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Article: Self-contempt, the working alliance and outcome in treatments for borderline personality disorder: an exploratory study

Authors: and affiliations:

Laura Sallin [1], Isabelle Geissbüehler[1], Loris Grandjean[3,4], Hélène Beuchat[3,4], Chantal Martin-Soelch[1], Antonio Pascual-Leone[2] & Ueli Kramer [2, 3,4]

[1] Reach Lab Unit of Clinical and Health Psychology, Department of Psychology, University of Fribourg, Switzerland

[2] Department of Psychology, University of Windsor, Canada

[3] Institute of Psychotherapy, Department of Psychiatry-CHUV, University of Lausanne, Switzerland

[4] General Psychiatry Service, Department of Psychiatry-CHUV, University of Lausanne, Switzerland

Corresponding author: Laura Sallin; e-mail: laura.sallin.93@gmail.com

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Abstract

Objective. We examined the role of expressed self-contempt in therapy for borderline personality disorder (BPD). Based on previous literature on BPD, we assumed an association between the self-contempt and the core symptoms of BPD. We also studied the progression of expressed self-contempt during the treatment and its effect on the alliance and the outcomes of treatment.

Method. We rated the expressed self-contempt in 148 tape-recorded sessions with patients with BPD (N = 50), during a brief psychiatric treatment. We rated self-contempt at three time-points, using an observer-rate scale. Self-reported questionnaires were used to assess symptoms and the working alliance.

Results. There are some associations between self-contempt and BPD symptoms. Expressed self-contempt did not change during the treatment. One measure of self-contempt was associated with a weaker alliance rated by the patients and with a stronger alliance rated by the therapists. The expression of high self-contempt was not predictive of outcomes when the initial level of problems was controlled for.

Conclusions. The results highlight the importance to examine the complex effects of self-contempt in BPD undergoing treatment in a differentiated manner and suggest to clinicians and researchers to be attentive to this specific emotional state, and change therein, in psychotherapy.

Key-Words: Self-contempt; Borderline Personality Disorder; Brief Treatment; Therapeutic Alliance; Emotion

Introduction

The role of expressing emotions has been demonstrated to be central for psychotherapy outcomes (Peluso & Freund, 2018). Beyond these general conclusions, it was argued that the *type* of emotional experience that is being expressed is crucial for understanding the role of expressed emotions in psychotherapy (Greenberg & Paivio, 2007; Kennedy-Moore & Watson, 2001). While the adaptiveness of emotional experience is assumed (Frijda, 1986), a differentiation should be introduced between adaptive and maladaptive in-session emotional experiences (Greenberg & Goldman, 2019; Pascual-Leone & Greenberg, 2007). As such, it becomes of critical importance to study emotional processes that, when expressed in-session, may potentially interfere with the patient's accessing of the underlying, more adaptive, emotional experiences (i.e, such as the state of self-compassion), with the collaborative process, and ultimately with outcome in psychotherapy. Recent studies have highlighted the possible role of expressed self-contempt as a central maladaptive emotion in several psychopathological conditions and symptom presentations (Whelton & Greenberg, 2005; Kramer & Pascual-Leone, 2016). Such findings point to the need to extend our knowledge about this issue and its implications for the clinical context, especially with borderline personality disorder, which is marked by negative affectivity and disturbance of the Self (Ogrodniczuk, & Sierra Hernandez, 2010; Meares et al., 2011).

Ekman and Friesen (1975) described contempt as a basic emotional state of cold anger and disgust, to create a distance with the object of contempt. Self-contempt as bio-behavioral self-organization in humans tends to push away a part of the self, perceived by the person as intolerable, despicable or immoral (Kramer et al., 2020; Pascual-Leone et al., 2013). Self-contempt may be understood as a secondary (maladaptive) emotional process, in reaction to a more core vulnerable state of shame, grief or brittle sense of self (Greenberg, 2011). This emotion may be understood as a secondary and maladaptive form of anger, a *rejecting anger*

that is directed towards the self (Pascual-Leone & Greenberg, 2007; Kramer & Pascual-Leone, 2016; Pascual-Leone, 2018). It often goes beyond the verbal harsh devaluation of the self, culminating in a self-organized state of bodily sensed sensations that tend to "spit on" a part of oneself, or secondary avoidance of dealing with the core underlying problematic state (Kramer et al., 2020; Pascual-Leone et al., 2013). As such, it is different from self-critical behavior or cognition, which may be healthy and functional per se, as it allows humans to fundamentally connect to their personal values and motives. We assume that self-contemptuous organizations, on the contrary, *prevent* humans from connecting with their fundamental needs. So, the dysfunctional nature of self-contempt calls for a better understanding of its effects on clinical disorders and their treatment.

Borderline personality disorder (BPD) is defined in DSM-5 as "a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity" (American Psychiatric Association, 2013). This psychological disorder is associated with self-aversive behaviors, affects and cognitions, maladaptive anger (Gunderson, 2011; Brown et al., 2009; Winter et al., 2017) and a high risk of suicidality (Linehan, 1993; Black et al., 2004). In this context, self-contempt being a self-aversive form of maladaptive anger, we assume it may be central in BPD, and also that it may impact its treatment in subtle ways. This is because it was observed that patients with BPD present with high emotional reactivity and lability (Linehan, 1993; Neacsiu et al., 2014), a predominance of negative and self-devaluing affects (Neacsiu et al., 2014; Rosenthal et al., 2008; Winter et al., 2017) and difficulty in mentalizing affective experiences (Sharp & Kalkpakci, 2015). It was observed that these patients are prone to guilt and shame (Winter et al., 2017), and that the negative affectivity predicts suicidal ideations and behaviors (Links et al., 2007). Furthermore, these patients self-harm (e.g., self-mutilation, high-risk impulsive behaviors), to punitively manage their emotions (Gunderson, 2011). From a psychodynamic and attachment theory viewpoint, one could argue that self-

contempt in BPD is underpinned by an internal part that is "alien" to the Self, based on incongruent mirroring experiences the person had with his/her attachment figures (Bateman & Fonagy, 2017). This unbearable experience may have been introjected and is activated within close relationships, including the therapeutic relationship, contributing possibly to the difficulty of treating patients with BPD. Independently from the theoretical viewpoint, it appears necessary to adopt a differentiated conception of the emotional expression in BPD: the study of how self-contempt as a maladaptive secondary emotion may contribute to borderline symptomatology, and how it potentially interferes with the collaborative psychotherapy process and outcome is needed.

