Published in final edited form as:

J Pers Disord. 2016 June ; 30(3): 419–432. doi:10.1521/pedi_2015_29_202.

GENDER DIFFERENCES IN BORDERLINE PERSONALITY DISORDER FEATURES IN AN EPIDEMIOLOGICAL SAMPLE OF ADULTS AGE 55–64: SELF VERSUS INFORMANT REPORT

Alexander J. Busch, BA, Steve Balsis, PhD, Leslie C. Morey, PhD, and Thomas F. Oltmanns, PhD

Department of Psychology, Texas A&M University, College Station (A. J. B., S. B., L. C. M.); and Department of Psychology, Washington University, St. Louis, Missouri (T. F.O.)

Abstract

The literature on the prevalence of borderline personality disorder (BPD) across gender reveals multiple trends. A number of studies indicate that women have a higher prevalence. Others indicate no difference, and a few even reveal that men have a higher prevalence. Yet existing studies are plagued by sampling biases, use mainly self-reported information, and tend to report general prevalence of BPD categorically defined. The current investigation attempted to shed new light on this literature by analyzing BPD features dimensionally in a representative epidemiological sample of adults ages 55–64, using both self- and informant-reported perspectives. Data from the St. Louis Personality and Aging Network study revealed a significant interaction across gender and perspective, $F(1, 1360) = 23.46, p < .01$. Gender differences were found for self-report only, such that men reported greater BPD severity. Meanwhile, informant report indicated no gender difference. Trends underscore the importance of epidemiological sampling and multiple assessment perspectives when analyzing BPD.

Borderline personality disorder (BPD) consists of unstable affect, problems in interpersonal relationships, impulsivity, and identity disturbances. These features could very well be exhibited in either men or women, but whether they are more common for men or women is still disputed in the literature. A number of studies indicate that BPD features are more commonly expressed by women (Akhtar, Byrne, & Doghramhi, 1986; Widiger & Trull, 1993), while others show no significant difference across gender (Bernstein et al., 1993; Jackson & Burgess, 2000; Morey, Warner, & Boggs, 2002; Torgersen, Kringlen, & Cramer, 2001; Zimmerman & Coryell, 1989). Meanwhile, a few indicate that BPD features are more common in men (Barzega, Maina, Venturello, & Bogetto, 2001; Carter, Joyce, Mulder, Sullivan, & Luty, 1999; Henry & Cohen, 1983). What's at the heart of these trends remains an open empirical question.

SELECTION BIAS

The discrepancy in the results of certain studies can potentially be explained by selection bias (Morey, Alexander, & Boggs, 2005). Selection bias is the distortion of the results of a study due to the atypical (non-generalizable) composition of the sample, and it has been shown to influence the results of BPD prevalence studies (Hartung & Widiger, 1998; Skodol & Bender, 2003). Indeed, past studies of BPD have focused largely on clinical samples, and so generalizations to the population at large have been questioned.

An early meta-analysis of 23 studies by Akhtar and colleagues (1986) found evidence to support the claim that BPD is more common for women. However, this study included data from samples with questionable recruitment techniques and failed to account for the base rates of men and women in the samples. In an attempt to remedy these problems, a meta-analysis of 75 studies by Widiger and Trull (1993) was conducted with efforts made to account for the initial base rates. Based on the results of this study, the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (*DSM-IV-TR*; American Psychiatric Association, 2000) estimated that 75% of those diagnosed with BPD are women. Yet, the results of these meta-analyses are derived largely from clinical samples, which means that the higher prevalence of women in these studies may be due at least in part to the fact that the clinical population is different from the population as a whole. Women may be more likely to seek treatment for example (Möller-Leimkühler, 2002), and it may follow in turn that a woman with BPD may be more likely to seek treatment than a man with BPD. This tendency could in theory lead to an overrepresentation of women with BPD and an underrepresentation of men with BPD in clinical populations. Focusing on only clinical samples is a valid approach to estimate the prevalence of BPD in a clinical population, but these findings may not generalize. Without using carefully selected, epidemiological samples, one cannot make the definitive claim that BPD features are more prevalent in women.

In contrast to the results found when focusing on clinical samples, results found using community samples tend to indicate there is no significant difference in the prevalence of BPD. This conclusion comes from analyzing four large studies with an average of over 3,000 participants per study, a wide representation of ages 18 and over, and representation from various regions including New York (Bernstein et al., 1993), Iowa (Zimmerman & Coryell, 1989), Australia (Jackson & Burgess, 2000), and Norway (Torgersen, Kringlen, & Cramer, 2001). Supporting this finding, no significant difference in BPD across gender is found in certain college samples (Morey, Warner, & Boggs, 2002). This consistent finding in non-clinical samples suggests that BPD is equally prevalent in men and women who generally are not seeking treatment. However, these studies are limited in their ability to generalize, because although they were large samples, they were not epidemiological samples.

