

Affect Instability in Adults With a Borderline Personality Disorder

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This study describes the pattern of affect instability in adults with borderline personality disorder (BPD). Clinical histories and the Diagnostic Inventory for Borderlines were used to identify 3 groups: 1) BPD ($N = 15$), 2) Asymptomatic ($N = 10$), and, 3) Non-BPD, Anorexia Nervosa Clinical Control ($N = 4$). An experience sampling procedure (Hormuth, 1986) was used to obtain 50 measures of affect over 10 days. The findings showed that BPD subjects experienced higher levels of unpleasant affects and greater short-term fluctuations in unpleasant affects than the asymptomatic subjects. However, BPD and asymptomatic subjects experienced more fluctuations in the pleasant affects than the AN subjects. These findings support the hypothesis that BPD is associated with a unique pattern of affect dysregulation.

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AFFECT INSTABILITY is widely recognized as a core feature of borderline personality disorder (BPD). Rapid and extreme shifts in mood from baseline into dysphoria, irritability or anxiety are identified in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Associations, 1994; 1987) as one of the essential criteria for BPD diagnosis. Clinical and theoretical accounts of the disorder suggest that adults with BPD have a limited ability to buffer the impact of stressors, and, consequently, react with marked shifts in affect each time a stressor is encountered (see Ellison & Adler, 1990; Gunderson & Phillips, 1991; Liebowitz & Klein, 1981; Linehan, 1987a).

Despite the broad consensus acknowledging the centrality of affective instability in BPD, remarkably little is known about the pattern of affect fluctuations that characterize this population. To date, most descriptions of affect instability in BPD are based on clinical accounts that broadly describe

angry outbursts and precipitous episodes of depression (Cowdry, Gardner, O'Leary, Leibenluft, & Rubinow, 1991). The few research studies that have examined affect instability have used global measures of affect that provide little information about the pattern of specific affect changes. For example, Cowdry et al. measured affect two times daily over a two-week period in four groups of subjects including adults with BPD, adults with major depression, adults with premenstrual syndrome, and normal adult controls (1991). In this study, two measures of affect were used including a visual analog and a 24-point scale both anchored by "best I've ever felt" and "worse I've ever felt." The findings showed that subjects in the BPD group experienced more variability in affect over the two-week period and less consistency in affect state from day-to-day than the other clinical and nonclinical groups. Although the findings provide general support for the notion that adults with BPD experience more short-term variability in affect than other clinical and nonclinical samples, they provide little specific information about the pattern of affect fluctuations.

The lack of detailed knowledge about the specific pattern of affect instability has had important consequences in the diagnosis and treatment of BPD. In a review paper on the utility of the

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Diagnostic and Statistical Manual 3rd-revised (DSM-III-R) criteria for establishing a BPD diagnosis, Gunderson, Zanarini, and Kiesel acknowledged the high prevalence of affect instability in samples of adults with BPD (1991). However, they questioned the extent to which the symptom contributes to the high rate of overlap between BPD and other personality and depressive diagnoses. They argued that the symptom, as it is currently defined, lacks specificity and suggested that the definition must be refined to improve the usefulness of the symptom in establishing a differential diagnosis.

The lack of clarity in defining the nature of affect instability in BPD has also impacted the development of effective affect-stabilizing interventions. For example, studies on the pharmacotherapy of BPD define affect instability in a variety of ways ranging from rejection sensitivity and irritability to depressive/hypomanic mood swings, and have identified a broad array of psychotropic agents including lithium, monoamine oxidase inhibitors (MAOI), and haloperidol to reduce or eliminate the symptom (for examples, see Cowdry & Gardner, 1988; Ellison & Adler, 1990; Links, Steiner, Boiago, & Irwin, 1990; Soloff, George, Nathan, Schulz, & Cornelius, 1988). Cognitive-behavioral approaches have tended to view affect instability in BPD as pathologically high levels of emotional reactivity to events and have proposed a variety of foci for intervention including helping individuals reduce the intensity of their reactions to events (see Beck & Freeman, 1990) and strengthening their capacity to tolerate and cope with intense negative affects (Linehan, 1987a; MacLeod, Williams, & Linehan, 1992).

Clearly, affect instability is recognized as an important focus of treatment in most approaches to the treatment of BPD, yet the specific affects experienced and the pattern of affect dysregulation remains unclear. Do persons with BPD experience variability in only negative affects, such as sadness or anger and anxiety? Or do they have difficulty regulating all affect states including positive and negative affects? Do adults with BPD differ from other populations according to the frequency of their emotional reactions, the intensity of emotion experienced, or in their ability to restore a baseline level of affect after a threat is encountered? Identification of specific properties of affect dysregulation that are unique to BPD not only holds the potential of improving the diagnostic utility of the

symptom but may enable clinicians to develop more focused biologic and cognitive-behavioral affect stabilizing interventions.

The purpose of this study is to describe the pattern of affect instability in adults with BPD and to compare the pattern with those experienced by other asymptomatic and non-BPD clinical samples.

METHODS

Sample

Three groups of subjects participated in this study, the Borderline Personality Disorder (BPD) Group ($N = 15$), the Anorexia Nervosa (AN) group ($N = 4$), and the Asymptomatic Control Group ($N = 10$). The AN group was included as a clinical control group to enable investigation of patterns of affect that distinguish adults with BPD from those with other non-BPD psychiatric disorders. Anorexia nervosa was selected for the comparison group because: (A) instability of affect is recognized as an important symptom of both disorders (Cowdry et al., 1991; Goodstitt, 1983) and (B) the severity of the disorders are comparable in that both are associated with severe impairments in self-care abilities that often necessitate inpatient hospitalization.

Subjects for the clinical groups were recruited from three inpatient psychiatric units at local hospitals. The Diagnostic Inventory For Borderlines (DIB) (Gunderson, Kolb, & Austin, 1981) and a clinical history were used to establish primary diagnosis and group placement. To establish a diagnosis of BPD, the individual had to meet *DSM-III-R* (American Psychological Association, 1987) criteria for BPD and score 7 or above on the DIB. Similarly, to establish a diagnosis of AN, the individual had to meet *DSM-III-R* criteria for AN and score 5 or below on the DIB. Individuals were considered asymptomatic if they had a negative history for psychiatric disorders and scored 5 or below on the DIB. Additional criteria for participation in the two groups included: (A) no history of organic, developmental, and chronic psychotic disorders and (B) literacy in English.

The DIB is a semi-structured interview that focuses on five areas of functioning including social adaptation, impulse/action patterns, psychotic symptomology, and interpersonal relations (Gunderson & Kolb, 1978). Based on the subjects' responses to 123 questions, the interviewer rates the subject on 29 items that are summed to

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