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Gender, Race, and Childhood Abuse as Predictors of Borderline Personality Disorder

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Gender, Race, and Childhood Abuse as Predictors of Borderline Personality Disorder

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by

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ABSTRACT

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Borderline Personality Disorder (BPD) is a debilitating personality disorder that impacts anywhere between 1% to 5% of Americans. Studies claim that women are more at risk than men to have BPD. Previous research indicates victims of childhood abuse such as sexual abuse, physical abuse, and neglect are more at risk for developing BPD as adults. Researchers claim there aren't detectable racial differences in BPD, but previous studies often have small sample sizes taken from clinical patients. To examine sociological patterns of BPD diagnosis with a representative population sample, data was analyzed from the National Epidemiologic Survey on Alcohol and Related Conditions to examine gender, race, and childhood abuse as predictors. Results show racial minority status is a stronger predictor than gender. Intersectional effects show that black women and Native American men have significantly elevated risks for BPD in adulthood. Overall, a history of sexual and emotional abuse are the most significant predictors of BPD, regardless of race and gender.

DEDICATION

To my loving grandmother, who encouraged, supported, and believed in me unconditionally. This would not have been possible without her unending enthusiasm, determination, and guidance in my pursuit for knowledge.

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CHAPTER 1

INTRODUCTION

Borderline Personality Disorder (BPD) is a debilitating personality disorder that impacts anywhere between 1% to 5% of Americans (De Genna et al. 2011; Kulkarni 2017; Lugboso and Aubeeluck 2017). Studies claim that women are significantly more at risk than men to suffer from this disorder and more likely to experience stronger symptoms (De Genna et al. 2012; Skodol and Bender 2003). One study claims that this gender split becomes evident only when surveying adults, not adolescents. This could be a result of study methodology; much research suggests that adequate samples from minority populations were not obtained during research, and clinical samples are heavily weighted toward Caucasian females (De Ganna et al. 2011, Newhill, Eack, and Connor 2009). Other studies have found that the wording or delivery of questionnaires pertaining to a BPD diagnosis may be more inclined to focus on the display of feminine symptoms, rather than addressing both genders. The clinical setting of the studies being conducted may also influence differences in the portrayal of and subsequent patterns in gender and race.

To address these limitations, the current study will use data from the National Epidemiologic Survey on Alcohol and Related Conditions, and nationally representative sample that is large enough to examine sociological patterns in BPD. Using this data, this research will provide further insight by examining racial and gender disparities in BPD in a non-clinical and large-scale sample. In addition to examining gender and race, this study will also investigate three types of childhood abuse that have been found to be predictors of Borderline Personality Disorder: physical abuse, sexual abuse, and emotional abuse.

This study examines four research questions. There first research question being examined is: How much of an impact does gender have on BPD? The second question is: How likely are minority ethnic groups to have BPD compared to whites? My third question is: Are there intersectional effects between race and gender for BPD? My fourth research question is: What is the impact of three types of childhood abuses—physical, sexual and emotional—on having BPD?

CHAPTER 2

LITERATURE REVIEW

Borderline Personality Disorder (BPD) is a severe personality disorder (Cluster B type) that impacts anywhere between 1%-5% of individuals, with women reportedly experiencing higher levels of disability than males (De Genna et al. 2011; Kulkarni 2017; Lugboso and Aubeeluck 2017). One study claims that this disorder impacts more individuals than those with schizophrenia or autism (De Genna et al. 2011). Recent studies found this disorder to be most prevalent in white middle-class women (De Genna et al. 2012; Skodol and Bender 2003), which could be a consequence of unrepresentative datasets sampling a very small number of minorities (Newhill, Eack, and Conner 2009). BPD is a disorder characterized by numerous negative personality traits, such as emotional and behavioral dysregulation.

Individuals with BPD often suffer from the following symptoms: excessive fear of abandonment, unstable and often volatile relationships, impulsive and self-destructive behavior (risky sex practices, alcohol, or drug abuse), suicidal thoughts and self-harm, unstable mood, persistent feelings of emptiness, difficulty controlling anger, and being paranoid when stressed (De Genna et al. 2011; De Genna et al. 2012; Oltmans, Weinstein, and Oltmans 2014). Research has also found that women with this disorder have higher instances of sexually transmitted diseases, as they tend to be more sexually promiscuous because of lack in impulse control (De Genna et al. 2011). The DSM-5 requires an individual to suffer from at least five of these symptoms for at least a year to be diagnosed with BPD (Fall and Craig 1998).