Further complications to the prevalence debate are introduced by studies that indicate BPD is more common in men. Evidence for this claim can be found across just a few particular samples including college students (Henry & Cohen, 1983), and clinical samples such as in depressed patients (Carter et al., 1999) and panic-disordered patients (Barzega et al., 2001).

The results of these studies are promising, but still come from specific types of samples that may not generalize. Thus, further research involving epidemiological samples is necessary to develop a full understanding of the prevalence of BPD and more fully understand these findings.

An epidemiological study that examined self-reported BPD across gender found that women had a slightly higher prevalence than men (Trull, Jahng, Tomko, Wood, & Sher, 2010). Even when the authors added a stipulation that each feature was considered present only if it led to impairment, the same relatively small difference remained. This study provided information on BPD using a generalizable epidemiological sample, but is limited in the information that it provides due to the implemented assessment techniques. Similar to previous studies, prevalence was defined using a categorical diagnostic threshold and also based only on one perspective, self-reported information in the context of a structured interview in which respondents may have been influenced by certain motivations to underreport BPD features. We discuss the limitations of these assessment techniques below, as well as provide a rationale for more informative techniques.

ASSESSMENT TECHNIQUES

Along with the potential issues from sampling bias, there are major issues that come from relying on categorical information about BPD. To meet diagnosis for BPD, an individual must exhibit at least five of the nine BPD features. This diagnostic threshold is somewhat arbitrary and based on minimal empirical evidence (Widiger & Trull, 2007), which means the prevalence of BPD may in fact be very different if one were considering a different threshold. Further, using a threshold implies that the phenomenon of interest is naturally categorical. However, evidence indicates that BPD is a dimensional construct (Krueger, 1999) and that individuals can have low, medium, or high degrees of BPD intensity. Thus, rather than specifying the percentage of people at or above a certain threshold, the dimensional approach would instead indicate the mean and a metric of variance (e.g., standard deviation), indicating the average standing and spread along the BPD spectrum, respectively. Many prior prevalence studies tend to lack this information.

Another important shortcoming that stems from relying solely on categorical *DSM*-based BPD diagnoses is that information about which features are present remains unknown. With five of nine features needed to meet the diagnostic threshold, mathematically there are 256 different ways to meet or exceed it. Prevalence studies that solely rely on this type of BPD categorization group all 256 of these different combinations together, despite the many potential differences that may exist between these supposedly similar individuals. Also, there are 256 different combinations that fall short of the diagnostic threshold, but many of these combinations have significant BPD pathology. This type of nuanced feature-level information is often lost in the prevalence studies. Rather than focusing on diagnosis, future studies should include at minimum summed information about the average standing along the BPD continuum. Ideally, information about individual features, or items, should be presented as well.

While the historical focus on categories omits potentially important information, the typical reliance on self-reported information (whether by questionnaire or by structured interview) also may fail to capture important and potentially valid information from other sources. Although self-report questionnaires are commonly used and provide a unique perspective that includes the individual's thoughts, intentions, feelings, and motivations (Mount, Barrick, & Strauss, 1994), these questionnaires often produce prevalence estimates that are discrepant from the results of other assessment techniques. For example, studies of PDs have found prevalence differences between self-report and clinical diagnoses (Hyler et al., 1989) and between self-report and informant report (Miller, Pilkonis, & Clifton, 2005; Oltmanns, Rodrigues, Weinstein, & Gleason, 2014).

Informant reports in particular may substantially add to the perspective provided by self-reports. Studies have shown, for example, that both self-reports and informant reports provide a unique and at least partially valid perspective for measuring BPD (Vazire & Mehl, 2008). In particular, the addition of informant-reported personality scores above and beyond self-reported personality scores accounted for an additional 8% to 20% of the overall variance in personality disorder features and 15% for BPD specifically (Miller et al., 2005). When attempting to establish the most accurate estimate of the prevalence of a disorder, it is important to study carefully selected epidemiological samples as well as to use multiple strategies for assessment.

What is at the heart of these discrepant findings between self and informant report remains an open empirical question, but several hypotheses have been suggested. Individuals with PDs may have, for example, an especially difficult time observing the ways in which their maladaptive personality features affect those around them (John & Robbins, 1994; Oltmanns, Turkheimer, & Strauss, 1998), and thus they may have trouble reporting accurately on these features. In a similar problem, evidence from a study of normal personality indicates that individuals might attempt to portray themselves in an overly positive or negative light (Furnham, 1997). This finding coupled with the inclusion of various useful validity scales (focused on lying, positive and negative impression management, etc.) on multiple different measures of disordered personality suggest that individuals across the spectrum of personality functioning may have tendencies to portray their personality in an overly positive or negative light. Although informant reports may circumvent the effects of this bias, there may be problems with informant reports as well. Both self reports and informant reports may help to characterize the disorder, such that one method is not necessarily superior to the other. Inaccuracies in the informant reports may also contribute to these discrepant findings. They could potentially be limited by the amount of available information, personal motivations, or their own reporting abilities. Given the extant evidence, neither informant- nor self-reported data should be thought of as privileged with respect to truth.

