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THE ROLE OF GENDER IN THE CLINICAL PRESENTATION OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER

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This study examined gender differences in the pattern of comorbid disorders and degree of impairment among outpatients with borderline personality disorder (BPD). A total of 130 outpatients with BPD were assessed for various lifetime impulse-related disorders and post-traumatic stress disorder and for indices of impairment. Compared with women with BPD, men with BPD reported significantly more lifetime substance abuse disorders, antisocial personality and met criteria of intermittent explosive disorder that did not overlap with a diagnosis of BPD. Women with BPD reported significantly more lifetime eating disorders than men with BPD. No gender differences were found in degree of overall impairment. These results suggest that male and female patients with BPD, although equally distressed, present with different lifetime patterns of impulse-related disorders.

In the last decade, the literature on the relationship between gender and borderline personality disorder (BPD) has generated much controversy and little clarity. Recently, BPD has been characterized as the "bad girl" of psychiatric labels (Becker, 2000), a charge that was based on the presumption of an increase in the application of the borderline diagnosis to women and the existence of a sex bias in the clinical diagnosis of BPD. Unfortunately, research on the gender rates of BPD and analogue studies of a sex bias in BPD have been equivocal. Two community-based studies did not find that BPD was related to gender (Torgenson, Kringlen, & Cramer, 2001; Zimmerman & Coryell, 1990), whereas another found that women were significantly more likely to have BPD than men (Maier, Lichtermann, Klinger, Heun, & Hallmayer, 1992). Although empirical studies with clinical samples generally report that BPD is predominately exhibited by women (e.g., Zanarini et al., 1998a), research conducted on outpatients with major depression has found that either (a) men were significantly more likely to meet criteria for BPD than women (Carter, Joyce, Mulder, Sullivan, & Luty, 1999); or (b) there was no significant gender differences in BPD (Golomb,

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Fava, Abraham, & Rosenbaum, 1995). Research that supports a sex bias in BPD has found that clinicians are more likely to rate female clients with a higher applicability of the BPD diagnosis than they rate male clients (Becker & Lamb, 1995), whereas other analogue research has found no significant relationship between the diagnostic attribution of BPD and gender of patient (Adler, Drake, & Teague, 1990).

Despite the accumulating research on the role of gender in the presence of BPD, little attention has been given to the different ways in which men and women are affected by the disorder. Within a sample of personality-disordered patients, Zanarini and colleagues (1998a) found gender differences in the "type of disorder of impulse in which they specialized" (p. 1738), with male borderline patients significantly more likely to meet criteria for lifetime substance use and females significantly more likely to meet criteria for lifetime eating disorders. Furthermore, women with BPD had a greater likelihood of posttraumatic stress disorder than men with BPD (61% vs. 35%). Also, different patterns of Axis II comorbidity for this sample of men and women were found, especially for the dramatic cluster (Zanarini, Frankenburg, Dubo, Sickel, Trikha, & Reynolds, 1998b).

The present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project examines whether male and female outpatients with BPD present with a different pattern of comorbidity, especially impulse-related disorders. This report extends prior research in that we examine gender differences in comorbidity within a patient sample unselected for personality disorders and also examine gender differences in level of impairment among borderline patients.

METHOD

Semistructured diagnostic interviews were administered to 1,500 patients who sought treatment at an outpatient private practice that is part of a general hospital. This private practice group predominantly treats individuals with medical insurance (including Medicare but not Medicaid) on a fee-for-service basis. Exclusion criteria for the study were participants who less than 18 years of age, had a history of a developmental disability, or had difficulty with the English language.

The patients were interviewed by a trained diagnostic rater who administered the Structured Clinical Interview for DSM-IV (SCID, First, Spitzer, Gibbon, & Williams, 1995) and the Structured Interview for DSM-IV Personality (SIDP-IV; Pfohl, Blum, & Zimmerman, 1997). Ninety participants were not administered the SIDP-IV. All raters were required to achieve adequate inter-rater reliability before independently administering the SCID interviews (Zimmerman & Mattia, 1999). During the course of the study, joint-interview BPD diagnostic reliability information was collected on 44 patients. The κ coefficient for BPD was 1.0. Although patients with BPD were not diagnosed with intermittent explosive disorder, an analysis of patients who met intermittent explosive disorder criteria A and B were included to assess gender differences in aggressiveness within the BPD sample. For eating disorders, we included eating disorders not otherwise

specified because prior research (Zanarini et al., 1998a) found that there were gender differences in this disorder among patients with BPD.

For level of impairment, patients were interviewed about the number of times they have been hospitalized for psychiatric reasons and their history of suicide attempts. Items from the Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978) were used to assess "current" (i.e., within the last 5 years) and "past" (i.e., within the past 5 years) social functioning and work impairment (i.e., how many days they were out of work due to emotional or psychiatric problems within the past month and past 5 years).

RESULTS

Of 1,410 participants who were administered the SIDP-IV, 15 were excluded due to missing data. Of the 1,395 participants included in the current study, 105 (70.5%) women and 44 (29.5%) men were diagnosed with BPD. Of these 149 patients, most were Caucasian ($N = 131$, 87.9%) and the mean age of patients was 31.4 years ($SD = 8.9$). The majority of the 149 participants had completed high school or some college education ($N = 132$, 88.6%) and 34.2% were married or cohabitating ($N = 51$). There were significantly more women with BPD ($N = 105/869$, 12.1%) than men with BPD ($N = 44/526$, 8.4%), ($\chi^2 = 4.7$, $df = 1$, $p < 0.05$). Women with BPD were significantly more likely to be younger ($M = 29.9$ years; $SD = 8.5$) than men with BPD ($M = 34.8$; $SD = 9.2$) ($t = -3.1$, df = 147, $p < .005$). No other demographic differences between men and women with BPD were found.