Studies have found that this disorder becomes diagnosable when the patient reaches early adulthood (De Genna et al. 2012). This is the result of clinicians being hesitant to diagnose someone under 18 years of age with Borderline Personality Disorder, although there are

definitive indicators that appear during adolescence (Ellison et al. 2018). Some studies show that the severity of symptoms increases with age (De Ganna et al. 2012; Macintosh, Godbout, Dubash 2015), although other studies posit that symptoms decline with age and suggest that impulsivity control is something that is developed as individuals mature (Ellison, Rosenstein, Morgan, and Zimmerman 2018).

BPD and Gender

Men are not diagnosed with BPD nearly as often as women. By reviewing current literature pertaining to this disorder, it is evident that there are several potential reasons why BPD is significantly underdiagnosed, particularly for men. The reasons could be the result of stigmatization that men may fear when admitting to childhood abuse/suicidality, as well as the belief of difference in presentation of symptoms between genders, or even gender-biased clinicians who remain under the impression that women are the only ones who may develop this disorder (De Ganna et al. 2011; Kling 2014; Koekkoek, van Meijel, and Hutschemaekers 2006; Skodol and Bender 2003).

Negative stigmatization from clinicians may lead to misdiagnosing or discouraging patients from returning to seek help rather than "sickness," and do not see a reason to provide mental health treatment (Bower 2013). Clinicians have also stigmatized or shamed their personality disorder patients and sometimes refuse to see patients with Borderline Personality (Kling 2014; Kulkarni 2017). There are several reasons for this stigmatization.

First, it is increasingly common for psychiatrists or therapists to define a BPD patient as "difficult," or they believe that the disorder is a sign of "badness" rather than "sickness," and do not see a reason to provide mental health treatment (Bower 2013). By creating this negative

connotation, particularly towards such an emotionally vulnerable population, clinicians may perpetuate negative self-image (Bower 2013; Kling 2014; Kulkarni 2017). Koekkoek et al. (2006) conducted interviews with mental health providers in order to determine which population was perceived to be the most difficult to work with, and the results indicated that mental health providers were four times more likely to view Borderline Personality Disorder patients as being most difficult. This finding suggests a potential negative bias that may be more permeated in mental health culture than realized previously.

Secondly, some clinicians argue that BPD is a controversial diagnosis that overlaps with too many other disorders (MacIntosh, Godbout, and Dubash 2015). BPD is most often misdiagnosed with Bipolar disorder, or in some cases completely overlooked (Zimmerman and Gazarian 2014; Skodol and Bender 2003; Sulzer 2015.) Very few clinicians claim that this personality disorder is not an actual disorder, but rather see it as a way to codify "needy," "manipulative," and "attention-seeking" individuals (Bower 2013; Sulzer 2015). Studies examining stigmatization and BPD suggest that clinicians may argue for Borderline Personality Disorder to be applied solely to extremely "difficult" patients that appear to be manipulative, clingy individuals not needing any real treatment (Bower 2013). Research indicates while it is already difficult to find a provider who understands BPD and has a solid knowledge of BPD, it becomes even more difficult when therapists and counselors refuse to see patients (Ntshingila et al. 2016).

Thirdly, BPD has been claimed to be vastly underdiagnosed, or often misdiagnosed due to lack of research/funding (Bayes and Parker 2017; Kulkarni 2014; Skodol and Bender 2003). According to Zimmerman and Gazarian (2014), Borderline Personality Disorder receives significantly less funding for research than better known personality disorders such as Bipolar

disorder. When they searched for specific keywords ("under recognition, underdiagnosis, BPD") on PubMed in 2014, they only found one article, which had been written 15 years previously. There is also severe underdiagnosing for men, which needs attention.

In a study involving prison inmates, Black et al. (2007) found that 30% of male and female offenders could receive a formal BPD diagnosis, and that females had a higher rate of the disorder than men. Another study found when sampling 220 male and female prisoners that females were twice as likely to be diagnosed with the disorder, as opposed to males; however, they also found that there was a surprisingly high number of male participants who also had the disorder and suggested that this indicated that both sexes should be screened upon entry of prison (Black et al. 2007). Further evidence of males having BPD was found in another sample of 164 violent male offenders, in which 57% met criteria for a formal diagnosis. Wetterborg et al. (2015) found BPD in roughly 20% of males on parole or probation in one sample.

