with mindfulness-based acceptance; four skills modules (mindfulness as the core, distress tolerance, emotion regulation, interpersonal effectiveness) through four modes (individual therapy, skills group, phone coaching, consultation team) on a target hierarchy of life-threatening, then therapy-interfering, then quality-of-life behaviours. Indication: borderline personality disorder with recurrent self-harm; the best-evidenced structured therapy for self-harm. Caution: must be comprehensive and delivered with fidelity, and trauma work waits for stage two.
- **Schema therapy (Jeffrey Young):** mechanism is healing early maladaptive schemas (self-defeating patterns from unmet childhood needs) through limited reparenting plus experiential mode work (imagery rescripting, chair work); the borderline patient is worked through four modes (vulnerable child, angry and impulsive child, detached protector, punitive parent) toward a strengthened Healthy Adult. Indication: chronic characterological pathology, strongest evidence in borderline personality disorder (superior to TFP in Giesen-Bloo 2006). Caution: strip out the reparenting and the experiential work and it collapses into ordinary CBT that leaves the schemas untouched.
- **Mentalisation-based therapy (Bateman and Fonagy):** mechanism is that borderline symptoms arise from a loss of mentalising under attachment-stress arousal, so the therapy restores it through a curious, not-knowing mentalising stance in the here and now, working close to conscious experience rather than interpreting the unconscious. Indication: borderline personality disorder (extended to antisocial and to adolescents). Caution: do *not* push interpretation while the patient is non-mentalising and highly aroused; lower arousal and re-open thinking first.
- **Transference-focused psychotherapy (Clarkin and Kernberg):** mechanism is an object-relations treatment reading the disorder as split, unintegrated self-and-other representations (object dyads) held apart by splitting, integrated by working the here-and-now transference through clarification, confrontation and interpretation, with identity diffusion the target and identity consolidation the goal. Indication: borderline and narcissistic organisation in a patient able to tolerate a long, interpretive treatment. Caution: interpretation needs a mind that can still mentalise, or it destabilises.

19.7 The whole-chapter synthesis map

Cover the branches and redraw from memory. The final and highest-value exercise is to reproduce the chapter as one picture. The accompanying figure sets out the **synthesis map** as a single tree, a trunk labelled by the master mnemonic and three primary branches: a *classification* branch (the general-criteria gate splitting into the DSM-5-TR categorical clusters and the ICD-11 severity-first dimensional model with its five trait domains), a *borderline* branch (the five-of-nine criterion set and the reactive-versus-autonomous bipolar-II discriminator), and a *treatment* branch (the four structured psychotherapies with their mechanisms, and the NICE psychotherapy-primary, no-drug-first-line rule). Study it once, then cover every branch and **redraw from memory** on blank paper, writing the discriminator or the mechanism at each leaf. A branch you cannot regrow is a branch to reread. This cover-the-branches redraw is the most compact single test of whether the chapter is genuinely consolidated.

INDIA

Four Indian threads run the length of this chapter and belong on the synthesis map. First, *under-recognition*: personality disorders are diagnosed far less often in Indian practice than Western prevalence would predict, because the ego-syntonic pattern surfaces only when it is actively sought behind the self-harm, overdose or comorbidity that brings the patient in. Second, *availability and cultural adaptation*: dialectical behaviour therapy and schema therapy are being delivered and culturally adapted at Indian tertiary and metropolitan centres rather than being widely accessible, so a realistic plan blends what is available with skilled general management. Third, the *medico-legal frame*, sharpest around antisocial personality disorder, is where the diagnosis carries legal weight in offender assessment and court reports (the forensic notes). Fourth, the *cultural expression of pathology*: deviation is judged against the person's own cultural, social and economic milieu, so collectivist family-embeddedness, deference and religiously framed idioms are never read as dependent, avoidant or dissociative pathology; personality is not read through a single culture's norms.

TRAP **The chapter's recurring errors, in one line.** Diagnosing a type without first clearing the general criteria of an enduring, pervasive, inflexible pattern with onset by adolescence; calling reactive, hours-long affective lability bipolar II and starting a mood stabiliser; reaching for a drug first-line for borderline personality disorder against NICE; mislabelling schizotypal as schizophrenia; confusing anankastic personality with OCD; and reading personality pathology through one culture's norms.

