Atypical Emotional Responses in Borderline Personality Disorder and Implications for Intervention

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Abstract. Borderline personality disorder (BPD) is defined as a mood instability personality disorder. Generally, people with BPD develop suicidal, self-harming behaviors, and comorbid disorders, such as major depression disorder (MDD) and anxiety disorder. BPD is mainly caused by traumatic experiences and abuse in childhood. The symptom of BPD usually begins at adolescence. According to the previous research, BPD patients expressed more negative emotions comparing with typically developing group. Their reference activity (RA) and reflective function (RF) are both damaged. Besides that, BPD patients are also different from the norm in terms of self-consciousness at two aspects. Additionally, BPD patients may experience emotional dysregulation and loss of emotional goals. They have greater aggressive tendency rather than cooperation. Moreover, BPD groups were difficult to discern ambiguous facial emotions, and traumatic experiences can also influence the facial recognition barriers. Regarding interventions for BPD, BPD patients are taught to use the emotional labels to regulate emotions. After intervention, BPD groups improved their patience and adjusted their emotional difficulties. In the previous studies, the samples were relatively small, and no long-term observation were conducted. Future research should adopt longitudinal designs to enable deeper understanding of this area. This review can give some suggestions to intervention studies and practices for adolescents who are at risk of BPD.

Keywords: Borderline Personality Disorder; invention; emotional response; emotional dysregulation

1. Introduction

Borderline personality disorder (BPD) describes a group of patients that are not belong to the psychotic and the psychoneurotic [1]. Destabilization in interpersonal relationships and self-image are characteristics of BPD. Individual with BPD tend to show impulsive behavior and always seem to be in conflict with the world around them [2]. Besides that, suicide and self-destructive behavior are also common in adolescent BPD patients. More than 70% of BPD attempted to conduct suicide at least once in their lifetime, and up to 10% suicided [3]. Beyond that, unstable relationship is also as a main symptom in BPD. Patients might experience a change from excessive admiration to severe disdain. Attempts to escape actual or perceived desertion may stain relationship.

In addition, BPD is also accompanied by other comorbidities. More than 71% to 83% of BPD patients comorbid with MDD and 88% of patients have an anxiety disorder in their lifetime [1]. It results in overlapping symptoms with other disorders in the symptoms of BPD. In addition, both severity of psychiatric diagnoses and the Big Five of personality traits were also taking into consideration regarding the diagnosis of BPD [1]. Negative affectivity, rejection capability and psychoticism are defined as characteristic of BPD [1].

Currently, psychotherapy can ultimately provide some improvements in BPD patients. However, the fluctuating interpersonal attitude of BPD patients can also make treatment difficult. The currently available treatment method for BPD is dialectical behavioral therapy (DBT), which is considered the best choice. It can greatly reduce the disorder's most difficult features, such as parasuicidal behavior. Psychiatric hospitalization, and treatment abandoning. In addition, transference focused psychotherapy (TFP) and cognitive behavioral therapy (CBT) are also effective in treating BPD [4].

In the existing literature, researchers focused on the emergence of BPD and the characteristics of the disease in patients with BPD at different ages. Typically, BPD characteristics first manifest in teenagers and many in the forms of aggressive conduct and emotional instability [1]. More than 30% of adults with BPD reported their self-destructive behaviors when they are age 13 [1]. Childhood

trauma, abuse (e.g., physical or sexual), mental and life pressure, parental neglect and wrong parenting style seem to be the main causes of BPD [1].

Recently, although the developments related to BPD have been recognized by pubic, the knowledge of atypical emotional response of BPD and interventions is continued to be lacking. This article integrated the latest view about atypical emotional response of borderline personality disorder and give some advice to intervention. In addition, this article discusses from regulation, perception, and intervention about emotional processing difficulties in BPD. It also provides some contributions to research on the diagnosis and intervention of BPD in early adolescents.

2. Emotion Related Deficits in BPD

2.1 Atypical Emotional Outcomes in BPD

Patients with BPD often exhibit negative emotional responses, which may be due to a variety of factors. The study by Fertuck et al. suggested that BPD has more expression of negative emotions rather than expression of positive emotions. In the study, the reference activity (RA) assessed that use verbal sign to represent arousal and emotional experiences in a specific and abundant way, and the narrative of low RA always used nonrepresentational, common, and ambiguous language. BPD group performed better RA on three dimensions which are concreteness, specific and imagery. In addition, it is possible that BPD group had a higher capacity for vocalizing and signifying emotions. Because of segmented characterizations which are particularly engendered in the presence of negative emotional responses have been found more active in this group.

Moreover, the capacity to articulately conceptualize is known as reflective function (RF), which is a scale for evaluating approach helps from narrative generated by people during in the test. High RF level convey a comprehensible and believable characterization of one's own and others' motives, feelings, perceptions, and preferences. As well as how these psychic elements influence relationship behaviors. The reflective function (RF) in BPD was also lower than healthy group.

