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## Emotional hyperreactivity in response to childhood abuse by primary caregivers in patients with borderline personality disorder



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### ABSTRACT

**Background:** One of the core postulated features of borderline personality disorder (BPD) is extreme emotional reactivity to a wide array of evocative stimuli. Findings from previous experimental research however are mixed, and some theories suggest specificity of hyper emotional responses, as being related to abuse, rejection and abandonment only.

**Objective:** The current experiment examines the specificity of emotional hyperreactivity in BPD.

**Method:** The impact of four film clips (BPD-specific: childhood abuse by primary caregivers; BPD-nonspecific: peer bullying; positive; and neutral) on self-reported emotional affect was assessed in three female groups; BPD-patients ( $n = 24$ ), cluster C personality disorder patients ( $n = 17$ ) and non-patient controls ( $n = 23$ ).

**Results:** Results showed that compared to the neutral film clip, BPD-patients reacted with more overall negative affect following the childhood abuse clip, and with more anger following the peer bullying clip than the two other groups.

**Limitations:** The current study was restricted to assessment of the impact of evocative stimuli on self-reported emotions, and the order in which the film clips were presented to the participants was fixed.

**Conclusions:** Results suggest that BPD-patients only react generally excessively emotional to stimuli related to childhood abuse by primary caregivers, and with excessive anger to peer-bullying stimuli. These findings are thus not in line with the core idea of *general* emotional hyperreactivity in BPD.

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### 1. Introduction

Borderline personality disorder (BPD) is a severe mental disorder that is mostly characterized by instability (APA, 2005). This instability is expressed in interpersonal relationships, identity, and affect. Following the biosocial theory (Linehan, 1993), the essence of BPD is postulated to be a dysregulated emotional system (Rosenthal et al., 2008). According to this general emotional dysregulation theory, the dysregulation includes three components: emotional sensitivity (low threshold for emotional responses), emotional hyperreactivity (intense emotional reactions to evocative cues), and a slower return to baseline arousal (Linehan, 1993). The current study focuses on the second component, and contrasts the general emotion hyperreactivity theory to theories that hypothesize that BPD is characterized by stronger emotional

responsivity to specific stimuli, such as emotional, sexual and physical abuse (see e.g. Lobbestael & Arntz, 2012; Rosenthal et al., 2008).

During the last decade, three lines of studies emerged to assess emotional reactivity in BPD. The first line used the Affect Intensity Measure (AIM, Larsen & Diener, 1987) to quantify self-reported characteristic intensity of positive and negative emotional reactions. BPD-patients reported higher intensity of negative affect than non-patient controls (Bland, Williams, Scharer, & Manning, 2004; Levine, Marziali, & Hood, 1997), and BPD-traits showed to be related to affect intensity on a dimensional level both in analogue (Cheavens et al., 2005; Rosenthal et al., 2008) and hospitalized samples (Yen et al., 2002). More strict comparisons with patient samples suffering from other personality disorders (Henry et al., 2001; Koenigsberg et al., 2002) and/or bipolar disorders (Henry et al., 2001) however failed to show affective hyperreactivity assessed with the AIM to be specific for BPD. The second line of studies likely reflects a more valid way of testing the emotional

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hyperreactivity hypothesis because these studies included confrontation with emotional stimuli in an experimental setting. Such studies have the advantage of not being hypothetical in nature, or prone to retrospective distortion. Findings were mixed. One abuse-related film clip led BPD-patients to report increased fear (Arntz, Klokman, & Sieswerda, 2005) or negative affect (Lobbestael & Arntz, 2010), but this was also observed in Cluster-C personality disorder patients in one study (Lobbestael, Arntz, Cima, & Chakhssi, 2009). In other studies using different emotional film clips BPD-patients did not display heightened affect in response to any emotional stimuli compared to a variety of control groups (Kuo & Linehan, 2009; Staebler, Gebhard, Barnett, & Renneberg, 2009; Veen & Arntz, 2000). In contrast, BPD-patients were sometimes shown to report more negative affect after confrontation with all kind of emotional film clips when compared to depressed or non-patients (Jacob et al., 2008, 2009). Laboratory emotional reactivity studies using stimuli like personalized scripts or anger-induction interviews did not find BPD-patients to react differently than other groups (Lobbestael et al., 2009; Schmahl et al., 2004). The third line of studies used ambulatory assessment to track alternations in affect over time. Only a handful of studies included clinical control groups, but findings are mixed as to whether the observed emotional hyperreactivity is BPD-specific, or rather a trans-diagnostic phenomenon (see e.g. Santangelo et al., 2014; Trull et al., 2008).