Lastly, the belief that men's and women's symptoms are presented uniformly may result in either gender not being properly diagnosed or being misdiagnosed. Studies have also found a difference in how symptoms are manifested between genders. First, men diagnosed with BPD have been found to be at risk for developing lifelong substance abuse disorders (Tadic 2009) as well as violent outbursts, or to exhibit symptoms of intermittent explosive disorder, and binge eating (Bayes and Parker 2017; Black et al. 2007). Tadic (2009) found that men have also been found to have a higher risk of having avoidant, depressive, narcissistic, schizotypal, paranoid, and sadistic personality disorders. Women have higher rates of avoidant, histrionic, anxiety, and eating disorders, as well as PTSD (Bayes and Parker 2017).

BPD and Abuse

Previous research has found that victims of childhood abuse such as sexual abuse, physical abuse, and neglect are strong predictors for those with Borderline Personality Disorder, particularly when paired with genetic susceptibility (Lugboso and Aubeeluck 2017; Kukarni 2014; Soloff, Feske, and Fabio 2008;). Research has indicated that the two strongest variables, particularly when combined, are neglect and sexual abuse, which has been found to be significantly correlated with Borderline Personality Disorder (De Genna et al. 2011; Lugboso and Aubeeluck 2017).

Sexual abuse, in the terms of this study, is defined as any act that is sexual and the victim did not give permission for, or was manipulated into giving consent (Ferreria et al. 2018). One important risk factor in females with BPD is a history of childhood sexual abuse and neglect, rather than physical abuse (Bayes and Parker 2017). Individuals also reported being sexually abused by more than one person (Kuo et al. 2015). One study found that 30% of female childhood sexual abuse (CSA) victims would receive a BPD diagnosis later on in life, while another claimed 91.6% of women in a study that had been diagnosed with BPD has suffered from some type of sexual abuse (Elzy 2011). Victims of CSA experience higher rates of attempting suicide as adults (Soloff, Feske, and Fabio 2008). Several studies have found that the severity of BPD is strongly dependent on the presence of childhood sexual abuse (Ferraz et al. 2013; Soloff, Feske, and Fabio 2008).

Further research claims that emotional abuse and neglect are the strongest predictors for BPD prevalence in males (Bayes and Parker 2017; Kuo et al. 2015). However, other research counters this claim, suggesting that males with BPD suffered from severe and frequent levels of physical abuse during childhood, as well as neglect (Kurdziel, Kors, and Macfie 2018). This

could be the result of females reporting higher instances of CSA in general than men. Most studies point to emotional abuse being a primary contributor to one developing Borderline Personality Disorder in adulthood. Overall these findings indicate that abuse is a significant predictor in predicting adulthood BPD.

BPD and Race

When examining symptoms stratified by gender and race, some literature suggests a variation of how symptoms are presented and the pervasiveness of them (Ellison et al. 2018). One powerful myth with Borderline Personality Disorder is that it is a disorder primarily affecting white, American women (De Genna and Feske 2013; Newhill, Eack, and Connor 2009). While the literature is lacking in this area, several new studies have emerged disproving this theory (Ellison et al. 2018), as research shows that this may be the result of African Americans not being diagnosed as frequently or accurately as Caucasians (De Genna and Feske 2015; Ellison et al. 2018; Newhill, Eack, and Connor 2009). Similarly, a study investigating the effect of a clinician's race and the patient's race indicated that African Americans were diagnosed more frequently when assigned a female African American clinician (Robinson 1995). This could suggest the lack of cultural awareness of some practitioners when working with patients of different ethnic or racial backgrounds.

There have been very few studies done that include large minority sample sizes, and most consist primarily of whites (Ellison et al. 2018; Newhill, Eack, and Connor 2009). This could be the source of the perception that Borderline Personality Disorder is exclusively a white female disease (Lugbosos and Aubeeluck 2017). More studies have claimed that symptoms may vary by race due to cultural differences. Present research has found that African American individuals,

for example, exhibit less suicidal behavior and self-harm than white Americans (Ellison et al. 2018; Newhill et al. 2009). The literature indicates that there needs to be a further analysis on racial differences regarding exhibition of symptoms. Research on men and the possible differences between their symptoms and treatment plans also need to be further investigated.

