



Increased attempts to suppress negative and positive emotions in Borderline Personality Disorder



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ABSTRACT

Patients with Borderline Personality Disorder (BPD) show evidence of disturbed emotion regulation. In particular, patients may try to suppress their emotions with possibly negative effects on mental health. We investigated the suppression of both negative and positive emotions in BPD patients and healthy participants. Thirty BPD patients and 30 matched healthy controls were assessed for emotion suppression using the Emotion Acceptance Questionnaire (EAQ). In addition, we administered additional questionnaires to validate emotion suppression findings. BPD patients reported increased attempts to suppress both negative and positive emotions. These findings indicate that BPD patients are not simply acting out negative emotions. Therapeutic approaches that focus on emotion acceptance of emotions are supported by our study data. Apart from negative emotions, treatment programs should consider positive emotions as well.

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1. Introduction

Emotional dysfunction is a main symptom of patients with Borderline Personality Disorder (BPD; Gratz et al., 2006). Compared with healthy subjects, BPD patients report more affective instability, increased affective intensity and reactivity related to negative emotional stimuli, and negative affectivity overall (Rosenthal et al., 2008). With respect to positive emotions, BPD patients suffer from anhedonia (Marissen et al., 2012) and experience less affective and cognitive positive states than healthy people (Reed and Zanarini, 2011). Several authors consider disturbed emotion regulation to be the primary emotional dysfunction in BPD patients and the main cause of further emotional symptoms in BPD (Glenn and Klonsky, 2009; Gratz et al., 2006; Putnam and Silk, 2005). Emotion regulation is defined as a set of actions aimed at influencing which emotions we have and how we experience and express those emotions (Gross, 2002).

The attempt to suppress emotions has been shown to be a maladaptive emotion regulation strategy and is related to psychopathology (Beblo et al., 2012; Aldao et al., 2010; Chawla and Ostafin, 2007). While Gross (2002) focuses primarily on suppression of

emotional expression, other authors relate the attempt to suppress emotions to the entire emotional response including psychological and physiological features (Liverant et al., 2008). There is some evidence that BPD patients show increased efforts to suppress emotions. In BPD patients (Conklin et al., 2006), outpatients with BPD symptoms (Iverson et al., 2011) and in female inmate participants (Chapman et al., 2005), BPD symptoms were related to experiential avoidance (Hayes et al., 1996). Experiential avoidance refers to attempts to suppress unwanted emotions and other internal experiences, e.g., thoughts. Sauer and Baer (2009) reported that thought suppression fully mediated the relationship between negative social conditions and BPD symptoms in a student sample with a wide range of BPD features. Rosenthal et al. (2005) found a mediating effect of thought suppression on the association between negative affect and BPD symptoms in a community sample. In addition, neuroimaging studies support the hypothesis that BPD is associated with increased attempts to control emotions. In a recent fMRI study, we asked BPD patients to recall unresolved negative life events. In contrast to resolved negative life events and compared to healthy subjects, BPD patients demonstrated increased activation of the amygdala and PFC areas, including the orbitofrontal cortex (Beblo et al., 2006). We interpreted the results to represent an effortful but insufficient attempt to control intense emotions in patients with BPD.

BPD symptoms have also been found to be associated with a decreased acceptance of current experiences in a psychiatric sample (Wupperman et al., 2009), and an acceptance-based

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emotion regulation group intervention decreased symptoms in BPD patients (Gratz and Gunderson, 2006). Emotion acceptance is often contrasted to emotion suppression (Hofmann and Asmundson, 2008; Stein et al., 2008; Williams et al., 2007), i.e., decreased emotion acceptance corresponds to increased emotion suppression efforts in BPD. Because there is some overlap between BPD and major depression symptomatology (MDD; Beblo et al., 2010; Goodman et al., 2010), findings of decreased acceptance of negative and positive emotions in MDD patients (Beblo et al., 2012) support the assumption that BPD patients may show a similar pattern of emotion dysregulation.

