Complex Case
Emotional processing in a ten-session general psychiatric treatment for borderline personality disorder: a case study

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ABSTRACT
This study examines the effects of a borderline-specific treatment, called general psychiatric management, on emotional change, outcome and therapeutic alliance of an outpatient presenting with borderline personality disorder. Based on the sequential model of emotional processing, emotional states were assessed in a 10-session setting. The case showed an increase in expressions of distress and no change in therapeutic alliance and tended towards general deterioration. Results suggest emotional processing may play a lesser role in general psychiatric management in early phase treatment than previously hypothesised. Copyright © 2015 John Wiley & Sons, Ltd.

Introduction
Borderline personality disorder (BPD) was considered for a long time untreatable. Recent effective therapeutic interventions have however shown that adaptive emotional processing is a key component for treating BPD (e.g. Linehan, 1993; Warwar, Links, Greenberg, & Bergmans, 2008). This paper aims to explore emotional change in a borderline-specific outpatient treatment, termed general psychiatric management (GPM), a manual-based approach based on the American Psychiatric Association recommendations for BPD (American Psychiatric Association, 2001). GPM consists of a combination of (1) dynamically informed psychotherapy focusing on disturbed attachment patterns and the enhancement of emotion regulation in relationships; (2) case management; and (3) symptom-targeted medication. In the first empirical evaluation of GPM, McMain et al. (2009) compared it to dialectical behaviour therapy, the most studied empirically proven treatment for BPD. Evidence of the effects of GPM underlined its usefulness on producing significant reductions in suicidal and non-suicidal self-injurious behaviours, specific borderline symptoms, general distress, depression, anger and improvements in interpersonal functioning after 1 year of treatment. Moreover, no significant differences between treatments were found. A 2-year follow-up study (McMain, Guimond, Streiner, Cardish,
& Links, 2012) showed that the effects of the treatment were either sustained (general and borderline psychopathologies and suicidal and non-suicidal self-injurious behaviours) or improved (anger, depression and interpersonal functioning). If supplementary empirical evidence were to confirm these findings, GPM could be considered an addition in the limited, yet growing, viable treatments for BPD.

**Emotional change in psychotherapy**

Appropriately managing intense feelings when treating BPD has been underlined in practice guidelines (e.g. American Psychiatric Association, 2001). Indeed, emotions are a vital meaning system, helping to adopt appropriate behaviours when interacting with the environment and when regulating interpersonal relations. Therefore, effective emotional use requires blending the ability to experience and accept emotion and the ability to regulate and change emotion (Greenberg & Paivio, 1997). To explore the effects of GPM on emotional processing, this study will use the sequential model of emotional processing (Pascual-Leone & Greenberg, 2007; Figure 1), which tracks in-session emotion progression. In sum, three levels of components have been identified, based on their hypothetical contribution to therapeutic change: (1) states that can be collectively described as early expressions of distress (EED); (2) intermediate states of meaning and symbolization; and (3) states that facilitate advanced meaning-making (AMM).

The aforementioned studies have shown that GPM affects outcome, which in turn has been shown to be affected by emotional processing (e.g. Greenberg & Pascual-Leone, 2006). However, no study has looked at the effects of GPM on emotional processing. The goal of this study is thus to tentatively link these two areas of process research by examining the minute-by-minute emotional change of a patient presenting with BPD in a 10-session early phase treatment. Our hypotheses are that (1) the frequency of EED will remain stable or decrease over the course of treatment; (2) an increase in the frequency of the intermediate level and (3) a possible increase in AMM will occur, thus showing a more effective emotional processing leading to (4) better outcome and (5) greater alliance progression across early phase treatment.

*Figure 1: The sequential model of emotional processing (modified from Pascual-Leone & Greenberg, 2007)*
Method

Treatment

The case participated in a randomized controlled trial studying the effects of GPM on BPD outpatients in early phase treatment (Kramer et al., 2014). A manual was elaborated in order to adapt GPM treatment principles to 10 sessions. The objectives were to (1) establish reliable psychiatric diagnoses and their communication to the patient; (2) establish a psychiatric anamnesis; (3) identify the main problems and the treatment focus; (4) define short-term objectives and enhance motivation; (5) identify and deal with treatment-interfering problems; and (6) formulate relational interpretations of core conflictual themes.

The case

Rachel is a 20-year-old woman referred by her previous psychiatrist because she presents suicidal ideation and cutting of the forearms. She was taken into treatment after being discharged from her second hospitalization after a 3-week stay. She wishes to stop her apprenticeship because of professional tensions and says she feels ‘under pressure’ with too many responsibilities. She asked for a treatment to enable her to get to know herself better and to feel better. Depressive symptomatology is at the forefront, so are very painful feelings such as a sense of inadequacy and marked self-devaluation. She feels foreign to herself and others. She cries a lot and is in a state of perplexity. She feels a great void, a lack of love; fears loneliness, abandonment and separation with the absence of a reassuring figure causing anxious and depressive symptoms; and presents asthenia. However, she also states that she needs to get away from others and to isolate herself. Rachel places the beginning of her unhappiness with the discovery of her younger brother’s leukaemia. Her mother was primarily concerned with him, and her father grew increasingly withdrawn. She expresses her great fear of losing her brother and at the same time felt much anger toward her parents who she felt minimized her existence. During her brother’s illness, Rachel developed an eating disorder (anorexia). The crux of her problem appears to be her difficulty in emancipating herself: the fear of being independent and responsible provokes movements of regression.