The result of this study showed that on object relationship scale, BPD groups had a higher frequency on representation of a horrible feeling and lower frequently do pleasant emotions get expressed. On adult attachment interview and object relation interview, BPD group both shows less positive emotion rather than healthy control group. BPD group has a higher level in RA and lower level in RF in their narration [5].

In addition, some types of self-conscious emotions also influence BPD patients in terms of emotional regulation. Shame as the perceived ego deficiency leads to negative feelings about the whole self. It has a significant related with misery and psychopathology. Compare with shame, guilt results from a moral infraction, whether real or imagined, for which another individual has suffered. Shame entails considering one's whole self to be worthless, and guilt tends to be a type of prosocial phenomenon with the intention of preserving, bolstering, and safeguarding crucial relationships. In the previous study investigated the self-conscious emotions, such as shame and guilt. Researchers used a test which examine implicit self-concept, to measure the shame and guilt relations. Self-conscious emotion is a distinguishable social feeling evoked by a subset by actual or imaginary interpersonal interaction. It was mainly concerned with three processes: self-awareness, other-awareness, and social norm-awareness. The research showed that the BPD group has a higher score in explicit and implicit Guilt-measurement than the control group. The reaction time (RT) were metrics to assess the relative importance of hidden relations between notions (e.g., self vs. others) and qualities (e.g., embarrassed vs. prideful or accused vs defenseless), with the assumption that fast load velocities contribute to greater affiliations. The result of this study showed significantly more implicit self-concepts of shame and guilt in females with BPD. Moreover, the research also showed that guilty has a strong influence on self-destructive behaviors. The finding supported that self-punishment as a poorly functioning response to a sense of guilt constituted one of the most common reasons for non-suicidal self-mutilation. Therefore, the difficulties of self-conscious emotion can also exacerbate the conditions of BPD patients [6].

2.2 Deficits in Emotional Regulation

Generally, people believe that BPD patients have difficulties in defining their emotional goals. Emotional goal is a type of mental images of the intended emotional outcomes. It adjusts the levels of both positive and negative emotions to match the intended emotional experience more closely. This emotional experience is related with how well the sentiment suits the situation rather than the value. The likelihood of experiencing happy is decreased and the likelihood of having negative emotions is increased for the typical person when they have excessive emotional goals for happiness. According to López-research Pérez's, a BPD is associated with difficulties regulating emotions as well as emotional goals. The basis of emotion regulation, which can decide the course of regulation attempts, is thought to be suitable for contextualized emotional objectives or particular emotional endpoints that support goal achievement. Emotional goals can alter the path of emotional processing by boosting or lowering both positive and negative feelings to resemble the intended exciting response more closely. For those who have BPD greater problems in emotion management is associated with a clear trend for aggressive and a greater tendency for aggressive cooperation. To be specific, the possible greater predilection for rage is an emotional goal in BPD patients. Such that, BPD has a stronger preference for aggression over cooperation was connected to impairments in emotion management. Thus, when exposed to equivocal scenarios, people with BPD may have a larger propensity for aggressive, more unexpected wrath shifts, and a greater anger bias [7].

Besides that, BPD patients also have unique behavior responses to match their emotional responses. BPD patients tend to overuse maladaptive strategies to fix their negative emotions. Southward et al. examined the relations with behavioral responses and emotions in borderline personality disorder. It also discussed the daily emotional experience in BPD and behavioral responses to emotions in patients with BPD. The emotion of the BPD group fluctuated on a daily basis or from one day to the next and BPD group always responded to neutral or negative emotions. This study's findings showed that BPD patients frequently express neutral to negative feelings. Participants in the current study most consistently cited feelings of worry and joy when measuring discrete emotional responses. BPD participants' behavioral responses in terms of reported using this strategy most frequently in response to pleasure or happiness in the current study. This resulted in a favorable correlation between scratching and the intensity of positive emotions, which may mean that people with BPD have adapted to responding behaviorally to positive emotions. However, BPD patients could face more distressing emotional circumstances, which lowers their perception of their capacity or efficacy to use coping mechanisms. These findings implied that anxiety predominates in people with BPD's emotional experience and correlates with a number of emotions correlated with strategies aimed at extending the emotional experience, in contrast to strategies aimed at regulating emotions [8].

2.3 Unusual Patterns of Emotion Perception in BPD

People react differently to traumatic experiences. Some people will not show visible signs but may develop stressful behaviors after experience significant trauma. Traumatic experiences during in BPD’s lifespan also related to the error evaluation when they try to explain others’ facial expressions. In the previous exams that the substantial deterioration of social communication and interaction was caused by perception, such as the recognition of facial emotions, in BPD patients. According to a meta-analysis, BPD patients frequently perceived neutral statements as emotional and struggle to recognize emotional displays of wrath and disgust when patients are expressed with all of their emotional resonance. Besides that, BPD patients tended to give prejudicial assessments of equivocal facial expressions indicative of wrath and demonstrate a pronounced bias against recognizing facial emotions, also their propensity to excessive emotional empowerment to emotionless faces. Thus, BPD patients displayed a skewed focus on risk cues in aggregate or on particular noxious feelings. Researchers used an eye-tracking study to exam the facial expressions of ambiguous emotions in BPD. Generally, people exhibit early concentration and focus on the eyes, particularly whenever an emotional expression is shown. There is more evidence supporting that trauma experience is also related to the prejudiced interpersonal perceptions. Patients in BPD with comorbid post-traumatic

stress disorder (PTSD) have visual attention bias to angry facial expressions and increased visual attention to the eyes area. This group also focused on angry/happy and fearful/sad blends longer than without PTSD. Therefore, BPD is not entirely due to a problem with facial emotion identification. In addition, the visual attentional bias to hazy facial expressions could be trauma-related as well [9].