Very little research has studied the relationship between the intensity of self-contempt and mental disorders. A study focused on disgust of the self (Ille et al., 2014; Rüsch et al., 2011). Self-disgust and self-contempt are close emotional states; it was argued that contempt may be disgust combined with anger (Ekman & Friesen, 1975). In a questionnaire study on self-disgust, patients with BPD presented more personal self-disgust (directed toward one's personality and physical appearance) and behavioral self-disgust (directed toward one's behavior) than control participants (Ille et al., 2014). The relationship between self-disgust and BPD has also been supported by Rüsch et al. (2011), using a self-report questionnaire and an implicit semantic task. Observer-rated assessment of self-contempt has been used in the context of psychotherapy research by Whelton and Greenberg (2005) and Kramer and Pascual-Leone (2016). Whelton and Greenberg (2005) found a link between self-contempt and dysthymic vulnerability. Students with vulnerability to depression were more prone to manifest self-contempt and were less resilient to their criticism compared with non-vulnerable students. Kramer and Pascual-Leone (2016) demonstrated that expressed self-contempt was related to maladaptive anger and predicted anger ruminations. Increased self-contempt prevented individuals from accessing their healthy existential needs. So, more than self-

critical behaviors or cognitions, it is the affective bio-behavioral self-organization of self-contempt, marked by bodily sensations and manifestations that seems to be crucial in explaining psychological vulnerabilities. So far, to our knowledge, no study has used an observer-rated approach to study self-contempt in clinical disorders, let alone in BPD.

Expressed self-contempt may affect the collaborative process of psychotherapy, as well as its outcomes. Self-contempt involves the rejection of a self-part and could thus interfere with patient's commitment to therapy, particularly among those with vulnerable senses of self, proneness to negative affectivity, such as observed in BPD. Self-devaluating affects as such, could interfere with patients' capacity to trust and engage in interpersonal relationships, because of a perception of an inaccurate self and the threat of being rejected (Black et al., 2013; Whelton et al., 2007). A past history of hostility or criticism could lead patients to perceive themselves as inadequate and prone to be rejected by others (Whelton et al., 2007). This introjecting perception may lead to rather paradoxical issues: maladaptive self-rejecting and protective behaviors against the threat of interpersonal rejection may be consequences, which are described in the context of BPD (APA, 2013). As such, we could suppose a negative effect of self-contempt on trust and bonding with the therapist, two main factors of patients' contribution to the therapeutic alliance (Bordin, 1979; Flückiger et al., 2018), which may be particularly important in the treatment of BPD (Fonagy et al., 2017; Signer et al., 2019). Specific studies have looked at the effect of self-blaming behaviors or coping style on working alliance, in samples presenting a variety of mental health difficulties (Whelton et al., 2007; Black et al., 2013). Whelton et al. (2007) demonstrated that self-critical patients were more prone to negatively perceive the working alliance with their therapists. Black et al. (2013) have studied with questionnaires measures the influence of shame as an emotional state, and four shame coping styles (withdrawal, attack self, attack others and avoidance) on the quality of the intimate relationship and the therapeutic alliance with the

therapist (as assessed by the patients). Self-critical patients studied by Whelton et al. (2007) tended to assess the therapeutic alliance as weaker, whereas the patients using the shame coping strategy "self-attack" did not (Black et al., 2013). Therefore, the mixed results found in the literature underline the need to study the potential effect of contemptuousness towards the self on the working alliance. Moreover, the alliance being a main predictor of therapeutic outcomes (Flückiger et al., 2018), patients who express self-contempt could lead to less effective therapeutic process and weaker outcomes.

Evidence-based treatment of BPD involves several promising psychotherapy models for which moderate to strong evidence is available (among others, dialectical-behavior therapy; Linehan, 1993). Despite advancement in demonstrating outcomes, studies lack a detailed understanding of how and why these effects are produced: this focus entails the study of their underlying mechanisms of change (Kazdin, 2009; Kramer, 2019). The meta-analysis by Rudge et al. (2020) demonstrated that several components of emotional processing may be strong candidates for mechanisms of change in treatments for BPD, in particular behavioral treatments, but also in psychodynamically informed brief treatments (Gunderson & Links, 2014), as demonstrated by the mediation analysis by Kramer et al. (2017) on the role of increased coping skills in the very early treatment of BPD. The latter study showed that while most treatments for BPD are long term, crucial changes, that are driving the subsequent core symptom change, may occur in the first five sessions of a standard psychiatric treatment focused on the disorder-specific problems. The current study focuses on a brief version of good psychiatric management (GPM; Gunderson & Links, 2014) and builds on the understanding of emotional change in the first treatment sessions in BPD. Our differentiated definition of emotional expression involves the assumption that expressed self-contempt as secondary emotional process initially interferes with a more productive emotional state of primary self-compassion (Kramer et al., 2020; Pascual-Leone, 2018). Such a dynamic

conception implies a focus on both the link between self-contempt and symptom level (and change), as well as alliance progression, but it also allows the exploration of self-contempt as a decreasing feature over the course of effective therapy. This conception will be tested in the present study focusing on brief psychiatric treatment.

