

Borderline Personality Symptomatology and History of Domestic Violence Among Women in an Internal Medicine Setting

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In this study of primary care patients, we examined the relationship between a history of domestic violence (measured with the Severity of Violence Against Women Scale [SVAWS]) and borderline personality (measured with the Self-Harm Inventory [SHI] and the Personality Diagnostic Questionnaire-4 [PDQ-4]). We elected borderline personality for examination because several diagnostic criteria sets describe relationship features suggestive of partner abuse. In this study, both measures of borderline personality were highly related to each other ($r = .73, p < .001$) as well as to the SVAWS ($r = .70, p < .001$, for the SHI; $r = .73, p < .001$, for the PDQ-4). Using diagnostic cutoff scores on the measures for borderline personality, 64.0% of those with histories of domestic violence scored in the positive range on either or both measures, while only 11.1% of nonabused women did. We discuss the clinical implications of these findings.

Keywords: personality disorders; Self-Harm Inventory; physical abuse; intimate partner violence

Unfortunately, many women experience domestic or intimate-partner violence. For example, using telephone interviews among a community sample, 6% of women reported physical violence or threats from their intimate partners (Weinbaum et al., 2001). The lifetime prevalence of such experiences appears to be considerably higher among women presenting for medical services. For example, about one-third (Ernst, Nick, Weiss, Houry, & Mills, 1997; Krishnan, Hilbert, & Pase, 2001) to one-half (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995) of women patients in emergency rooms and approximately half of women surveyed in primary care settings

have experienced violence from an intimate partner (Fairchild, Fairchild, & Stoner, 1998; Johnson & Elliott, 1997; Richardson et al., 2002).

Is there any possible relationship between a history of domestic violence and borderline personality symptomatology (BPS)? Several diagnostic criteria sets suggest so. One of the diagnostic criteria for borderline personality disorder (BPD) in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [DSM-IV]; American Psychiatric Association, 1994) is "a pattern of unstable and intense interpersonal relationships." In the Diagnostic Interview for Borderlines (DIB; Kolb & Gunderson, 1980), one item queries, "Do you often find that you are hurt, abused, or feel victimized in close relationships?" This item is further clarified by the statement, "... problems with dependency and masochism recur in the patient's close relationships." In the Borderline Personality Disorder Scale (Perry, 1982), two items relate to interpersonal violence: (a) "repeated intense but short-lived relationships that are unstable or stormy" and (b) "subject has been emotionally or physically abused in relationships (becomes somewhat masochistic)." In the Diagnostic Interview for Personality Disorders (Zanarini, 1983), one criterion for BPD diagnosis is, "... had any close friendships, love affairs, or relationships with family members that have been stormy (i.e., troubled by a lot of intense arguments or repeated breakups)?"

There is an additional area of research that is suggestive of a relationship between BPS/BPD and domestic violence. Childhood sexual abuse is one of several variables that demonstrates a correlation with BPS (Goodman & Yehuda, 2002; Johnson et al., 2003; McLean & Gallop, 2003; Sansone, Gaither, & Songer, 2002; Zanarini et al., 2002), and childhood sexual abuse has been associated with revictimization in adulthood (Beitchman et al., 1992; Gladstone et al., 2004). Interestingly, childhood victimization appears to be a risk factor for intimate partner abuse in adulthood for women but not for men (Desai, Arias, Thompson, & Basile, 2002).

We are aware of only one study that has explicitly examined the relationship between domestic violence and BPS. Watson et al. (1997) examined 110 abused women who were recruited primarily from residential shelters and compared these with controls who were predominantly hospital employees. Using the Structured Clinical Interview for Mental Disorders-III-Revised (Spitzer, Williams, Gibbon, & First, 1990), these investigators found no between-group differences with regard to the prevalence of BPD (9% for abused subjects vs. 2% for controls).

In the current study, we hypothesized that BPS/BPD might heighten the exposure of women to volatile intimate partners, resulting in a higher likelihood of being a victim of domestic violence. Therefore, in comparison to those without histories of domestic violence, those with such histories should theoretically evidence a higher prevalence of BPS/BPD.

METHOD

Participants

Study candidates were women, ages 18 or older, unaccompanied at presentation, and seeking nonemergent treatment at an outpatient internal medicine clinic. This setting was elected because of recruitment convenience. Services in this clinic are provided by residents and faculty in the Department of Internal Medicine, which is sponsored by a private, community hospital in a midsized midwestern city. Candidates for this study were excluded if they were not able to complete a research booklet because of medical, physical, or cognitive impairment. A total of 57 candidates were approached; 52 agreed to participate for a response rate of 91.2%.