To address some of the problems identified with previous research in terms of sample limitations for accurately understanding the social patterns of BPD diagnosis, this study analyzes the differences in BPD diagnosis between gender and race, as well as the impact that sexual and emotional abuse may have on the individual using a large-scale, nationally representative sample of Americans.

CHAPTER 3

METHODOLOGY

Data Source

To examine the sociological patterns of BPD diagnosis, I analyzed data from the National Epidemiologic Survey on Alcohol and Related Conditions. This dataset was collected via face-to-face interviews, from August 2004 to September 2005. The data that was collected has information on participants' lives from 2002 until the date of the interview. The population surveyed were the adult population of the United States (this includes Alaska, Hawaii, and DC) that were not in any institutions at the time. This data set is composed of 34,653 respondents who either answered "yes" or "no" when asked if they had Borderline Personality Disorder. This is the second wave in this study, as the first was done between 2001 and 2002. This sample was randomly selected by a systematic sample of houses. The researchers who collected this data controlled for areas that were extremely dense in population. They also oversampled Blacks and Hispanics, sampling 19.1% of blacks rather than the 12.3% of the American population at the time, and 19.3% of Hispanics as opposed to 12.5%.

Variables

As shown below in table 1, I have listed each independent variable as well as examples of the questions used to survey respondents, as well as the answer choices they were provided.

Table 1. *Variables Used*

Independent Variables	**Questions**	**Responses**
Race	"What is your race"	White—Black—Asian Hispanic—American Indian
Gender	"What is your gender?"	Male or Female
Sexual Abuse ***(Scale composed of 16 questions) Severity ranging from 0 (never) to 16 (Always)***	"Before age 18, how often did an adult or parent fondle/ touch you in a sexual way?" "Before age 18,	Never—Almost Never—Sometimes—Fairly Often—Very often
Emotional Abuse ***(Scale composed of 3 questions) Severity ranging from 0 to 3***	"Before age 18, how often did a parent/caregiver swear, insult or say hurtful things to you?"	Never—Almost Never—Sometimes—Fairly Often—Very Often
Physical Abuse: ***(Scale composed of 6 questions.) Severity ranging from 0-6.***	Before the age of 18, how often did a parent/caregiver push, grab, shove, slap, or hit you?	Never—Almost Never—Sometimes—Fairly Often—Very Often

Income	Total Personal Income (Including any income from food stamps)	$0 (No personal income)--$35,000 to $39,999 $1 to $4,999 ----------$40,000 to $49,000 $5,000 to $7,999----------$50,000 to $59,999 $8,000 to $9,999----------$60,000 to $69,000 $10,000 to $12,999---------$70,000 to $79,000 $13,000 to $14,999---------$80,000 to $89,000 $15,000 to $19,999---------$90,000 to $99,000 $20,000 to $24,999----------$100,000 or more $25,000 to $29,999 $30,000 to $34,999
Age	Age at time of interview	20 years old to 89 years old 90 years old or older
Education	Highest Grade of School Completed	No formal schooling----------Some high school Grade K, 1, or 2--------Completed High School Grade 3 or 4----------GED Grade 5 or 6----------Some college Grade 7----------Associates Grade 8----------Bachelor's Some High School----------Some graduate Completed Master's degree or higher

Race

Participants were asked to select from the following to determine their ethnic or racial identity: 1) White, non-Hispanic 2) Black, non-Hispanic 3) American Indian 4) Asian 5) Hispanic, any race. In order to examine the relationship between each race and borderline personality disorder, I dummy coded each racial category into its own variable, comparing each group to whites.

Gender

Participants were asked to select their gender: "Are you female or male?" Data collectors had assigned male as 1, and females as 2. I recoded this to ensure that females were the reference group. By dummy coding this variable, it allowed me to contrast men and women to my other variables.

Sexual Abuse Scale

Participants were asked to respond with one of the following options, with severity ranging from: 0) Never, 1) Almost Never 2) Sometimes 3) Fairly Often 4) Very Often. An example of this question was "Before Age 18, how often did an adult or parent fondle/touch in a sexual way that made you uncomfortable? There were four total questions about childhood sexual abuse, the researchers who collected the data created a scale that ranged from 0-16, with 0 indicating never been sexually abused, and 16 indicating severe, frequent sexual abuse. The Cronbach's alpha for this was .907.