However, studies that focus on attempts to suppress or accept emotions are primarily based on sub-clinical samples or other patient groups, and studies that investigate the regulation of positive emotions in BPD are missing. Therefore, definite conclusion about emotion suppression and emotion acceptance in BPD patients cannot be drawn. The present study aims to investigate attempts to suppress or accept negative and positive emotions in BPD patients and healthy participants. We hypothesized that BPD patients would show increased suppression and decreased acceptance of both negative and positive emotions.

2. Methods

2.1. Participants

The study included 30 BPD patients who were diagnosed based on DSM IV criteria and 30 healthy controls. All potential participants with BPD were treated as inpatients at the time of the study. Eligible patients who agreed to participate in the study were individually enrolled. Healthy subjects were recruited through advertisements. Exclusion criteria for participation in the study included diagnosis of psychosis, anorexia, alcohol or drug abuse, and severe physical disorders (e.g., neurological disorders involving the central nervous system, mental retardation, malignant diseases, and liver cirrhosis). In addition, pregnant women were not included. Healthy controls were free of any axis I or II disorders. We obtained written, informed consent from all subjects. The study was approved by the IRB (University of Muenster Ethics Committee).

Table 1 shows the basic demographic characteristics of the participants. Age, basic school education and gender were almost identical in both groups and did not differ significantly. Several patients with BPD were noted to have comorbid mental disorders. Twelve patients suffered from affective disorders (major depression: $n=9$, dysthymia: $n=3$). Eight patients had evidence of anxiety disorders (panic disorder: $n=3$, social phobia: $n=2$, posttraumatic stress disorder: $n=1$, obsessive compulsive disorder: $n=1$, generalized anxiety disorder: $n=1$, specific anxiety disorder: $n=1$), two patients suffered from Bulimia, and one patient had somatoform disorder. With regard to comorbid Axis II disorders, three patients fulfilled the diagnostic criteria for avoidant personality disorder. Eleven patients were free of any acute Axis I or comorbid Axis II disorder.

Of the patients, 14 took antidepressants (SSRIs or SNRIs: $n=8$, tricyclics: $n=5$, lithium: $n=1$, other antidepressants: $n=6$). For sedation, 14 patients received neuroleptics, five received antiepileptics, and one received benzodiazepines. Two patients were receiving pain medication. Only seven patients were free of any medication. None of the healthy subjects took medication.

As expected, BPD patients reported more psychopathology as assessed by a short version of the "Symptom Checklist-revised" (SCL-90-R, Franke, 1995), the SCL-K-9 (Prinz et al., 2008), than healthy subjects (**Table 1**). This result was also observed for patients without acute axis I and axis II comorbidity and for medication-free patients. On average, patients reported 6.6 DSM IV criteria for BPD ($mdn=7$, range=5–9).

2.2. Instruments

2.2.1. Clinical examination

The presence or absence of psychiatric diagnoses in the patient and control groups was made using the "Structured Clinical Interviews for DSM IV (SCID)". The SCID I was used to assess Axis I disorders, while the SCID II was used to assess personality disorders (Wittchen et al., 1997). Trained psychologists administered these interviews. To assess the severity of psychopathology, we administered a short version of the "Symptom Checklist-revised" (SCL-90-R, Franke, 1995), the SCL-K-9. While the SCL-90-R contains several subscales that allow for the evaluation of different psychopathological symptoms, the SCL-K-9 focuses on general psychopathological burden. The psychometric properties of the scale have been studied and are satisfactory (Prinz et al., 2008).