The 52 women ranged in age from 24 to 70 years, with a mean age of 48.94 ($SD = 11.32$). The large majority (92.3%) was Caucasian; the remaining four respondents

self-identified as African American ($n = 3$) or "Other" ethnicity ($n = 1$). The majority (57.7%) was currently married or had been married (25.0%); only 9 (17.3%) respondents had never been married. A substantial minority of the women had some college exposure (36.5%) or a bachelor's (21.2%) or graduate degree (15.4%). Ten (19.2%) had graduated high school only, and the remaining four women had not graduated high school.

Procedure

Each candidate was approached by one of two investigators as time permitted (i.e., a sample of convenience). After an introductory explanation to the project, each was given a research booklet to complete. Completion of the research booklet was assumed to be informed consent. The institutional review boards of both the community hospital and the university approved this project.

The research booklet explored demographic information and contained the following three measures (two for BPS/BPD and one for domestic violence):

Borderline Personality Disorder Scale of the Personality Diagnostic Questionnaire-4 (PDQ-4; Hyler, 1994). The PDQ-4 is a nine-item, true-false, self-report measure that directly reflects the *DSM-IV* criteria for BPD. All endorsements are pathological and scores of 5 or higher are highly suggestive of BPD. Previous versions of the PDQ have been found to be useful screening tools for BPD in both clinical (Dubro, Wetzler, & Kahn, 1988; Hyler et al., 1990) and nonclinical (Johnson & Bornstein, 1992) settings, including the use of the freestanding borderline scale (Patrick, Links, Van Reekum, & Mitton, 1995). In this study, the Cronbach's alpha for this scale was .86.

Self-Harm Inventory (SHI; Sansone, Wiederman, & Sansone, 1998). The SHI is a 22-item, yes/no, self-report survey that investigates respondents' histories of self-harm behavior. Each item is preceded by the phrase, "Have you ever intentionally, or on purpose," and items include "overdosed, cut yourself on purpose, burned yourself on purpose," and "hit yourself." Each endorsement on the SHI is in the pathological direction, and the total number of "yes" responses constitutes the overall SHI score. In addition to serving as a face-valid measure of self-harm behavior, the SHI is predictive of BPS/BPD. Using a cut-off score of 5, in comparison with the DIB (Kolb & Gunderson, 1980), the SHI correctly identified 84.7% of women with regard to meeting or not the diagnostic criteria for BPD (Sansone et al., 1998). In this study, the Cronbach's alpha for this scale was .89.

Severity of Violence Against Women Scale (SVAWS; Marshall, 1992). The SVAWS is a 46-item, self-report measure that explores three elements of violence against women: threats (19 items), acts (21 items), and sexual aggression (6 items). We modified the SVAWS for this study. First, because of the busy clinic setting, we eliminated items relating to sexual aggression and used only those related to threats and acts of violence, resulting in a 40-item scale. Second, we reduced the number of Likert-type response options from 10 to 5: 1 = "Never," 2 = "Rarely," 3 = "On Occasion," 4 = "Often," and 5 = "Very Often." Finally, rather than having participants respond to each item as it applied "over the past 12 months," we specified "throughout adulthood" to capture the lifetime prevalence of such experiences. The Cronbach's alphas for the Threats subscale and Acts subscale were .97 and .97, respectively.

RESULTS

Scores on the Threats subscale and the Acts subscale of the SVAWS were highly correlated ($r = .91$), leading to the decision to consider the 40 items as a single scale (Cronbach's

alpha = .98). Possible scores could range from 40 to 200, and actual scores ranged from 40 to 180 ($M = 63.20$, $SD = 30.48$).

As expected, scores on the PDQ-4 and SHI were highly related ($r = .73$, $p < .001$). Although there was a high degree of predictive overlap between the PDQ-4 and SHI, they were not entirely interchangeable. Ten of the 52 (19.2%) respondents scored above the diagnostic cutoff on both measures, four scored above the cutoff on the SHI but not the PDQ-4, and five scored above the cutoff on the PDQ-4 but not the SHI (i.e., 17.3% scored in the BPS/BPD range on one measure only). The remaining 63.5% of the sample scored below the BPS/BPD diagnostic cutoff on both the SHI and the PDQ-4.