HOLD THIS

If you can say *MAD BAD SAD, FIVE DOMAINS, NINE-FOR-FIVE, FOUR TO COPE* and, from it, regrow the general-criteria gate, the ICD-11 severity-first dimensional model with its five trait domains, the five-or-more-of-nine borderline count, the reactive-versus-autonomous bipolar-II split, and the psychotherapy-primary, no-drug-first-line NICE rule, the chapter is consolidated; wherever you cannot, that gap is the reread.

For the deep pharmacology of the mood stabilisers, low-dose antipsychotics and serotonin reuptake inhibitors that appear only as symptom-targeted adjuncts here see the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes; for the bipolar-II side of the differential the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; for the forensic implications of antisocial personality disorder the Mental health legislation and forensic psychiatry notes; for the complex-PTSD-versus-borderline boundary the Anxiety, OCD and trauma-related disorders notes; for the schizotypal-versus-schizophrenia boundary the Schizophrenia: aetiology, phenomenology, classification and course notes; and for the wider psychotherapy models and technique the Psychotherapies, clinical assessment, MSE and nosology notes.

Previously asked

This territory is examined at two levels at once: the disorder (its clinical features, its differential diagnosis, its aetiology and its course) and the treatment (which structured psychotherapy, the

integrated borderline plan, and the place of symptom-targeted medication). The reliable pattern is that borderline personality disorder carries far the most weight, asked at every length and from every angle, that the classification and the clinical assessment of personality recur as standalone notes and essays, and that a single therapy such as dialectical behaviour therapy or a single type such as avoidant personality disorder can be asked as a note in its own right. Every long essay ends in a management plan, so the rule that structured psychological therapy is primary and that a drug is not the first-line treatment for borderline personality disorder must be exam-ready. The genuine questions on record are grouped by band below. The deep pharmacology of the agents used in symptom-targeted treatment is developed in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes; the bipolar side of the differential in the Mood disorders: classification, depressive and bipolar syndromes, neurobiology notes; the forensic frame of antisocial personality disorder in the Mental health legislation and forensic psychiatry notes; and the wider psychotherapy models in the Psychotherapies, clinical assessment, MSE and nosology notes, while dialectical behaviour therapy, schema therapy, mentalisation-based therapy and transference-focused psychotherapy are owned here.

HOW THIS TERRITORY IS ACTUALLY TESTED

- **Borderline personality disorder, the dominant essay and note.** This is by far the most heavily examined topic in the section. "Describe Kernberg's test of personality organisation. Discuss clinical features and management of Borderline Personality Disorder" and "Discuss aetiology and presentation of Borderline Personality Disorder" have both come as full 25-mark essays, while "Borderline personality disorder", "Borderline personality disorder, clinical features and differential diagnosis" and "Discuss clinical features and psychopharmacological management of Borderline Personality Disorder" recur as 10-mark notes across several sittings. Prepare borderline personality disorder end to end: the criteria and the threshold, the course and complications, the borderline-versus-bipolar-II differential, the Linehan biosocial and the schema-mode formulations, the integrated management plan, and the point that medication is symptom-targeted and adjunctive only. essay and short note, recurring

- **The classification and the clinical assessment of personality.** "Classification of Personality Disorders" has come as a 10-mark note and "Discuss the clinical assessment of personality" as a 25-mark essay, with the assessment of personality also examined on the psychology side. Prepare the general criteria that gate every diagnosis, the ICD-11 dimensional model against the DSM-5 categorical clusters and the alternative model, the categorical-versus-dimensional debate, and the structured instruments and interviews with the state-versus-trait caution. essay and short note, recurring

- **The approach to management and the named psychotherapies.** "Discuss approaches to personality disorders management" has come as a 25-mark essay and "Dialectical Behaviour Therapy (DBT)" as a standalone 10-mark note, and Kernberg's object-relations frame is drawn into the borderline essay. Prepare the guideline-anchored, structured-psychotherapy-first approach, dialectical behaviour therapy with its four skills modules and four modes, schema therapy on the modes framework, mentalisation-based and transference-focused psychotherapy, and the symptom-targeted pharmacotherapy with the not-first-line rule. essay and short note, recurring

- **The individual types as standalone notes.** "Avoidant personality disorder" has come as a 10-mark note, and any single type can be asked this way. Prepare each cluster A, B and C type by its one defining feature

and its discriminator from its neighbours, so a type can be written up cleanly on its own. **short note, recurring**

