*Seu modelo de prova está na página seguinte

Curso de Inglês Instrumental Online

preparatório para Provas de Proficiência do Mestrado e Doutorado com Certificado de Proficiência

SAIBA MAIS

UFRN
UNIVERSIDADE FEDERAL DO RIO GRANDE DO NORTE

Exame de Proficiência
2020.1

Inglês

Ciências da Saúde

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1	Confira se os dados contidos na parte inferior desta capa estão corretos e, em seguida, assine no espaço reservado para isso. Se, em qualquer outro local deste Caderno, você assinar, rubricar, escrever mensagem, etc., será excluído do Exame.
2	Este Caderno contém 5 questões discursivas referentes à Prova da Língua Estrangeira escolhida pelo candidato. Não destaque nenhuma folha.
3	As respostas às questões deverão ser redigidas em PORTUGUÊS.
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5	Será avaliado apenas o que estiver escrito no espaço reservado para cada resposta, razão por que os rascunhos não serão considerados.
6	Escreva de modo legível, pois dúvida gerada por grafia, sinal ou rasura implicará redução de pontos.
7	Só será permitido o uso de dicionário INGLÊS/INGLÊS.
8	A Comperve recomenda o uso de caneta esferográfica, confeccionada em material transparente, de tinta preta. Em nenhuma hipótese se avaliará resposta escrita com grafite.
9	Utilize para rascunhos, o verso de cada página deste Caderno.
10	Você dispõe de, no máximo, três horas, para responder as 5 questões que constituem a Prova.
11	Antes de retirar-se definitivamente da sala, devolva ao Fiscal este Caderno.

Assinatura do Candidato: _____

ATENÇÃO! As respostas às questões deverão ser redigidas em PORTUGUÊS.

Questions 01 to 05 refer to the text below.

BORDERLINE PERSONALITY DISORDER IN ADOLESCENTS: PREVALENCE, DIAGNOSIS, AND TREATMENT STRATEGIES

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Introduction

The clinical existence of borderline personality disorder (BPD) in adolescence has long been debated. However, the disorder has now been better ascertained, and the evidence justifies the diagnosis and management of BPD in adolescents. BPD comprises an interiorized component (identity disturbance, stress-related paranoid ideation, chronic feelings of emptiness, and efforts to avoid abandonment), an emotional component (affective instability and inappropriate, intense anger), and an externalized component (impulsivity, suicidal and self-mutilating behaviors, and interpersonal relationships instability). In fact, the affective instability corresponds to hypervigilance and affective hyperreactivity. It manifests itself as a markedly unstable emotional state that depends on the subject's environment, interactions, and the responses elicited by the subject's requests and behaviors. Affective instability may be the key factor in adolescents treated as outpatients, whereas the identity disturbance may be the most important factor in hospitalized adolescents, i.e., those suffering from the most severe forms of BPD. The clinical presentation as a whole is marked by instability. The intensity and duration of the symptoms fluctuate as a function of the affective context and the degree to which the situation is experienced as stressful by the adolescent.

As described notably in the Diagnostic and Statistical Manual of Mental Disorders, fifth version (DSM-V), the concept of BPD translates the broader psychoanalytic concept of a borderline personality organization (BPO, referred to as an "état limite" (borderline state) by French-speaking authors) into observable, semiological criteria. Hence, BPD is one of a broader variety of personality disorders through which a BPO can be symptomatically expressed. Historically, the BPD construct was derived from psychoanalytical work; however, it has been examined from neuroscientific and genetic standpoints for more than a decade now. Several studies have screened adolescents for the cognitive and neuronal correlates of BPD observed in adults. With regard to information processing, the tendency to negatively interpret neutral or ambiguous facial emotions in others is not observed in the adolescent; this might only be a feature of the most severe forms or might arise later in the development of BPD. In neuronal terms, hyperactivity of the amygdala and hippocampus has been observed not only in adolescent females with repeated self-injury and depression but also in nondepressed adolescent females with BPD. Exposure to environmental stressors modifies the activation of these amygdala networks. With regard to hyperactivity of the amygdala, research has highlighted patterns of reactiveness to stressors, with hyper-reactivity of the corticotropic axis and then the development of hypo-reactivity (when the exposure to stressors becomes chronic) or the maintenance of hyper-reactivity when BPD is combined with depression. The activity of these neuronal networks (and notably that of the amygdala networks) is determined not only by environmental stressors but also by genetic vulnerability factors.