In terms of gender differences in the comorbidity profiles of patients with BPD, table 1 shows that men were significantly more likely than women to meet criteria for a lifetime substance abuse disorder, intermittent explosive disorder (had it not been eliminated due to co-occurrence with BPD), and antisocial personality disorder, whereas women were significantly more likely than men to meet criteria for a lifetime eating disorder. To examine whether these gender differences were specific to the impulse-related disorders, we examined gender differences in patients with BPD in disorders that are related to gender and disorders in which impulsivity is not a feature of the disorder (i.e., panic disorder and major depression). There were no significant differences between men and women with BPD in these comorbid disorders. In a series of logistic regressions controlling for age, with gender as the dependent variable, and with the comorbid disorder, which was found to be significant in the above analyses as the independent variable, each of the comorbid disorders remained significant.

To explore whether the pattern of comorbidity in male and female patients with BPD was specific to only those patients with BPD, we examined the comorbidity profiles of the full sample of patients with the exclusion of those patients who met criteria for BPD ($N = 1,246$). Within this larger sample ($N = 1,246$), men were significantly more likely than women to meet criteria for a lifetime substance abuse disorder, intermittent explosive disorder, and antisocial personality disorder, whereas women were significantly more likely

TABLE 1. Differences in Selected Comorbid Disorders Between Male and Female Patients with Borderline Personality Disorder

	Females		Males		
	n	%	*n*	%	χ^2
Major depressive disorder	71	67.6	30	68.2	0.0
Panic disorder	38	36.2	19	43.2	0.6
Posttraumatic stress disorder	54	51.4	15	34.1	3.7
Any eating disorder	31	29.5	6	13.6	4.2*
Substance use disorder	40	38.1	28	63.6	8.2**
Intermittent explosive disorder (Criteria A and B)	50	47.6	32	72.7	7.9**
Antisocial personality disorder	12	11.4	17	38.6	14.6***

Note. $p < 0.05$; **$p < 0.01$; ***$p < 0.001$.

than men to meet criteria for a lifetime eating disorder, posttraumatic stress disorder, major depressive disorder, and panic disorder.

A multivariate analysis of covariance was conducted with the men and women with BPD as independent variables and the measures of impairment as dependent variables, controlling for age. No significant differences were found between the two groups on the dependent variables (Wilks' $\lambda = 0.9$, F (6, 141) = 1.7, p = not significant).

A power analyses using an α level of .05 showed that the size of our study group had acceptable power (0.81) for at least medium effects to be detected, as defined by Cohen (1988), in each of the analyses in our report.

DISCUSSION

The main finding of this report is that there were gender differences in the pattern of lifetime impulse-related disorders in a sample of outpatients with BPD. More specifically, substance abuse disorders, intermittent explosive disorder, and antisocial personality disorder were found to be significantly more common in the histories of male borderline patients than female borderline patients. In contrast, eating disorders were found to be significantly more common in the histories of female borderline patients than male borderline patients. These findings are consistent with those of earlier studies of borderline inpatients that found lifetime substance use disorder and antisocial personality disorder to be more common among men and lifetime eating disorders to be more common among women (Zanarini et al., 1998a,1998b). Unlike prior research (Zanarini et al.,1998a), this report did not find significant gender differences in comorbid posttraumatic stress disorder among patients with BPD. Differences in methodology and samples may have accounted for the divergent findings, especially since the sample used in prior research was comprised of inpatients who were selected for a personality disorder. Another possibility for the difference in this result is that the inpatient sample in the other study, in contrast to our outpatient sample, was more clinically severe and may have experienced more sexual trauma, a trauma that is strongly associated with posttraumatic

stress disorder and the female gender (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

The current report found no gender differences in degree of impairment among patients with BPD. This finding of gender differences in the type of disorder suggest that both groups of borderline patients are equally impaired but, perhaps, express their distress differently. In this study, the gender differences in Axis I and Axis II disorders found in our subsample of outpatients with BPD were also found in the larger sample of outpatients without BPD; these findings are congruent with findings in epidemiologic studies of gender differences in psychiatric disorders (Hsu, 1996; Kessler et al., 1994). Therefore, it is possible, that the pattern of differences found in men and women with BPD is not associated with the diagnosis of BPD but is an expression of male and female pathology in general. However, this report, unlike our larger sample of outpatients without BPD and unlike epidemiologic studies (Kessler et al., 1994, 1995), did not find gender differences in rates of major depression, posttraumatic stress disorder and panic disorder. This report's finding that there were gender differences in only the type of impulse-related disorders (i.e., eating disorders for women and substance abuse, antisocial personality disorder, and intermittent disorder in men) is consistent with gender role theories on affect regulation, which suggest that in response to negative affect, women use more self-focused activities than men (Morrow & Nolen-Hoeksema, 1990). Because the data in this report were correlational, it cannot be presumed that the diagnosis of BPD differentially increases the risk of certain impulse-related disorders in women and men. Clearly, prospective, longitudinal research is needed to address the role of premorbid BPD in the development of comorbidity in both genders.

Future studies are also needed to assess whether gender differences in patterns of comorbidity among borderline patients persist over time and whether these disorders differentially impact the course, outcome, and treatment of BPD. The findings from this study need to be replicated, especially with a community sample and with a sample of general psychiatric inpatients.

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