In the present study we aim to extend the understanding of the role of self-contempt on the therapeutic alliance and outcome in brief psychiatric treatment for BPD. We investigated the associations between expressed self-contempt in patients with BPD and the general symptoms and impaired functioning, BPD specific symptoms and interpersonal problems. We assumed that self-contempt would progressively weaken over the course of therapy. We studied how self-contempt was associated with working alliance over time and with the outcomes of a brief treatment for BPD. We formulated four hypotheses: (1) expressed self-contempt correlates with the intensity of symptoms in BPD: general symptoms, BPD specific symptoms and interpersonal problems, (2) there is a decrease in expressed self-contempt in patients with BPD over the course of the brief treatment, (3) expressed self-contempt affects negatively the working alliance, and (4) expressed self-contempt affects negatively the outcomes after brief treatment for patients with BPD.

Method

Design

The current study uses data from patients studied in a previous treatment trial by Kramer, Kolly et al. (2014). The original study was a randomized controlled trial and compared two therapy conditions to test the additive effect of a set of specific therapeutic interventions (the motive-oriented therapeutic relationship, MOTR; Caspar, 2007) to a brief version of a standard psychiatric treatment for BPD (Gunderson & Links, 2014). This brief treatment covered ten sessions. During the course of treatment, patients completed measures assessing symptom level and the quality of the working alliance. The original research was

approved by the responsible ethic board (registration number 254/08; registered in ClinicalTrials.gov database NCT01896024).

Patients and therapists

From the $N = 60$ completer sample described by Kramer, Kolly et al. (2014), $n = 50$ were randomly selected using an online selection procedure with 50 random number generations between 1 and 60. In the original study, the patients were recruited in an ambulatory outpatient center. The inclusion criterias were the diagnostic of BPD, assessed using the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First et al., 2004) and age between 18 and 65 years. Psychotic disorders, a primary disorder of mental retardation or addiction were the exclusion criterias. The comorbidities were assessed using the Mini Neuropsychiatric Interview for DSM-IV Axis I disorders (MINI; Lecrubier et al., 1997). The participants ($N = 50$) of the present sample were mostly female (68%, $n = 33$), unemployed (74%, $n = 37$) and were on average 33.5 years old ($SD = 9.50$). They had on average 1.86 ($SD = 1.05$) comorbid Axis I disorders and on average 0.66 ($SD = 0.8$) Axis II disorders. They presented on average 6.66 ($SD = 1.44$) borderline symptoms criteria (SCID-II; First et al., 2004). They had 11.4 ($SD = 1.80$) years of education on average, 19 were never married, 17 were married and 14 were separated or divorced. Most of them, 68% ($n = 34$), had psychopharmacological medication during the treatment. At baseline, their mean levels on the borderline symptom list (Bohus et al., 2009) were 1.80 ($SD = .095$) their mean levels on the outcome questionnaire (Lambert et al., 2004) were 95 ($SD = 26.54$) and their mean levels on the inventory of interpersonal problems (Horowitz et al., 1988) were 1.82 ($SD = .09$). Twenty-two therapists were involved and they had at least one year of residency in the treatment of psychiatric disorders ($M = 2.5$ years). Nineteen were psychiatrists or psychologists, and three were nurses. All therapists were trained and supervised in the relevant treatment procedures.

Treatments

The original study (Kramer, Kolly et al., 2014) compared two therapeutic conditions. In the first condition patients underwent a ten-session version of a standard treatment for BPD of general psychiatric management (GPM) developed by Gunderson and Links (2014). This approach involves psychoeducation on BPD, validation of distress and therapeutic frame with clear and accessible goals. The second condition was the GPM augmented with a motive-oriented therapeutic relationship (MOTR; Caspar, 2007). MOTR involves a set of particularly responsive therapeutic interventions that are tailored to the individual patient based on the Plan Analysis case formulation method. More information may be found in the parent study. The frequency of sessions was almost once-weekly and the setting was 1:1 (one therapist per patient), except for the first session when in general two therapists were present.

The sample of the current study included patients in the first condition (GPM only; n = 23) and in the second (GPM with MOTR; n = 27). The specificity of the treatment was not the subject of the present study and all patients were pooled in the statistical analysis. Prior to combining the two original conditions, the homogeneity of the expressed self-contempt between the two conditions was verified (see preliminary analyses).

Instrument

Outcome questionnaire – 45.2 (OQ-45 ; Lambert et al., 2004). This self-report questionnaire assesses the symptomatic level at a specific time-point and is widely used to assess outcomes of a psychotherapeutic treatment (Lambert et al., 1996). It includes the measure of the symptomatic distress, the interpersonal relationships and the social role (Lambert et al., 1996). The 45 items are rated on a 5-points Likert-type scale (0= *never* to 4=*always*) and the overall score ranges between 0 and 150, where higher scores signal greater distress. The OQ-45 is a well validated measure (Lambert et al., 1996). A French translation

was made by Emond et al. (2004), and the current sample had good internal consistency, with a Cronbach alpha of .92.

Borderline symptom list- short form (BSL-23; Bohus et al., 2009). It is a short form of the BSL-90 (Bohus et al., 2007), a well-validated self-report questionnaire assessing specific BPD symptoms. It was developed from DSM-IV-TR (APA, 2003) criteria, patient's complaints, and expert's views (Bohus et al., 2007). The short form has 23 items with good psychometric properties (Bohus et al., 2009). The items are rated on a 5-points Likert-type scale (0 = *not at all* to 4= *very strong*) and yield overall score ranging from 0 to 4 (Bohus et al., 2009). The French translation was developed by Page et al. (2010), and the current sample had a Cronbach alpha of .91.