Emotional Abuse Scale

Participants were asked three questions, with severity ranging from: 0) Never 1) Almost Never 2) Sometimes 3) Fairly often 4) Very often. An example of a question asked: "Before age 18, how often did a parent/caregiver swear, insult, or say hurtful things to you?" Those who collected data then created a scale that ranged from 0 to 3, with 0 indicated no emotional abuse, and 3 indicating severe and frequent emotional abuse. I dichotomized the variables into abuse or no abuse, as "almost never" being abused still indicates some level of abuse. The Cronbach's alpha for this scale was .850.

Physical Abuse Scale

To measure physical abuse, participants were asked six questions with severity ranging from: 0) Never 1) Almost Never 2) Sometimes 3) Fairly often 4) Very often. An example of these questions was: "Before the age of 18, did parent/caregiver push, grab, shove, slap, or hit you?" I dichotomized the variables into abuse or no abuse, as "almost never" being abused still indicates some level of abuse The Cronbach's alpha for this scale was .809.

Analytical Strategy

To measure the accuracy of the three abuse scales, I inserted them into the reliability analysis to measure the mathematical likelihood of answering all three scales with similar probability. All of the abuse scales had Cronbach's alpha scores higher than .8. indicating high levels of internal reliability to the scales. I conducted contingency table analyses to examine the relationship between different races and BPD, and as well as for BPD and gender. This revealed how many males or females, and each member of the races surveyed that have BPD. Doing this will allow me to test the idea that only white females are diagnosable with BPD, as well as whether there are racial differences in BPD between whites and minorities. I then utilized a t-test to compare the averages of my three abuse scales to see whether those diagnosed with BPD have experienced significantly higher levels of childhood abuse.

After looking at bivariate patterns of BPD by race, gender, and childhood abuse, I conducted three binary logistic regressions to show the impact of independent variables while controlling for other factors. To measure all variables compared to one another while controlling for gender and race I performed a binary logistic regression I compared gender, race, and borderline personality disorder alone at first. Then, to determine if types of abuse was a stronger

influence on the variables, I added a sexual abuse, physical abuse, and emotional abuse scale. I then ran separate analyses for men and women to determine if there are any predictors of BPD that are conditioned on gender identity.

CHAPTER 4

RESULTS

Reliability Analysis

Table 2 shows the mean, standard deviation, internal reliability of each of the childhood abuse scales. The authors of the scales originally did not include what the Cronbach alpha was, therefore this was necessary to ensure each abuse scale was answered in a similar mathematical way.

Table 2. *Reliability of Abuse Scales*

Variable	Cronbach Alpha	Mean	SD
Physical Abuse	*.809*	*1.65*	*3.10*
Emotional Abuse	*.850*	*1.44*	*2.46*
Sexual Abuse	*.907*	*.439*	*1.70*

Chi-Square: Gender

Then, a cross tab analysis was conducted, where I performed a chi square with borderline personality disorder and gender. This found a marginally significant relationship between gender and Borderline Personality Disorder $\chi^2(1)=82.097$, p=.053. The data found that 6.1% of men reported having BPD, and 6.7% of females did. Using a non-clinical sample, there is very little difference between men and women on having BPD. This calls the idea that BPD is more of an issue for women into question.

Chi-Square: Race

Another cross-tab analysis was conducted with Borderline Personality Disorder and the racial self-identification. The chi-square indicates that race is a significant predictor regarding BPD, χ^2 (4)=82.097, p=.000. On Table 4 below, the percentages of respondents by race are

listed. Native Americans (12.8%) are by far the most likely to report BPD, followed by African Americans (8%), and then white (6%) and Hispanic Americans (6%). These results dispel the idea that BPD is more common among white people.

