



Parsing sensitivity to negative affect in borderline personality disorder: A comparison of anxiety and disgust



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ABSTRACT

Difficulty tolerating emotional distress is a core feature in theoretical accounts of borderline personality disorder (BPD). However, few studies have attempted to parse emotional sensitivity in BPD in terms of specific qualities of negative affect. The present study compares the incremental validity of anxiety sensitivity (AS) and disgust sensitivity (DS) in predicting concurrent symptoms of BPD. Prior to receiving treatment, patients at a partial hospital ($n = 134$) completed measures of AS and DS in addition to a larger survey battery and clinical interview. This study found that AS, but not DS, was correlated with BPD symptoms, and AS continued to predict concurrent BPD symptoms when controlling for demographic variables, symptoms of anxiety and depression, and experiential avoidance. However, the relationship between AS and BPD symptoms was partially mediated by experiential avoidance, consistent with prior research using a categorical approach to BPD symptoms. The AS domain of cognitive concerns was most robustly related to BPD symptoms. These findings highlight the importance of distinguishing between specific negative affects when conceptualizing emotional sensitivity in BPD and may suggest new avenues for treatment through targeting specific sensitivities.

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Borderline personality disorder (BPD) is estimated to affect 1.6% of the population (American Psychiatry Association [APA], 2013) and is defined by a pattern of instability in one's identity, relationships, and emotions, with accompanying impulsivity, self-harm, fear of abandonment, anger, feelings of emptiness, and stress-induced paranoia (APA, 2013). While the pathophysiology of BPD remains elusive, these diverse symptoms appear to arise from an underlying emotional dysfunction. Linehan's (1993) influential biosocial theory, for example, proposes that BPD is rooted in an overly reactive emotional temperament that elicits an invalidating social environment. Indeed, a wealth of research documents heightened emotional responding in BPD through self-report, psychophysiological, and neuroimaging measures (see Rosenthal et al., 2008).

However, the precise nature of these emotional problems remains unclear. Some have attempted to parse emotional dysfunction in BPD by distinguishing between a primary emotional response to a stimulus and a secondary response to the emotion itself (Gratz & Roemer, 2004; Linehan, 1993). While BPD is believed to involve exaggerated, dysfunctional responding at both levels, secondary 'meta-emotional'

responding appears to be more central to BPD. Linehan (1993) has proposed that BPD involves deficits in emotion regulation, and in particular, difficulty tolerating emotional arousal. This sensitivity to emotion can lead patients with BPD to engage in experiential avoidance, which encompasses several strategies used to suppress or modify internal events (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Indeed, hallmark symptoms of BPD, such as dissociation and self-harm, can be viewed as experiential avoidance strategies that distance or distract oneself from unwanted, painful emotions that are perceived as intolerable (Chapman, Gratz, & Brown, 2006).

In research on anxiety-related disorders, there is a similar distinction between primary and secondary emotional responding, in which an individual's propensity to experience an affective state is distinguished from the individual's sensitivity to the emotional state itself (Taylor et al., 2007; van Overveld, de Jong, Peters, Cavanagh, & Davey, 2006). Whereas research on BPD focuses on sensitivity to emotional arousal in general, research on anxiety-related disorders has begun to identify robust individual differences in sensitivity to specific qualities of negative affect. Researchers have established the traits of anxiety sensitivity (AS; Reiss, Peterson, Gursky, & McNally, 1986) and disgust sensitivity (DS; van Overveld et al., 2006) as psychometrically distinct from their respective propensities and capable of predicting unique clinical phenomena. AS and DS are the only specific negative affective sensitivities

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that have been thoroughly studied, and hence were the focus of this study; however, recent work has sought to establish an additional trait of guilt sensitivity (Melli, Carraresi, Poli, Marazziti, & Pinto, 2017).

Anxiety sensitivity (AS; Taylor et al., 2007) refers to individual differences in the tendency to interpret the somatic, cognitive, and social effects of anxiety as threatening. For example, an individual high in AS would be more likely to interpret a pounding heartbeat as a sign of heart disease and, in turn, would find the sensation more unpleasant and difficult to tolerate (Schmidt, 1999). AS may be relevant to BPD, as patients with BPD show elevated anxiety (Gunderson & Singer, 1975), and have comorbid anxiety-related disorders (e.g., McGlashan et al., 2000). Anxiety also appears to be particularly difficult to regulate for patients with BPD (Livesley, Jang, & Vernon, 1998). Psychometric studies have identified three components of AS: concern with physical manifestations of anxiety that might indicate somatic illness (e.g., rapid heartbeat), concern with cognitive manifestations of anxiety that could indicate mental illness (e.g., dissociation), and concerns with social consequences of anxiety such as public embarrassment. The physical component of AS may be less central to BPD than it is in anxiety-related disorders (e.g., generalized anxiety disorders, post-traumatic stress disorder, panic disorder; see Naragon-Gainey, 2010), because BPD is not defined by the chronic experience of physical symptoms of anxiety, hyper-arousal, or concerns with the bodily sensations of anxiety. Instead, the cognitive component of AS may be more relevant, due to the frequency of dissociation in BPD. Also, the social component of AS may be relevant to BPD due to the frequency of concern with abandonment in patients with the disorder.