Inventory of interpersonal problem (IIP; Horowitz et al., 1988). This self-report questionnaire assesses the patient's interpersonal functioning with 64 items, rated on a Likert-type scale ranging between 0 (=*not at all*) and 4 (=*absolutely*) and yields an overall mean score. This measure was translated in French by Stigler (unpublished manuscript). The internal consistency is good, with a Cronbach alpha of .94.

Working alliance inventory-short form (WAI-12; Tracey & Kokotovic, 1989). It is a short version of the working alliance inventory with 36 items developed by Horvath and Greenberg (1989). The WAI assesses the three components of the working alliance identified by Bordin (1979): the bond, the task and the goal. The short form was computed by Tracey and Kokotovic (1989) by taking the four most preponderant items on the factorial analysis for every component. The 12 items of the short version are assessed on a 7-points Likert-type scale (from 1 = *never* to 7 = *always*). This self-report measure has two versions and permits one to assess the level of working alliance from the patient's view or the therapist's view (Horvath & Greenberg, 1989). The overall score of WAI-12 ranges between 0 to 84 (Tracey & Kokotovic, 1989). This measure was translated to French by Corbière et al., (2006). The

original short version and French short version have good psychometric properties (Tracey & Kokotovic, 1989; Corbière et al., 2006). In the present sample, Cronbach alphas are .88 (patient version) and .89 (therapist version).

Self-contempt measure. Assessment of self-contempt was done in the same way as in the validation study by Kramer and Pascual-Leone (2016) which presented a theory-driven scale as addendum to the Classification of Affective Meaning States (CAMS; Pascual-Leone, 2018). Criteria were defined according to Ekman & Friesen (1975), Gottman (1994), Rice and Kerr (1986) and Whelton and Greenberg (2005). In the present study, expressed self-contempt was rated on video and audio recordings of the therapeutic sessions using the coding criteria described in the manual by Kramer and Pascual-Leone (2014). External raters assessed the expressed self-contempt on a 3-points Likert-type scale, ranging from 0 (= no contemptuousness), over 1 (= moderate contemptuousness) to 2 (= high contemptuousness). Consistent with the self-contempt as a specific self-organization, we based the coding on several concurrent information sources: a) verbal expressions (insults or negative cognitions), b) para-verbal expressions (e.g. *sarcastic voice, emotional voice, contemptuous sigh*), and c) (if the videos were available) non-verbal expressions (e.g. *curled lips, shaking the head*). Pre-tests and experiences from earlier studies (Kramer & Pascual-Leone, 2016) underlined the necessity of having concurrent information from a) and b), in order to code the phenomenon reliably. Ratings were done continuously, and the results were collapsed according to the instructions in the manual into bits of 5 minutes. Scores for the latter were used in the present study, in keeping with earlier studies on emotional categories in psychotherapy. Given the concurrent information necessary from the verbal and para-verbal assessment viewpoints, five minutes represent a sufficiently short amount of time with yet a significant verbal elaboration, supported by a voice pattern and non-verbal expressions. Concurrent information was defined as follows: the higher score of expressed self-contempt (= 2) was given if the patient insulted

him-/herself at least once during a 5 minutes segment (e.g. *I am so stupid, pathetic*). A score of 1 (= moderate contemptuousness) was given if the patient expressed two or more para/non-verbal manifestations of self-contempt or if the patient expressed a negative cognition (e.g. *I am embarrassing, should be ashamed of myself*) with a para/non-verbal manifestation of self-contempt. When the patient expressed only one para/non-verbal manifestation of self-contempt or a negative cognition without para/non-verbal manifestation of self-contempt during the 5 minute segment, a score of 0 (= *no contemptuousness*) was given. These ratings of 5 minute segments were added up and averaged to create means of expressed self-contempt per session.

As demonstrated by Kramer and Pascual-Leone (2016), the scale measuring self-contempt as specific elaboration of the rejecting anger category in the CAMS presents with sufficient validity and reliability. Kramer et al. (2016) showed that the self-contempt scale differentiated significantly between individuals with and without anger problems when they work through their self-criticism. Inter-rater reliability was sufficient (mean Intra-Class Correlation Coefficient (1, 2) = .77) in the original validation study.

Given the exploratory character of the application of the scale in the context of a clinical population, three ways of operationalizing self-contempt were used in the present study: 1) the mean level per session (and per patient); 2) the mean level per session, controlled by the number of words produced in the session by the patient; and 3) the frequency of the maximum score (= 2, presence of contemptuous insults) per session. The second parameter of measure was computed dividing the mean by the number of words per session (only *patient* utterances counted) and then multiplied by 1,000 (i.e., the latter transformation was to assure to end up with manageable sizes of numbers). Overall means per patient comprising the average across the three sessions were also computed for the three parameters, given a 1) overall mean, a 2) overall controlled mean, and a 3) overall frequency of the score of 2.