At intake, Rachel was diagnosed with a severe depressive episode without psychotic symptoms (Hamilton score: 23) and BPD and schizotypal traits. Adjunct pharmacotherapy was used to aid with anxiety and her difficulty sleeping. She benefited from a crisis treatment at the same time as early phase treatment, the latter lasting 10 sessions and consisting of one session per week. Rachel later engaged in psychotherapy.

Instruments

Classification of Affective-Meaning States (CAMS) (Pascual-Leone & Greenberg, 2005) is an observer-based rating system developed for the systematic identification and measurement of emotion states. The CAMS uses 12 nominal codes, which include the emotion states of the aforementioned model (Figure 1).

Outcome Questionnaire-45.2 (OQ-45) is a self-report questionnaire designed to repeatedly assess patients’ progress during therapy through three subscales: symptom distress, interpersonal relations and social role functioning, which can be summed to form a general mental health score.

Working Alliance Inventory—short version (WAI-S) is a 12-item self-reported questionnaire assessing three subscales: goal, task and bond. Two parallel forms of the WAI-S exist assessing the relationship either from the patient’s or the therapist’s perspective.

Procedure

The sessions were audio-taped except for the intake session, which was video-taped. The CAMS was used to assess four sessions—the intake, S3, S6 and S7—by coding 2-min blocks. The patient filled in the OQ-45 at intake and at the end of treatment. The patient and the
therapist filled in the WAI-S at the end of each session. One PhD candidate and one senior researcher were involved in the ratings of the CAMS. Both have over 2 years of extensive training in using the coding system and were supervised by the first author of the scale.

Results

CAMS coding reliability was considered good with 83% of agreement (κ = 0.59). 93 2-min blocks were coded for all four sessions (Table 1). Once the non-specific ‘uncodable’ codes—suggesting either little marked or mixed emotional arousal—were removed, global distress (29 codes for all four sessions, representing 58% of all codable units) is the most dominant affective-meaning state, followed by fear/shame (20%) and negative evaluation (14%). The frequency of EED increases between intake (12) and discharge (16) (strong increase in global distress, stability in fear/shame; Figure 2), with the exception of S3; however, this sudden change is not maintained in the following sessions. No AMM is present at either time.

On the outcome level (Table 2), all scores are above the clinical cut-off at both intake and discharge. More specifically, Rachel presents a reliable symptom increase and no change in the other two subscales over the 10 sessions, leading to a 12-point increase in the total outcome score, which represents a strong tendency towards a general negative change.

On the alliance level (Figure 2), scores remain stable throughout treatment for both the patient (intercept = 59.93; slope = 0.35; R² = 0.61) and the therapist (intercept = 63.57; slope = −0.52; R² = 0.16).

Discussion

This case aimed at exploring the effects of GPM on emotional processing. In regards to the hypotheses made, the results show that (1) the frequency

<table>
<thead>
<tr>
<th>Affective-Meaning States</th>
<th>Total of units</th>
<th>Codable units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Global distress</td>
<td>29 (58%)</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>2. Fear/shame</td>
<td>10 (20%)</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>3. Rejecting anger</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>4. Negative evaluation</td>
<td>7 (14%)</td>
<td>7 (14%)</td>
</tr>
<tr>
<td>5. Existential need</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>6. Relief</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>7. Grief/hurt</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>8. Self-soothing/assertive anger</td>
<td>2 (4%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>9. Acceptance/agency</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Figure 2: Early expressions of distress and working alliance across treatment (raw scores). WAI, Working Alliance Inventory
of EED did not diminish or remain stable but increased; (2) a momentary change in intermediate states occurred in S3—less Negative Evaluation, emergence of an Existential Need—but was not maintained; (3) no increase in frequency of AMM was noted, except briefly Self-Soothing in S3; and thus, it was not possible to verify the effects of effective emotional processing on either (4) outcome or (5) alliance; nevertheless, a general outcome deterioration tendency and an unchanged alliance level were observed.

The findings suggest an emotional processing “profile” of distress: Rachel presents a global, vague and unspecific distress; she is uncertain of why the feelings exist, and the observer is unable to determine from what she is suffering (e.g. ‘I feel so sad’). The negative emotions remain ‘fused’ together. This state is characterized by feeling as one is a victim of emotional suffering. Additionally, the expression of harsh and overt self-criticism, usually indicating shame about her competence in the world or ability to have relationships, and fear towards the danger of being destroyed as a result of abandonment, rejection or personal incompetence are present.

We wish to point out several limitations of the study. First, these findings should be interpreted with caution as it is not yet known if they are generally applicable. Indeed, the diagnosis of BPD is diverse, and the need for specific assessment of BPD symptomatology was underlined. Second, changes in emotional processing may occur after 10 sessions, previous studies on GPM being based on a longer treatment setting (1 year). A possible explanation for the effects of GPM found on emotional processing, outcome and alliance variables may be that the patient was in a state where she benefited more from containment, support and structure than actualization aiming at fulfilling her potential. Ultimately, all conclusions remain tentative at best, as idiosyncratic variables related to the patient–therapist interaction may have influenced the results on emotional processing.

In addition to confirming the relevance and feasibility of using the CAMS on BPD patients, this case has provided interesting data and ideas such as the possibility of identifying different emotional processing degrees as starting points—in Rachel’s case, global distress—and of distinguishing their potential evolution.

References


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