Taken together, results of previous studies on emotional reactivity vary across stimulus type (e.g., film clips, personalized scripts), emotional valence of the stimulus (i.e. neutral, positive, negative, anger- or abuse-related), comparison groups (i.e. non-patients, other Axis I or II groups), and emotional outcomes (self-reported total negative affect vs. specific emotions). There are hardly any studies that included enough variation across these factors to allow drawing specific conclusions about the presumed emotional hyperreactivity in BPD. The current study aimed to fill this gap by designing an experiment with the following characteristics; (1) film clips were selected as stimulus type because their dynamic nature optimally mimics reality, a meta-analysis showed them to be among the most potent subjective and physiological emotion induction methods (Westermann, Spies, Stahl, & Hesse, 1996), and media presentations were the most commonly reported trigger of recall of victimization by abuse victims (Elliott, 1997); (2) four differently valenced film clips were used; childhood abuse by primary caregivers, peer bullying, positive, and neutral. The first film clip can be considered BPD-specific because BPD-schemata have been shown to mainly center around abandonment, rejection and abusive themes (see Lobbestael & Arntz, 2012 for an overview) and there is a large body of evidence showing BPD to be related to abuse by primary caregivers (Bierer et al., 2003; Johnson, Cohen, Chen, Kasen, & Brook, 2006; Lobbestael, Arntz, & Bernstein, 2010); (3) both a non-patient and a Cluster C personality disorder comparison group were included to allow drawing personality disorder specific conclusions; and (4) the impact of the film clips was assessed on self-reported tension, depression, anger, vigor, and fatigue, and total negative affect.

There is a possibility that BPD-patients display increased baseline levels of emotional intensity (Kuo & Linehan, 2009). Indeed, some studies demonstrated a negative baseline affect in BPD but also in other pathological comparison groups (Kuo & Linehan, 2009; Lobbestael et al., 2009; Lobbestael & Arntz, 2010; Staebler et al., 2009), while others did not found higher negative baseline effect in BPD at all (Arntz et al., 2005; Veen & Arntz, 2000). Therefore, the current study will operationalize emotional reactivity as the change in self-reported emotions after confrontation with emotional film clips compared to a neutral film clip. This allows distinguishing whether possible higher emotional intensity in

BPD-patients is due to increased baseline levels or to increased reactivity. With this experiment, we aim to contribute to the knowledge on the disorder- and valence specificity of emotional reactivity in BPD, albeit restricted to the use of film clips and self-reported outcome measures. We hypothesize BPD-patients to respond emotionally hyperreactive after watching the BPD-specific film clip of childhood abuse by primary caregivers.

## 2. Method

### 2.1. Participants

Data were analyzed from  $N = 64$  female subjects, divided into three groups: patients with BPD ( $n = 24$ ) or cluster C personality disorder (CIC-PD,  $n = 17$ ) and non-patient controls (NpCs) without psychopathology ( $n = 23$ ). Patients were recruited from the general community and mental health care institutions within the Netherlands and Belgium. General exclusion criteria were psychotic or bipolar disorder, age  $<18$  and  $>65$ , intoxication by alcohol or drugs during testing, IQ below 80 and not being native speaker of the Dutch language. The CIC-PD patients were not allowed to have more than two BPD criteria, and NpCs could not have an Axis I or II disorder. The characteristics of the study groups are presented in Table 1.

Testing of between group differences revealed that there were no differences in age, education level or marital status.<sup>1</sup> The BPD group had significantly more axis II disorders than the CIC-PD group. There were no differences in number of axis I disorders.

### 2.2. Materials

#### 2.2.1. Screening instruments

Dutch versions of the Structured Clinical Interview for DSM-IV Axis I and Axis II disorders (SCID I and SCID II, First, Spitzer, Gibbon, & Williams, 1997; First, Spitzer, Gibbon, Williams, & Benjamin, 1994; Van Groenestijn, Akkerhuis, Kupka, Schneider, & Nolen, 1999; Weertman, Arntz, & Kerkhofs, 2000) were used to assess DSM-IV axis I and II diagnoses. Previous studies have supported the reliability and validity of the SCID I and II. Inter-rater reliability proved to be adequate for SCID I (Lobbestael, Leurgans, & Arntz, 2011; Martin, Pollock, Bukstein, & Lynch, 2000; Zanarini & Frankenburg, 2001; Zanarini et al., 2000) and SCID II (Lobbestael et al., 2011; Maffei et al., 1997; Weertman, Arntz, Dreesen, van Velzen, & Vertommen, 2003). Furthermore, internal consistencies of the trait scales of the SCID II were satisfactory (Maffei et al., 1997). Interviewers were extensively trained and supervised by the first author.

#### 2.2.2. Emotional states

Self-reported affect was assessed with the Profile of Mood States (POMS), short version (McNair, Lorr, & Droppleman, 1992), with five subscales of tension, depression, anger, vigor, and fatigue, and one total negative affect score. Participants had to indicate to which degree each of the 32 items suited their current emotional state on a 5-point likert scale ranging from 'not at all' to 'very strong'. The internal reliability of the subscales of the Dutch version of the POMS appeared to be good (De Groot, 1991). The five-factor model of the Dutch version demonstrated to outperform a one-factor model (Wald & Mellenbergh, 1990; Wicherts & Vorst, 2004).

<sup>1</sup> Further analyses did reveal that age marginally affected the group comparison scores. Therefore, age was added as a extra predictor in all group analyses.

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