Procedure

Sessions were video-recorded or audio-recorded (50 available video and 98 audio-recording).. The patients completed the symptoms' measures at the beginning and the end of treatment while both patients and therapists completed the working alliance measure after every therapy session. Training for coders rating self-contempt was carried out on different clinical material than the current sample, and self-contempt was rated on the recordings of 148 sessions by two external raters (graduate students: *author 1* & *author 2*). Three sessions per patient were rated: session 1 (representing process at the beginning of treatment), session 5 (representing the process at mid-treatment) and session 9 (representing the end of the brief treatment) -- the last session (10) was not used on account of it being a more structured discussion about further treatment and it was unsuitable for coding the spontaneous psychotherapy process. Thirty sessions (20,3% of all rated sessions) were selected randomly (using a random generation system) and were coded by two independent coders, blinded to the treatment condition. Given the contents in the sessions, a full blinding of session number was not feasible in this study. This reliability sample demonstrated sufficient inter-rater reliability with 88.7% agreement. We computed the number of perfect agreements between the two coders per therapy session (100% meaning all scores corresponded perfectly) between the two coders for all time chunks.

Statistical analyses

First, the association between expressed self-contempt (the overall mean, the overall controlled mean and the overall frequency of the maximum score, i.e., the average across the three time-points) and symptom measures were tested with Pearson's correlations, except for the tests with non-normally distributed variables - *frequency of the maximum score of self-contempt* and *OQ-45 scores* (at beginning)- where Spearman's rank correlations were used. Second, the effect of time on expressed self-contempt (by sessions) was assessed with a

repeated-measures ANOVA. Third, the effect of expressed self-contempt on the progression of the working alliance was tested first using correlations coefficient (between the working alliance and the overall mean, the overall controlled mean and the overall frequency of the maximum score of self-contempt) and then using two parallel Hierarchical Linear Models (HLM; Bryk & Raudenbush, 1987), where time (level 1) was nested within patients (level 2), one for each alliance rating perspective, patients' and therapists', following the formula: $WAI_{ij} = \beta_0 + \beta_1$ *(overall controlled mean of self-contempt) $+ \beta_2$*(condition) β_3 *(time) $+ \beta_4$ *(time*contempt) $+ u_j + \varepsilon_{ij}$, where u_j represents the random effect on the subject levels and ε_{ij} represents the white noise. These HLM analyses permitted to test the effect of expressed self-contempt on the progression of the working alliance over the course of treatment (in order to have manageable and meaningful estimates, we re-transformed the contempt variable with a multiplication by 100 for this analysis). The correlations analyses with working alliance were Pearson's correlations, except for the *frequency of the maximum score* (Spearman's rank correlations). Fourth, we hypothesized an association between expressed self-contempt and treatment outcome, i.e., BPD symptom severity. Thus, we analyzed correlations between the expressed self-contempt (the overall mean, the overall controlled mean and the overall frequency of the maximum score) and symptom changes. Spearman's rank correlations were used except for the tests between *IIP scores* and *mean* or *controlled mean of expressed self-contempt*, which are normally distributed. Then we used a linear regression model (to test the predictive effect of self-contempt on outcomes) and controlled for the level of symptom at baseline. For the inferential analyses, a significance threshold of .05 was applied. The data analyses were made with IBM SPSS 25 (IBM Corp., 2017) and HLM7.

Results

Preliminary analyses

An examination of missing data showed one case to have missing *BSL scores* at intake, *IIP scores* at intake and missings in the session-by-session assessment of the *WAI*. Another participant had a WAI mean score but no data from specific sessions, as such HLM analyses included 48 patients. Three additional participants did not complete the IIP at discharge. So, the variable *BSL change* included 49 participants, while *IIP change* included 46 participants. For the observation of self-contempt, two missing sessions at the beginning of the brief treatment, resulted in rating of 148 sessions out of 150 possible. Furthermore, due to a technical problem, ratings of one participant's self-contempt could not be done adequately in his/her third session.

Because this study does not focus on treatment differences, between-condition comparisons of self-contempt were conducted prior to aggregating the two treatment conditions. There is no significant difference between groups for the overall mean of expressed self-contempt, $t(48) = -1.42$, $p = .16$ (Student's t-test), the overall controlled mean of expressed self-contempt, $t(48) = -1.98$, $p = .052$ and for the overall frequency of the maximum score of self-contempt, $U = 305$, $p = .91$(Mann-Whitney U test). Furthermore, analyses by session did not show any significant differences between groups. Thus, in the following analyses, patients of both treatment conditions are examined together.

Correlations between expressed self-contempt and symptom levels

The intake level of general symptoms OQ-45 was not significantly correlated with either the overall mean nor overall controlled mean of expressed self-contempt (Table 1). However, it was significantly linked with the overall frequency of the maximum score of self-contempt (= presence of contemptuous insults), $r = .28$, $p = .048$. All expressed self-contempt measures (the overall mean, the overall controlled mean and the overall frequency of the maximum score) were associated with the intensity of BPD symptoms assessed by the BSL-23 with moderate correlations (Cohen, 1988) from .30 to .35, as shown in Table 1. Finally,

only the overall controlled mean of self-contempt and the overall frequency of the maximum score were related to interpersonal functioning rated by IIP with correlations' coefficients from .27 to .36 (see Table 1).

Expressed self-contempt over the course of treatment

Patient with BPD presented moderate intensity of self-contempt during sessions, as depicted in Figure 1. Time had no effect on the expressed self-contempt across the three time-points: The mean of expressed self-contempt did not vary significantly during the course of treatment, $F(2) = 5.42$, $p = .066$, nor the controlled mean, $F(2) = 5.37$, $p = .07$, nor the frequency of higher score, $F(2) = .63$, $p = .73$ (Figure 1). Given this result, for the subsequent analysis on explaining the progression of the therapeutic alliance over the course of treatment by self-contempt, we decided to use only the average, over the course of three time-points, of the mean, the controlled mean of self-contempt and the frequency of insults. This strategy ensured that all ratings from all time-points were taken into account in the analyses.