Similar to AS, disgust sensitivity (DS) encompasses individual differences in the tendency to interpret the experience of disgust as threatening (Van Overveld et al., 2006). For example, an individual high in DS might interpret nausea associated with disgust as a sign of infection, illness, or impending vomiting, and in turn find the experience more aversive and difficult to tolerate (Van Overveld et al., 2006). Unlike spider phobia or contamination-based obsessive-compulsive disorder, BPD is not defined by concerns with stimuli that frequently elicit disgust, which may suggest that individual differences related to disgust have less relevance in BPD. However, there is increasing evidence that more abstract stimuli can elicit disgust. Chapman, Kim, Susskind, and Anderson (2009) found that disgust can be elicited by moral transgressions that do not involve concrete disgust elicitors (e.g., violating principle of economic fairness). It is possible that perceived transgressions by others, which elicit the BPD symptom of intense anger, may also elicit disgust, particularly if the transgressor is perceived as base and inferior due to the transgression. Others have suggested that disgust can be elicited by abstract appraisals of oneself ("self-loathing"; Ille et al., 2014). Self-disgust could be relevant to negative self-perceptions in BPD and perhaps the urge to self-harm.

Parsing intolerance of emotional experiences into distinct constructs, such as AS and DS, may further understanding of BPD. Although no studies have directly compared the links between these traits and symptoms of BPD, some have examined these relations separately. Lilienfeld and Perna (2001) found that AS predicted concurrent symptoms of BPD, but not after covarying for trait anxiety, indicating that AS may only be linked to BPD due to its shared variance with the broader trait of negative affect. However, this study used a convenience sample of unselected students, which may not have provided sufficient variability in symptoms of BPD. Gratz, Tull, and Gunderson (2008) addressed this limitation, examining levels of AS in outpatients diagnosed with BPD and a clinical control group of outpatients without a personality disorder. Gratz and colleagues found that elevated AS distinguished the BPD group from the clinical control group, and the effect of AS on BPD was mediated by experiential avoidance. In addition, these relationships remained when accounting for negative affect and other broad vulnerability factors. Thus, there is preliminary evidence that AS may play a unique role in BPD, perhaps by increasing experiential avoidance. However, it is not clear if these effects are specific to AS, or if they

would be observed for sensitivities to additional qualities of negative affect.

A small number of studies have documented an increased propensity to experience disgust in BPD. However, only one study examined secondary disgust responding, as captured by disgust sensitivity. In a study that compared patients with BPD to healthy controls, Schienle, Haas-Krammer, Schögl, Kapfhammer, and Ille (2013) found that BPD was characterized by elevated DS, in addition to higher disgust propensity and self-disgust. In addition, Schienle and colleagues found that within the BPD group, DS predicted the severity of concurrent BPD symptoms. However, they did not control for negative affect, leaving open the possibility that the relation observed between DS and BPD is explained by their shared relation to negative affect, rather than a unique contribution of DS to BPD.

Much of the prior research on the role of AS (Gratz et al., 2008) and DS (Schienle et al., 2013) in BPD has taken a categorical approach, comparing a relatively homogenous BPD patient group to a healthy control group (Schienle et al., 2013) or to a non-personality disorder patient group (Gratz et al., 2008). However, a taxometric analysis by Trull, Widiger, and Guthrie (1990) suggests that BPD is best conceptualized as dimensional, rather than categorical, with no clear boundary demarcating the presence or absence of BPD. In light of the dimensional nature of BPD symptoms, findings from studies that define BPD categorically may not generalize to the diverse samples representative of actual treatment settings.

The present study seeks to parse sensitivity to negative affect in BPD by examining the relative contributions of AS and DS in predicting concurrent symptoms of BPD, rather than categorical diagnoses of BPD, in a psychiatric sample. To assess the incremental validity of these traits in predicting BPD symptoms, we included demographic variables, negative affect (i.e., symptoms of depression and generalized anxiety), and experiential avoidance as covariates. In light of the stronger conceptual and empirical evidence for a link between AS and BPD, we predicted that AS, but not DS, would uniquely predict BPD symptoms. To provide further insight into the relation between AS and DS, we attempted to replicate Gratz et al.' (2008) finding that experiential avoidance mediates the effect of AS on symptoms of BPD. In light of the multidimensional nature of AS, we also examined which components of AS show the strongest link to BPD and predicted that cognitive and social, but not physical domains of AS would predict BPD symptoms, consistent with Gratz et al. (2008).

1. Methods

1.1. Participants

Participants were patients ($n = 134$) receiving treatment at a partial hospital program in a northeastern private psychiatric hospital. Table 1 presents demographic and clinical information. Patients at the partial hospital present with complex, heterogeneous diagnoses that include mood, anxiety, psychotic, and personality disorders. Approximately half of patients are referred from outpatient treatment as a step up in the level of care, and half are referred from inpatient treatment as a step down in the level of care (see Björgvinsson et al., 2014; Kertz, Bigda-Peyton, Rosmarin, & Björgvinsson, 2012). Although formal diagnoses of BPD were not made, 19.4% of patients ($n = 26$) scored above the recommended diagnostic cutoff score of 7 on the McLean Screening Instrument for BPD (MSI-BPD; Zanarini et al., 2003), scores of which ranged from 0 (lowest possible score) to 10 (highest possible score) in the present sample.

1.2. Measures

DSM-IV diagnoses were established using the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), a structured interview for DSM-IV Axis-I disorders with strong reliability and validity

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