Table 4. *BPD Rates by Race and Ethnicity*

Races	Percent with BPD
Native Indian	12.8%
Asian	4.1%
Black	8%
Hispanic	6%

Binary Logistic Regressions

Table 5. *Binary Logistic Regression Predicting BPD with Race and Gender*

Variables	b	Odds Ratio
Native Indian	.829***	2.292
Asian	-.395*	.674
Black	.299***	1.349
Hispanic	-.010	.990
Men	-.069	.934
Model Stats		
N	34653	
Nagelkerke R^2	.006	

Source: 2005 National Epidemiologic Survey on Alcohol and Related Conditions
*p<.05; **p<.01; ***p<.001

I conducted a binary logistic regression (see table 5) to determine the relationship between races and gender with borderline personality disorder. Each race was dummy coded (0=not black 1=black) and gender was as well (0=females 1=males) to determine if race and or gender was positively related with BPD. When controlling for race and gender, I found that the regression indicates a positive relationship between blacks and Native Americans for BPD compared to whites. Blacks have 34.9% higher odds than whites to be diagnosed with BPD.

Native Americans were 2.2 times more likely than whites to be diagnosed with BPD than whites. When comparing race and gender to Borderline Personality Disorder, it appears that gender is not a significant predictor, while there are important and significant differences by race.

Table 5. *Binary Logistic Regression Predicting BPD by Race, Gender, and Abuse*

Variables	b	OR
Native American	-.265	.767
Black	.318***	1.374
Men	.095*	1.100
Hispanic	-.022	.978
Asian	-.265	.767
Sexual Abuse***	.130	1.139
Physical Abuse	.034	1.034
Emotional Abuse	.188***	1.207
Model Stats		
N	33954	
Nagelkerke R^2	.117	

Source: 2005 National Epidemiologic Survey on Alcohol and Related Conditions
*p<.05; **p<.01; ***p<.001

In Table 5 I added sexual abuse, physical abuse, and emotional abuse into the regression model. I found that sexual and emotional abuse, as well as being African American or Native American are significant when controlling for abuse with BPD. The first model explained only .6% of variance. The model now explains 11.7% of variance in Borderline Personality Disorder. When abuse factors are introduced to the model, men have 10% higher odds than women to have BPD. Increasing severity in sexual abuse increased the odds of having BPD by 13.9% for each unit increase on the abuse scale, while emotional abuse increased the odds by 20.7% for each unit increase on the emotion abuse scale. Based on the predictors in this model, Blacks, males, and those impacted by sexual and emotional abuse were all more likely to have BPD. Blacks have 37.4% higher odds than whites to have Borderline Personality Disorder. After controlling for childhood abuse, Native Americans were not significantly more likely to have BPD than

whites, indicating that the elevated levels of BPD among Native Americans are the result of higher levels of childhood abuse.

Table 6: Binary Logistic Regression Predicting BPD Separately for Men and Women

	Men		Women	
Variables	b	Odds Ratio	b	Odds Ratio
Age	-.022***	.978	-.032***	.969
Education	-.049*	.952	-.084***	.919
Income	-.100***	.905	-.046***	.955
Native American	.621*	1.861	.116	1.124
Asian	-.196	.822	-.591**	.554
Black	.100	1.105	.173**	1.189
Hispanic	-.227*	.797	-.463***	.629
Physical Abuse	.088*	1.092	.025	1.025
Sexual Abuse	.174***	1.190	.112***	1.118
Emotional Abuse	.167***	1.182	.186***	1.204
Model Stats				
N	14,564		20,089	
Nagelkerke R^2	.144		.173	

Source: 2005 National Epidemiologic Survey on Alcohol and Related Conditions
*p<.05; **p<.01; ***p<.001

Table 6 shows binary logistic regression models predicting BPD separately for men and women to see if there were any differential predictors depending on gender. These models also added age, education, and income as control variables. Black men have 10.5% higher odds than white men of having BPD. Black women did not have significantly higher odds than white women of having BPD. Native American men have 86.1% higher odds than white males, while Native American women do not. Asian women are 55.4% less likely than white women to have BPD. Asian men did not have statistically higher odds that white men of having BPD. Hispanic women are 37.1% less likely than white women to have BPD. Hispanic men are 20.3% less likely than white men to have BPD. Women are 11.8% more likely to develop BPD for unit increase on the sexual abuse scale, and 20.4% more likely to develop BPD for each unit increase on the emotional abuse scale. Physical abuse is not a significant predictor for women; however,

it is for men. Men have 9.2% higher odds of developing BPD when physical abuse is present. Men also have 19% higher odds of having BPD when sexual abuse is present, and 18.6% higher odds when emotional abuse is present. Data suggests that men have 2.2% lower odds of developing BPD for each additional year of age, while women have 3.1% lower odds of developing BPD for every year they get older. For every year of education achieved, men have 4.8% lower odds of developing BPD, while women have 8.1% lower odds.