Effects of expressed self-contempt on the therapeutic alliance

First, the correlations between the means of self-contempt (overall controlled mean and overall mean) and working alliance were negative for *patients*' rating of alliance and - contrary to our predictions - positive for *therapists'* rating of alliance. Specifically, overall controlled mean of self-contempt presented a significant negative correlation with patients' rating of alliance, $r = -.30$, $p = .04$, and a positive significant correlation with therapists' rating of alliance, $r = .29$, $p = .04$. The correlations with the overall (untransformed) mean of self-contempt and with the overall frequency of highest scores of self-contempt were not significant. All the correlation coefficients and *p* values are reported in Table 2. In order to test the effect of expressed self-contempt on the progression of the working alliance during the ten sessions, Hierarchical Linear Models were used. The results indicate that the overall controlled mean of expressed self-contempt (i.e., the average across the three time-points)

tended to explain the progression of the working alliance rated by the patients (Estimate: -.15; SE = .09; t = -1.63; p =.09; 95% confidence interval between -.33 and .03) and a trend for the ratings done by the therapists (Estimate: .14; SE = .08; t = 1.48; p = .09; 95% confidence interval between -.04 and .28). Furthermore, this model tended to confirm the precedent observations: expressed (averaged) self-contempt tended to negatively predict patients' rating of the therapeutic alliance, but tended to positively predict therapists' rating of the therapeutic alliance. We re-ran the afore-mentioned analyses for the first time-point of assessment (baseline only) of the different operationalizations of self-contempt and found consistent results.

Correlation between expressed self-contempt and symptom changes

The evolution of general symptomatic state between the beginning and the end of treatment, assessed by the OQ-45, was not related to the overall mean nor the overall controlled mean of self-contempt (i.e., the average across the three time-points) (r = -.14, p = .33 and r = -.21, p = .14, respectively). However, symptom change on OQ-45 presented a negative correlation with the overall frequency of the maximum score of self-contempt, r = -.32, p = .03. The scores of symptom change (the difference between OQ-45 at the end and OQ-45 score at baseline) were mostly negative, indicating a decrease in distress and functional impairment over time. In a linear regression model, where we controlled the level of problems (on the OQ-45) at intake, we found that this relationship between the averaged number of contemptuous insults and the symptom change (on the OQ-45) was not significant anymore (β = -.13; t = -.96; p = .34). The different self-contempt measures (overall mean, overall controlled mean and overall frequency of the maximum score) were not associated with pre-post change on specific BPD symptomatology (BSL-23) and interpersonal relationships (IIP). The detailed results are presented in Table 1.

Discussion

The present study investigated the associations between expressed self-contempt, symptom level, the therapeutic alliance and outcome in a brief psychiatric treatment for patients with BPD. We adopted a differentiated conception of emotional change in psychotherapy, assuming that the expression of self-contempt interferes with key therapeutic processes and outcomes in patients with borderline personality disorder. We also assumed that while self-contempt should decrease over the course of effective treatment (giving eventually way to more self-compassionate stances), self-contempt is also associated with the level of symptoms.

The association between the level of borderline symptoms and self-contempt is noteworthy. With regards to previous findings on the predominance of negative emotion, maladaptive anger and self-harming behaviors (e.g., self-mutilation) associated with BPD (Gunderson, 2011; Brown et al., 2009; Winter et al., 2017), we expected a correlation between expressed self-contempt and symptom severity (at baseline) which was confirmed by the results on borderline specific symptoms. The intensity of expressed self-contempt was associated with the level of borderline symptoms at baseline: this was true for all operationalized measures of self-contempt. The interpersonal symptoms correlated with two measures of self-contempt and the general symptoms correlated with the frequency of contemptuous insults toward the self. These findings underline the link between the expression of self-contempt and the symptomatic intensity, particularly for the core symptoms found in these patients, whereas other symptom measures presented significant correlations with only one or two parameters of self-contempt. These conclusions are in line with results from Ille et al. (2014) and Rüsch et al. (2011), who showed the presence of self-devaluing affects (e.g., self-disgust, self-contempt) in BPD. Furthermore, Ille et al. (2014) found stronger associations of self-disgust with BPD than with other mental disorders, which is consistent with our results. The specific role of self-contempt still needs to be further

examined and the reciprocal influences between specific BPD symptoms, psychopathology and self-contempt need to be deepenend. It may also be of interest to understand in more detail the harmful nature of self-contempt for identity processes, and construction of the Self in the development of borderline personality disorder.

Specifically, general distress correlated with the frequency of insults, but not with the other indices of self-contempt. As such, we cannot rule out the possibility that insults directed towards the self may be the expression of some broader emotional state (Whelton & Greenberg, 2005), or a personality trait, for example, antagonism or quarrelsomeness which we did not measure (Meyer et al., 2019). Insulting oneself may also be a reflection of a patients' verbal impulsivity, rather than self-contempt per se. Some patients may be both harsh with themselves in self-criticism, and also confident and assertive when responding to such internal critic, and may therefore have generally heightened levels of emotional experience and intensity of affect expression. An additional rating of patient's response to self-critical words could be used, for example in the context of an experiential two-chair dialogue, to gauge the level of an individual's resilience in the face of self-contempt, which has been shown to be a protective factor (Whelton & Greenberg, 2005) in the development of psychopathology.

The associations between two parameters of self-contempt (the controlled mean and the frequency of contemptuous insults) and interpersonal symptoms are in line with findings by Black et al. (2013). They found a negative effect of self-aversive coping style on intimate relationships. Clinical theory suggests that self-contempt may be expressed in reaction to a more vulnerable state of maladaptive shame (Pascual-Leone et al., 2013). This implies that similar results on interpersonal functioning with self-aversive reaction to shame are of particular interest. More studies are needed to investigate how self-aversive expressions (self-attack coping style, self-contemptuous manifestations) might differentially affect

interpersonal functioning in social, intimate, or therapeutic contexts. Since patients with BPD have significant interpersonal difficulties, it is important to understand the directional impact of expressed contemptuousness on their interpersonal functioning in daily life.