Several candidate genetic factors have been explored, including the serotonin-transporter-linked polymorphic region (5-HTTLPR) and the NR3C1 gene encoding the glucocorticoid receptor. Adversity in early life (maltreatment, in particular) modifies the neuronal and cognitive processes underlying the stress response via epigenetic mechanisms.

The relationships between these mechanisms and vulnerability factors (both genetic and environmental) must be considered from a developmental perspective. These relationships are bidirectional and fluctuating, since they strengthen or weaken as the adolescent interacts with

his/her family and peers. Early adversity, maltreatment, and maternal separation are associated with BPD. These early risk factors disrupt attachment, which in turn produces psychopathologic conditions such as BPD. In a family environment marked by early relationship instability, maltreatment, the absence of emotion-containing parenting, and disorganized attachment, the youngster's progression depends on his/her ability to build a coherent self-image. In fact, the persistence of a disorganized attachment style prevents the development of mentalization abilities. The child cannot pull together the succession of emotions experienced with his/her family and friends into a single, coherent image. Parental figures do not constitute internal objects (in the psychodynamic sense) that contribute to the youngster's psychological development.

On the psychological level, a BPO, as defined within a psychodynamically oriented perspective, results from the failure to interiorize and identify with reassuring, emotion-containing, and structure-giving objects – leaving the adolescent confronted with nonsense, emptiness, and his/ her internal destructiveness. Psychological functioning is organized around a permanently unstable relationship with objects (rather than internal conflict), repeating the early confrontation with absent, unpredictable, or maltreating external objects. This translates into identity disturbance (a DSM-V criterion). The adolescent feels very different and lacks coherence at certain times and in certain life situations.

When interacting with others, the adolescent does not adequately perceive the boundary between his/her own ideas and emotions and those of other people. These observations from the field of clinical psychodynamics have recently been operationalized (in adult BPD) into research studies of metacognitive capacities. To the best of our knowledge, this type of study has not yet been performed in the adolescent. In summary, research evidence from the biological, psychological, and social domains supports a stress-diathesis model of BPD. In turn, understanding an adolescent's clinical situation with regard to this model results in a more appropriate management and treatment plan for BPD.

A number of large epidemiological studies (based on national registries) have documented the current increase in reports of BPD – including those in adolescents. A Danish study found that the incidence of BPD in females aged 15 years or over increased linearly from 1970 to 2009. A Canadian study of diagnostic information collected through the public health insurance system found a steady increase in the incidence of BPD in 14- to 17-year-old girls between 2000 and 2012. These studies captured data on individuals having received care in the public hospital system but excluded the least impaired cases (eg, those having received care in the private sector) and the most severely impaired cases (eg, those who ended up in detention without receiving care). It is important to note that these studies highlight the diminishing reluctance of clinicians to diagnose BPD in adolescents, since the work was based on diagnostic data recorded by the adolescent's treating physicians. Prevalence studies have been also conducted in various clinical populations, regardless of the institutions' public or private sector status. Although the clinical samples are heterogeneous, one observes an increase in the prevalence of BPD with the severity of the clinical picture and the type of psychiatric care received: 11% in outpatient adolescents, between 19% and 53% in hospitalized adolescents, 62% in hospitalized suicidal adolescents, and 78% in adolescents attending the emergency department for suicidal behaviors.

ATENÇÃO! As respostas às questões deverão ser redigidas em PORTUGUÊS.

Question 1

According to the text, discuss the components associated to BPD and how they differently affect outpatients and hospitalized adolescents.

Espaço para Resposta

Question 2

Write about the recent neuronal correlates of BPD observed in the amygdala networks of adolescents, according to the text.

Espaço para Resposta

Question 3

Discuss what the authors mean when they claim that BPD must be considered from a developmental perspective.

Espaço para Resposta

Question 4

According to the studies reviewed by the authors, discuss the recent findings of epidemiological and clinical research on BPD.

Espaço para Resposta

Question 5

- Translate the excerpt below in the space provided.
- The translated text should be clear and accurate in terms of structure and meaning.

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