Prepare this material to be diagnosed and treated, not just recited: the general criteria and the classification shift, the borderline criteria and the borderline-versus-bipolar-II discriminator, the criterion-anchored good-to-remember boxes, the psychotherapy frameworks and the integrated borderline plan in these notes are built to the way the block is examined. The deep pharmacology of the mood stabilisers, low-dose antipsychotics and serotonin reuptake inhibitors used in symptom-targeted treatment lives in the Mood disorders: pharmacotherapy notes and the Schizophrenia: management, antipsychotics and adverse effects notes; the forensic frame of antisocial personality disorder in the Mental health legislation and forensic psychiatry notes; and the wider psychotherapy models in the Psychotherapies, clinical assessment, MSE and nosology notes.

Quick review

THE FRAMEWORK: THE GENERAL CRITERIA AND THE CLASSIFICATION SHIFT	
THE GATE BEFORE ANY TYPE	No type is named until the **general criteria** hold: an **enduring**, **pervasive** and **inflexible** pattern across cognition, affectivity, interpersonal functioning and impulse control, **deviating from cultural expectation**, with **onset by adolescence or early adulthood**, causing distress or impairment, and not better explained by another disorder.
ICD-11 (THE HEADLINE SHIFT)	ICD-11 **abolished the categorical types.** Rate **severity first** (personality difficulty, then mild, moderate, severe), then the **five trait domains** (negative affectivity, detachment, dissociality, disinhibition, anankastia) and the **borderline pattern** qualifier. Severity leads because it predicts outcome and need better than type.
DSM-5-TR (CATEGORICAL) AND THE ALTERNATIVE MODEL	Ten types in three clusters: **A** odd or eccentric, **B** dramatic or erratic, **C** anxious or fearful. Section III **alternative model** = the level-of-personality-functioning scale plus five pathological trait domains (negative affectivity, detachment, antagonism, disinhibition, psychoticism) and six retained types. **ICD-10 kept** the categorical types, which is why exams still test them.
CATEGORICAL VERSUS DIMENSIONAL	Categorical is familiar and communicable but gives excessive comorbidity, arbitrary thresholds and a large not-otherwise-specified group; dimensional has better validity and covers the subthreshold majority. The field moved dimensional (ICD-11 and the DSM-5 alternative model).
THE DISORDERS BY CLUSTER	
CLUSTER A (ODD OR ECCENTRIC)	**Paranoid** (pervasive distrust and suspiciousness), **schizoid** (detachment and restricted affect), **schizotypal** (cognitive and perceptual distortions and eccentricity). Schizotypal sits on the **schizophrenia spectrum** (ICD-11 6A22, outside the personality disorders); the discriminator from schizophrenia is that the signs are attenuated and never become sustained frank psychosis.
BORDERLINE (THE HIGHEST-YIELD TYPE)	Abandonment fears, unstable intense relationships, identity disturbance, impulsivity, recurrent self-harm and suicidality, affective instability, chronic emptiness, inappropriate anger, transient stress-related paranoia or dissociation: **five or more of the nine criteria**. Course trends to **symptomatic remission** over years; sustained functional recovery is harder.