The main and most surprising finding of this study concerns the link between expressed self-contempt (the controlled mean) and the therapeutic alliance. We hypothesized that self-contempt would negatively predict the working alliance, but the association between expressed self-contempt and the therapeutic alliance was more complex than initially anticipated. The results indicated the presence of a bidirectional pattern: the controlled mean of self-contempt negatively predicted the working alliance as rated by *patients*, while it positively predicted (at least as trend in the longitudinal analysis) the working alliance as rated by *therapist*s. The results from the patients' perspective were expected and are in line with earlier studies (Whelton et al., 2007; Kramer, Pascual-Leone et al., 2014). It confirms previous results showing the negative interfering effects of self-criticism and related maladaptive self-organizations on the therapeutic alliance as rated by the patients. Self-contemptuous patients may be less confident in engaging in therapeutic bonding – implying interpersonal closeness – because of a devaluating self-perception of being inadequate and prone to interpersonal rejection (Whelton et al., 2007). Self-contempt manifestations may thus become a marker of the patients' difficulties to engage in the therapeutic relationship and the therapists should be attentive to it.

Unexpectedly, we found that patients' expressions of self-contempt (the controlled mean) tended to be related with a greater increase in the working alliance, as rated by the *therapists*. There are different ways of explaining this result. Therapist alliance ratings may be influenced by his/her actual experience of the collaboration, interacting with therapist's background knowledge and experience. Trained therapists, as the ones in our study using psychiatric treatment consistent with BPD-specific principles (according to Good Psychiatric

Management; Gunderson & Links, 2014) may notice that expressed self-contempt is part of the clinical presentation related with BPD and these therapists may at this point become increasingly hopeful about the ongoing process. *In fine*, expressed self-contempt in this context is also a sign of the patient's emotional involvement with his/her core issue, a willingness to expose the underlying core process, thus it may be understood by the therapist as an emergent commitment to the therapeutic process. We may speculate that this expression of self-contempt may be interpreted by the therapist as a marker of emerging trust in the therapeutic relationship. Furthermore, we may assume that expressions of self-contempt could provoke an empathic reaction in the therapist who witnesses his/her patient's harsh and painful self-treatment, thus, somehow surprisingly, creating interpersonal closeness in the therapist experience. This is consistent with the principles of good clinical intervention, as well as with evidence-based practice, facing patients with BPD expressing hostility in-session: Gunderson and Links (2014) recommend in these critical situations for the therapist to "lean in" and express interest, genuineness and empathy for the ongoing expressed (hostile) process.

Finally, although we hypothesized that self-contempt would be positively related to symptom progression, our results did not confirm this assumption. When we controlled for the symptom level at baseline, the frequency of contemptuous insults did not predict the outcomes (symptom change at OQ-45). In the present study, the self-contempt measures were not directly associated with outcomes after brief treatment for patients with BPD.

It is crucial to note that BPD affects up to 20% of psychiatric inpatients (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004) and that the suicide rate is high in this population with up to 10% of patients committing suicide (APA, 2001), which implies that studying closely the therapy for these patients is of first importance. In this context, taking a closer look at mechanisms of change underlying the treatment may be key for improving

clinical care and understanding why treatment works. Studying in-session mechanisms of change is therefore important in that it helps understand and conceptualize how and why the effects of intervention occur (Doss, 2004; Kramer et al., 2020). In doing so, the current work demonstrates how important it is to disentangle the details of the in-session process the researcher is interested in, by combining a categorical definition of the event of interest (i.e., the emotional category of self-contempt) with the actual intensity of the phenomenon at study (i.e., studying its intensity moment-by-moment, and session by session; Greenberg, 1984). Zooming in on a specific emotional category, such as self-contempt, within a broader theoretical framework of sequential emotional change in psychotherapy (Pascual-Leone, 2019) may be productive and may lead to the definition of even more detailed step-by-step models explaining psychotherapy process and outcome. This is important clinically, as change in self-contempt may become a possible target for clinical intervention as intermediate outcome in BPD treatments. More controlled research on this emotional state is needed before such conclusions can be drawn.

The present research highlights important findings, but there are some study limitations. First, self-contempt was assessed on video and audio recorded sessions. Based on pre-test and previous experiences (Kramer & Pascual-Leone, 2016), we assumed that the validity of the measure, mainly based on the concurrent information from the verbal and para-verbal (voice) manifestations, is acceptable. However, using only video recorded sessions would be better to have homogenous measure and to precise the measure with the non-verbal cues. A rating was given every 5 minutes of the session but smaller time bins (e.g., 1-2 minutes) might conceivably have yielded different results. Furthermore, the 3-points Likert-type scale of expressed self-contempt could be too restrictive to reflect the complexity and great variability of the clinical phenomenon (Whelton & Greenberg, 2005). The small sample size could be a limitation. There are also limitations to the interpretation of results. As

discussed, one cannot exclude the possibility that the measure of self-contempt is actually capturing another emotion or more stable personality trait, especially given the focus on frequency of insults as an index of contempt (Whelton & Greenberg, 2005). Certainly, the absence of a control group does not permit to test whether patients with BPD expressed more self-contempt than patients with other psychopathologies, or than control participants. Most of the results relied on correlations and not on prediction analysis. Finally, the non-transformed mean of self-contempt and frequency of higher score of self-contempt did not present any significant associations with working alliance (only the controlled mean of self-contempt did) and so further research is needed to confirm and better understand these results.