As hypothesized, scores on the measures of BPS/BPD were highly related to scores on the SVAWS ($r = .70$, $p < .001$, for the SHI; $r = .73$, $p < .001$, for the PDQ-4). We next created comparison groups by determining which respondents endorsed SVAWS items with a greater frequency than "Never" or "Rarely." Nearly half ($n = 25$) of the 52 women respondents endorsed multiple SVAWS items as pertaining to "On occasion," "Often," or "Very Often." This group was labeled as having experienced domestic violence from relationship partners. The remaining 27 respondents indicated having experienced violence from relationship partners "Never" or "Rarely." This group was labeled the control group.

With regard to SHI scores, the domestic violence group ($M = 5.16$, $SD = 4.56$) and the control group ($M = 1.26$, $SD = 2.33$) exhibited a statistically significant difference, $F(1, 50) = 15.42$, $p < .001$. Similarly, with regard to PDQ-4 scores, the domestic violence group ($M = 4.36$, $SD = 2.68$) and the control group ($M = 0.93$, $SD = 1.62$) exhibited a statistically significant difference, $F(1, 50) = 31.94$, $p < .001$. Using the diagnostic cutoff score of 5 on the SHI, 48.0% of the domestic violence group compared to only 7.4% of the control group qualified for BPS/BPD, $\chi^2(1) = 10.87$, $p < .001$. Similarly, using the diagnostic cutoff score of 5 on the PDQ-4, 52.0% of the domestic violence group compared to only 7.4% of the control group qualified for BPS/BPD, $\chi^2(1) = 12.58$, $p < .001$. Using the diagnostic cutoff score of 5 on either the SHI or the PDQ-4, 64.0% of the domestic violence group compared to only 11.1% of the control group qualified for BPS/BPD on either measure, $\chi^2(1) = 15.66$, $p < .001$.

DISCUSSION

In a group of predominantly married, well-educated women in an outpatient primary care setting, we found that (a) scores on two measures of borderline personality significantly and positively correlated with a reported history of domestic violence and that (b) compared to those without such histories, those with a history of domestic violence had significantly greater likelihoods of a diagnostic score on either or both measures of BPS. These findings suggest that there is an association between BPS and an increased likelihood of being the victim of intimate-partner violence or abuse.

From a clinical perspective, these findings are highly relevant. For therapists treating victims of domestic abuse, it would appear critical to initially assess for comorbid BPS/BPD. If BPS/BPD is not present, it would seem clinically logical to facilitate the patient's departure from the abusive relationship (e.g., assist with physical relocation, job training, social support) and anticipate a relatively time-limited intervention, probably shaped by the presence or lack of posttraumatic stress disorder symptoms. If BPD is present, we would foresee a protracted course of psychological treatment, focused on attachment and relationship issues—that is, a longitudinal effort to circumvent the patient's reengagement in future abusive relationships.

Given our strong recommendation for the evaluation of BPS/BPD among victims of intimate-partner violence, we suggest adjunctive self-report tools for clinicians, including the PDQ-4 and the SHI. There is also the McLean Screening Instrument for Borderline Personality Disorder (Zanarini et al., 2003), which is a 10-item, yes/no, self-report questionnaire. From our experience with the first two measures, we strongly suspect that each identifies slightly different subpopulations with BPS/BPD. Whether one of the preceding measures will be particularly diagnostic among victims of domestic violence is unknown, but in this study, scores on the PDQ-4 and SHI were highly correlated.

Our findings differ from those of Watson and colleagues (1997). These differences may relate to the recruitment sites (i.e., residential shelters vs. primary care setting), the measures employed (i.e., structured clinical interview vs. self-report measures), and/or the population characteristics (e.g., education, marital status, elected departure from the home for those women in shelters). That our findings diverge indicates the importance of further studies in this area.

In this study, a substantial minority of participants demonstrated BPS. This percentage is comparable to our previous studies in this clinic and probably reflects the potential overinclusiveness of the self-report measures, our close geographic location to a community mental health center, and/or the nature of resident-staffed clinics that tend to attract uninsured patients.

This study has several potential limitations. First, the sample was one of convenience. Second, all data were self-report in nature (e.g., we did not corroborate histories of intimate-partner violence). Third, the sample size is relatively small. However, this is the second empirical study to examine the relationship between BPS/BPD and domestic violence, the first to confirm a positive correlation (despite weak statistical power), and the only one to use two measures for BPS/BPD assessment. These findings warrant further investigation in different samples using various measures for BPS/BPD.

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