THE DISORDERS BY CLUSTER	
ANTISOCIAL	Pervasive disregard for the rights of others (deceit, impulsivity, aggression, recklessness, irresponsibility, lack of remorse); requires **conduct disorder before age fifteen** and is diagnosed **from age eighteen**. **Psychopathy** (the affective-interpersonal core, PCL-R) is a narrower construct nested within it. The forensic frame is cross-referenced.
HISTRIONIC AND NARCISSISTIC	Histrionic: excessive emotionality and **attention-seeking**. Narcissistic: grandiosity, need for admiration, lack of empathy, split into **grandiose** (overt, entitled) and **vulnerable** (covert, shame-prone) presentations over a shared fragile self-esteem.
CLUSTER C (ANXIOUS OR FEARFUL)	**Avoidant** (social inhibition, feels inadequate, wants closeness but withdraws), **dependent** (needs to be taken care of, submissive, fears separation), **anankastic / obsessive-compulsive** (order, perfectionism, control). Anankastic is **ego-syntonic** traits with **no true obsessions or compulsions**, which is the line from OCD.
THE HIGH-YIELD DISCRIMINATORS	
BORDERLINE VERSUS BIPOLAR II	Borderline mood shifts are **rapid (minutes to hours) and reactive** to interpersonal triggers, with identity disturbance and chronic emptiness; bipolar II episodes are **sustained (days to weeks) and autonomous**, with a bipolar family history and a response to a mood stabiliser. The trap is calling reactive personality-based lability bipolar and starting a mood stabiliser.
COMPLEX PTSD VERSUS BORDERLINE	Complex PTSD carries the PTSD triad plus disturbances in self-organisation with a **stable** negative self-view and relationships of avoidance, after prolonged trauma; borderline shows unstable identity and frantic abandonment fears. Missing complex PTSD behind a personality-disorder label is the classic error.
ANANKASTIC PERSONALITY VERSUS OCD	Anankastic personality is the ego-syntonic character of perfectionism and control with no discrete obsessions or compulsions; OCD is ego-dystonic intrusive obsessions and resisted compulsions.
DO NOT DIAGNOSE IN AN ACUTE STATE	The pattern must be enduring and pervasive. Do not diagnose a personality disorder during an acute episode of another disorder (the state-versus-trait caution); use a structured instrument (IPDE, SCID-5-PD) and corroborating history.
THE TREATMENT BLOCK, THE GUIDELINE SPINE AND THE HARD RULES	
THE GUIDELINE ORDER	Guidelines-first on the where-to-treat, target-by-phase, modes-of-treatment spine: **NICE leads** (the borderline and the antisocial guidelines), then the **Indian Psychiatric Society** and **WFSBP**. Structured psychological therapy is primary throughout.

THE TREATMENT BLOCK, THE GUIDELINE SPINE AND THE HARD RULES	
THE PSYCHOTHERAPIES	**Dialectical behaviour therapy**: four skills modules (mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness) across four modes (individual, skills group, phone coaching, consultation team). **Schema therapy**: work the modes (vulnerable child, angry child, detached protector, punitive parent, healthy adult) by limited reparenting. **Mentalisation-based therapy**: restore the mentalising stance. **Transference-focused psychotherapy**: integrate split object relations in the here-and-now transference.
PHARMACOTHERAPY (THE KEY RULE)	**No drug is first-line for borderline personality disorder** and none is licensed (NICE); no drug reduces total borderline severity (Cochrane). Medication is **symptom-targeted and adjunctive**: a low-dose antipsychotic for cognitive-perceptual and impulsive-behavioural dyscontrol, a mood stabiliser for impulsive aggression, an SSRI for the affective and anxiety domain, only for a comorbidity or a crisis. **Avoid benzodiazepines** and **avoid polypharmacy**; review and deprescribe.
THE INTEGRATED BORDERLINE PLAN	LOCUS: outpatient and community by default, admission avoided and brief. FOCUS: short-term safety and crisis, mid-term the core features via structured therapy, long-term function and remission. MODUS: structured psychotherapy primary, symptom-targeted time-limited medication only, multidisciplinary care planning and a crisis plan.
THE FIVE TRAPS	Diagnosing a type without the general criteria; calling reactive affective lability bipolar and starting a mood stabiliser; giving a drug first-line for borderline personality disorder; reading schizotypal as schizophrenia; and confusing ego-syntonic anankastic personality with ego-dystonic OCD.

References

The personality-disorder content is grounded in the standard psychiatry sources (the source hierarchy below), with Kaplan and Sadock and the New Oxford Textbook as the depth bar for the phenomenology, the classification and the course, the ICD-11 Clinical Descriptions and Diagnostic Requirements and the DSM-5-TR for the criteria and the two classification systems, and the primary psychotherapy literature for dialectical behaviour therapy, schema therapy, mentalisation-based therapy and transference-focused psychotherapy. The management is guideline-first, led by NICE (the borderline and the antisocial guidelines), with the Indian Psychiatric Society, WFSBP and the American Psychiatric Association. Every criterion, trait domain, cluster mapping, severity anchor and guideline rule was checked against these sources and the adversarial content pass; anything that could not be confirmed was omitted and flagged rather than guessed, so several prevalence and effect-size figures are stated by direction rather than by a specific number. Each journal PMID below was verified against PubMed this build and

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