In conclusion, this study offers an initial exploratory observation of self-contempt in psychotherapy in patients diagnosed with borderline personality disorder. Expressed self-contempt was reliably rated by independent coders and was related with the level of core symptoms of borderline personality disorder. Some links were also found with other measures of symptom level and interpersonal functioning. Most interestingly, results indicated that on the one hand, patient's self-contempt is linked to a less positive perception of the therapeutic alliance assessed by the patients across time, on the other, expressing self-contempt is associated with improvement in the therapists' perception of working relationship across time. A self-contemptuous affective state seems to be implicated in borderline symptomatology, as well as in the collaborative process of the working alliance. Therefore, understanding even better the role of self-contempt in borderline personality disorder undergoing treatment is crucial, as such an understanding may help define empirically valid intermediate outcomes, and explanations of how and why these patients change in psychotherapy.

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Table 1.

Correlations between self-contempt and symptoms/symptoms changes

Expressed self-contempt:	Mean	Controlled mean	Frequency of insults
OQ-45 intake	.26 (*p*=.07)	.26 (*p*=.07)	**.28 (*p*=.048)**
OQ-45 change	-.14 (*p*=.33)	-.21 (*p*=.14)	**-.32 (*p*=.03)**
BSL-23 intake	**.30 (*p*=.04)**	**.35 (*p*=.01)**	**.31 (*p*=.03)**
BSL-23 change	.08 (*p*=.60)	.03 (*p*=.86)	-.04 (*p*=.80)
IIP intake	.27 (*p*=.06)	**.33 (*p*=.02)**	**.36 (*p*=.01)**
IIP change	.13 (*p*=.38)	.03 (*p*=.83)	.21 (*p*=.17)

Note. Spearman's rank correlations except for the correlations between mean or controlled mean of self-contempt and *BSL-23 at intake*, *IIP at intake* and *IIP change*, where Pearson's coefficient is used.

OQ-45: Outcome Questionnaire – 45.2. BSL-23 : Borderline symptom list- short form. IIP : Inventory of interpersonal problem.

Table 2.

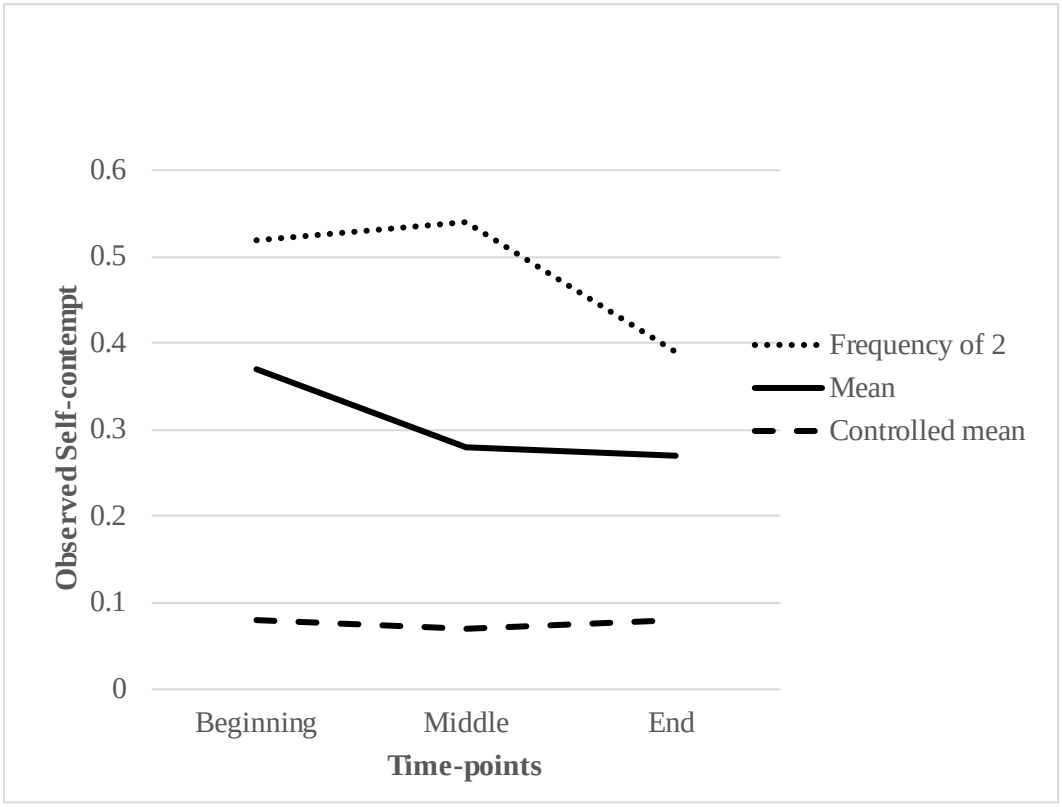
Correlations between self-contempt and working alliance from patient and therapist perspectives

Rating perspective:	Patients	Therapists
Mean of self-contempt	-.13 (p = .36)	.28 (p = .052)
Controlled mean of self-contempt	**-.30 (p = .04)**	**.29 (p = .04)**
Frequency of contemptuous insults	.04 (p = .81)	.09 (p = .55)

Note. Pearson's correlations are used except for the frequency of contemptuous insults, where Spearman's rank correlation is used.

Figure 1.

Observed self-contempt across phases of treatment



Note: N = 47. Mean of expressed self-contempt did not vary significantly during the course of treatment, $F(2) = 5.42$, $p = .066$, nor the controlled mean, $F(2) = 5.37$, $p = .07$, nor the frequency of higher score, $F(2) = .63$, $p = .73$