3. Relevant Interventions for BPD

As discussed above, emotional dysregulation and emotion regulation deficit are major symptoms of BPD patients. Emotional label would be a path of intervention for BPD to regulate their emotions, and they need to learn how to label their emotions. According to the previous study, it discussed the effect of emotional labels of BPD patients on adjust emotion. Emotional label is defined as use a particular word to describe a type of emotion. Researchers considers that DBT as the treatment of BPD improves the ability to control emotions to regulate emotional openness and address deficiencies in emotion control. Both DBT and CBT place a strong emphasis on teaching clients how to define their emotions in order to reduce their negative feelings. Emotional label as the amount to which individuals construct their own labels may influence an accidental emotion management technique. People in BPD are thought to have problems regulating their emotions and show more feelings of hopelessness. Thus, emotional label looks like a challenge for BPD patients, and it is a common sense that state dissociation in BPD. Emotional label affects the accident emotion regulation and intentional emotion regulation. Moreover, emotional label also affects the accident emotion regulation that inhibits emotional response, and intentional emotion regulation defined as cognitive reappraisal and mindfulness. The BPD group's self-reported accidental emotional modulation may be enhanced by emotion labelling rather than intentional emotion regulation [10].

Interpersonal relationship environment also relates to the dysregulation of emotions in BPD. The study by Cardona et al. determined that the precise relationships between prompting events and chosen regulatory tactics (adaptive and maladaptive) have yet to be determined of emotion dysregulation. According to the ecological momentary assessment (EMA), which is people frequently report on their in-the-moment experiences, can indicate trends in the particular circumstances and feelings that give rise to particular behaviors. BPD patients reported that they have a higher level of quantity and strength in negative emotions. Researchers focused on the self-report by participants on prompting events, discrete emotion, and regulation strategies through daily diary. Participants are most frequently reported achievement oriented as prompting events. BPD patients tended to use problem-solving and intentional avoidance to alter their emotions. Besides that, understanding discrete emotions in BPD patients was more likely to help predict the use of specific adverse emotion regulation strategies. After receiving a short skills training, BPD patients can improve the use of adaptable methods [11].

As mentioned above, interventions for RF can also help people with BPD coordinate their emotions, and it is an approach adopted by many psychotherapeutics. The study by Kivity et al. investigated RF as an important point in self-growth, social learning, and emotional regulation. BPD patients are considered dysfunctional in reflective functioning. There is a treatment called TFP, which is psychodynamic therapy, related to increasing reflective functioning. According to the research, encouraging patients thinking about their cognitive processes enhanced the accuracy of RF, and indicated less excitement in verbally transmitted speech. Thereby, RF facilitates significance that encouraged the equipped for a social and emotional experiences, thus boosting patience and regulating disturbing mental states. Therapist talk-turns were graded on whether they requested that individuals think on their mental state (bids for RF) or not. The result of this study was TFP had twice the number of bids as DBT and SPT. Moreover, in TFP, the RF score increased only during an attachment interview in pre-intervention and post-intervention rather than in conversation [12].

4. Conclusion

BPD is a type of comprehensive disorder. The patients always have more negative emotional expressions, and they tend to have more aggressive behaviors. According to previous research, BPD groups have a greater ability in expression and symbolization, and their RF level is lower than the control group. In addition, self-consciousness is also related to the atypical emotional response in BPD. The emotional regulation of BPD patients also varies more than the healthy group, which may be due to the influence of wrong emotional targets. BPD patients prefer to lash out at emotional goals and misinterpret neutral feelings as negative. Anxiety emotion is a dominant status in BPD emotional experience. The atypical emotional response also embodies the perception of confusing facial expressions that are biased. BPD patients may have prejudice toward risky cues. On the invention aspect of BPD, researchers focused on the effect of emotional labels on regulating emotions, as they can evoke the emotional regulation system. Moreover, TFP also can increase the RF accuracy of BPD which can improve the patients' cognition and reduce emotional dysregulation. Despite these views, there are also some limitations of previous studies. Most samples of the research are WEIRD and usually focused on the young people. For more comprehensive findings, researchers need to focus on a more diverse sample to obtain a wider range of results. Moreover, researchers also need to conduct longitudinal studies to determine the long-term impact. This article can provide some new perspectives for future diagnosis, intervention, and treatment of BPD in adolescents.

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