CHAPTER 5

CONCLUSION

Borderline Personality Disorder is often assumed to be a "white woman's disease." In contrast to this idea, data from a large-scale and nationally representative sample of Americans shows that minorities actually experience higher incidences than whites regarding BPD. In particular, Native Americans and African Americans have elevated levels of BPD compared to whites. This contradicts most of the literature that is currently present based on clinical samples. Most studies have not had a large enough sample of minorities, and as a result have not accurately explained the impact of BPD on racial minorities.

Similarly, in contrast to the assumption that BPD is more common among women, data from this larger epidemiological sample show little difference between men and women on having BPD. Most studies also claim that gender is a significant driving factor; however, I have found that it is only marginally significant and that there was very little difference between men and women on having BPD. Further, after controlling for levels of childhood physical, sexual, and emotional abuse, it was actually men that were significantly more likely to have BPD. This suggests that to the extent women are more likely to have BPD it is because they are more often victims of emotional and sexual abuse, and therefore are more at risk. Overall, the data and analyses shown here suggest that gender alone is not a significant driving force behind BPD.

The strongest predictors of BPD identified for all people, regardless of gender or race, were higher levels of experiencing childhood abuse. In this sense it is important to recognize that BPD is often a response to traumatic abuse rather than something that is primarily the result of gender or race.

Limitations for this study include the attrition from wave 1 and using older secondary data. There needs to be more research on the relationship of racial and ethnic identification and BPD, particularly regarding abuse exposure. Lastly, there needs to be more of a targeted sample of respondents specifically with BPD. Even with a large dataset such as the one analyzed in the current study, there is still a low number of individuals with this diagnosis. At the same time, this study is one of the first to assess BPD in a non-clinical sample in order to test some of assumptions and myths that have come about from reliance on clinical samples.

The results of this study could be utilized in regards to alterations or additions to current policies pertaining to childhood abuse. Clinicians can use the information provided from this analysis, to better evaluate individuals who exhibit symptoms of BPD. Childhood abuse is the strongest predictor for developing Borderline Personality Disorder, and therefore needs to be more closely examined when assessing a person. It is possible that this critical variable is not being investigated as thoroughly as it needs to be. For example, the data suggested that physical abuse a predictor for men. Does this influence the presentation of symptoms due to gender or type of abuse?

Future research should also address the variation of symptom presentation. By developing, or utilizing a symptom measure, researchers could further analyze the breakdown of specific symptoms by race, gender, type and severity of childhood abuse. This would allow investigators to examine a broad range of symptoms and why/how they are presented. By including a thorough history of childhood abuse, further variance may be explained.

In conclusion, the myth that Borderline Personality Disorder is a “white woman’s disease” masks the many people of color and men who have it, as well as the fact that the most important predictors of BPD across all social statuses, according to this research, are experiences

of childhood abuse. The type and severity of abuse does seem to influence men and women differently. This too represents the immense need for further research and analysis in order to understand the predictors and patterns of BPD, a disorder that affects the lives of millions of people, regardless of race or gender, every day.

The results of this study could be utilized in regards to alterations or additions to current policies pertaining to childhood abuse. Clinicians can use the information provided from this analysis, to better evaluate individuals who exhibit symptoms of BPD. Childhood abuse is the strongest predictor for developing Borderline Personality Disorder, and therefore needs to be more closely examined when assessing a person. It is possible that this critical variable is not being investigated as thoroughly as it needs to be. For example, the data suggested that physical abuse as a significant predictor for men. Does this influence the presentation of symptoms due to gender or type of abuse?

Future research should also address the variation of symptom presentation. The current study was unable to do so, and rather treated Borderline Personality Disorder as a monolithic category. By developing, or utilizing a symptom measure, researchers could further analyze the variations of BPD as well as examining the important social categories such as race, class, gender, and across the various types of childhood abuse categories. By doing so, we can further pinpoint the significance of particular symptoms and predictors, and develop better tools to detect BPD closer to the onset of symptoms.

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