2.2.2. Emotion suppression

2.2.2.1. Emotion Acceptance Questionnaire (EAQ). Emotion suppression was assessed using the "Emotion Acceptance Questionnaire" (EAQ, in German "FrAGe"; Beblo et al., 2011, 2012). Participants were asked to indicate whether items applied to them, with responses ranging from 1 ("does not apply at all") to 6 ("applies completely"). The EAQ contains 32 items divided equally into the following four subscales: (1) acceptance of negative emotions (e.g., "I usually allow myself to accept unpleasant feelings"), (2) suppression of negative emotions, (e.g., "I try to push aside unpleasant feelings"), (3) acceptance of positive emotions (e.g., "I can easily let in pleasant feelings"), and (4) suppression of positive emotions (e.g., "I block out pleasant feelings"). Subscales 1 and 2 are used to create the total score for the suppression of negative emotions ("main scale negative emotions"), while subscales 3 and 4 are used to create the total score for the suppression of positive emotions ("main scale positive emotions"). All four subscales were summed to create the total score ("main scale EAQ"). Item scores of subscales 2 and 4 were recoded (1=6, 2=5, 3=4, 4=3, 5=2, 6=1) to build the scores of the main scales. Cronbach's Alpha and split half reliability were considered to be highly satisfying for the total score ($\alpha=0.91$, split half=0.89), the total scores for negative emotions ($\alpha=0.89$, split half=0.89) and the total score for positive emotions ($\alpha=0.90$, split half=0.83) emotions, while it was considered sufficient for the four subscales (acceptance negative emotions: $\alpha=0.86$, split half=0.86, suppression negative emotions: $\alpha=0.83$, split half=0.83, acceptance positive emotions: $\alpha=0.87$, split half=0.80), and suppression positive emotions ($\alpha=0.82$, split half=0.77; Beblo et al., 2011). Correlations with comparable questionnaires have confirmed the validity of the EAQ (Beblo et al., 2011). For both samples in the present study, Cronbach's alpha was highly satisfying with a range of 0.82–0.90 for the subscales and a range from 0.88 to 0.93 for the main scales (0.93 for healthy subjects and 0.88 for BPD patients for the main scale EAQ). Correlations between the EAQ and the "non-acceptance" subscale of the Difficulties in Emotion Regulation Scale (DERS; Ehring et al., 2008; Gratz and Roemer, 2004) were $r=-0.65$ ($p < 0.01$) for the healthy subjects and $r=-0.43$ ($p < 0.05$) for BPD patients and were used to demonstrate the validity of the EAQ.

2.2.2.2. Difficulties in Emotion Regulation Scale (DERS). The "Difficulties in Emotion Regulation Scale" (DERS, Ehring et al., 2008; Gratz and Roemer, 2004) is a 36-item, self-report questionnaire designed to assess multiple aspects of emotion dysregulation. The questionnaire contains of six subscales that constitute the total score. The subscales are as follows: (1) non-acceptance of emotional responses, (2) difficulties engaging in goal-directed behavior, (3) impulse control difficulties, (4) lack of emotional awareness, (5) limited access to emotion regulation strategies, and (6) lack of emotional clarity. Cronbach's Alpha was considered to be highly satisfying for the total score (0.93; Gratz and Roemer, 2004). The "nonacceptance of emotions" subscale was used to validate EAQ results. Cronbach's Alpha was satisfactory at 0.85 (Gratz and Roemer, 2004). Similar psychometric properties were reported for the German translation used here (Ehring et al., 2008).

2.3. Data analysis

Given the lack of studies investigating the suppression of negative and positive emotions in BPD, we conducted two-tailed tests of significance for all analyses and set the original level of significance to 0.05. With *t*-tests we investigated, step by step, differences between BPD patients and healthy subjects with regard to emotion suppression. We began by comparing the groups with respect to emotion suppression in general (main scale EAQ) and later compared total scores for negative and positive emotions as separate analyses (main scales negative and positive emotions); finally, we compared groups with regard to the four subscales. We applied the Bonferroni correction for multiple comparisons ($p=0.125$). Demographic variables were compared using *t*-tests (age, years of school education) and a Chi-square test (gender). To control for comorbidity and medication use, we repeated these analyses for exploratory reasons for the BPD subgroup without acute axis I and axis II comorbidities and for the non-medicated BPD subgroup. Because the sub-sample sizes were small ($n=11$ for BPD patients without axis I and axis II comorbidity, $n=7$ for non-medicated BPD patients), we applied non-parametric statistics (Mann–Whitney-*U*-tests) and considered the analyses to be exploratory.

3. Results

BPD patients showed more emotion suppression than healthy subjects (**Table 1**). This applied for both negative and positive emotions (**Table 1**). We achieved identical results when suppression and acceptance were evaluated separately (subscales of the Emotion Acceptance Questionnaire, **Table 1**). To exclude the influence of comorbid disorders, we also compared healthy subjects to BPD patients without acute axis I and axis II comorbidity ($n=11$), and the effects remained stable. BPD patients without comorbid

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