Regardless of the mechanisms at play, data tend to indicate that differing assessment perspectives (for example, self vs. informant report) can lead a researcher to draw different conclusions about PDs. This too may be true of attempts by researchers to estimate the prevalence of BPD in a population. The lack of substantial and definitive data that clearly describe the prevalence of BPD and its base rates within various populations can limit a

clinician's ability to make accurate predictions or sound clinical decisions (Meehl & Rosen, 1955). Studies that include multiple perspectives and non-biased representative samples are needed so that clinicians have more comprehensive information about base rates on which to base their clinical decisions.

THE PRESENT STUDY

The goal of this study is to provide further information on the intensity of BPD and its features across gender. To ensure that the data largely are free from selection bias, the data for the current analyses come from a carefully selected epidemiological sample of the St. Louis area that includes an accurate and proportional representation of men and women. To ensure that the data are not limited by exclusive reliance on self-report, we include both self- and informant-reported perspectives. We also focus on the BPD dimension and item level information because these more relatively natural and granular levels of analysis map nicely onto the dimensional nature of the general BPD construct. They also fit conceptually within the suggested model of personality pathology the field is moving towards (Krueger et al., 2011).

METHODS

PARTICIPANTS AND INFORMANTS

Participants came from the St. Louis Personality and Aging Network (SPAN) sample (Oltmanns et al., 2014), which is a longitudinal epidemiological sample that was formed through phone recruitment and has a 43% participation level of eligible households (out of 1,630 adults ages 55–64). All but 193 of the participants then provided an informant, leaving 1,437 participant and informant dyads. Seventy-seven dyads were not used in this particular study due to lack of complete information, leaving a final sample of 1,360 participant and informant dyads. Consistent with estimates of the St. Louis area population, 55.6% (756) of the participants were female and 67.9% (923) identified themselves as White while 29.8% (405) identified as Black. The highest level of education achieved for 30.7% of the participants was graduating high school. As for informants, 68.5% (756) were female, and 67.9% (923) identified as White, while 30.1% (408) identified as Black. Informants were slightly more educated than participants, as 15.3% of the informants' highest educational level was high school graduate, while the rest had received some form of post-secondary education. Of the eligible informants, 49% were romantic partners of the participant, 27% were family members of the participant, and 22% were friends of the participant. On average, participants reported knowing their informants for more than 30 years. The participants were compensated \$60 for completing the baseline assessment, and the informants were compensated \$30 for their participation in the baseline assessment.

MEASURES

The participants and informants were administered the Multi-source Assessment of Personality Pathology (MAPP; Oltmanns & Turkheimer, 2006). The MAPP is a self-report and informant-report measure designed specifically to assess *DSM-IV*PDs from the perspectives of multiple individuals. The MAPP includes one item for each diagnostic

criterion representing PDs in *DSM-IV*. The items were developed to translate diagnostic criteria into lay language, with each of the 81 items representing a PD symptom. The order of the items was randomized, and responses were made on a five point Likert scale ranging from 0–4. Each item provides a description of a PD criterion and a score that ranges from “0,” which indicates that the participant is “never like this,” to “4,” which indicates that the participant is “always like this.” The internal consistency of the MAPP in the same sample was calculated to be .69 for self report and .79 for informant report, which is on par with other commonly used and validated measures of psychopathology (Balsis, Cooper, & Oltmanns, 2014). The items on the self-report version are identical to the items on the informant-report version with the exception of the pronouns (i.e., “I” on the self-report version was changed to “he/she”). The fact that the measures are nearly identical allows us to compare the results between self-report and informant-report measures. For categorical analyses, items were considered present if they received a score of “2” or more.

RESULTS

Findings from a two by two (Gender $\times$ Perspective) ANOVA of the BPD dimension revealed a significant interaction across gender and perspective, $F(1, 1360) = 23.46, p < .01$. Gender differences were found for self-report only, such that men produced higher scores on the BPD scale ($M = 4.55, SD = 3.73$) than did women ($M = 3.23, SD = 3.25$). Meanwhile, informant report indicated no gender difference, Men, $M = 4.97, SD = 4.54$; Women, $M = 5.01, SD = 5.09$. We replicated this gender by perspective interaction at the scale level, treating each item as present or absent, $F(1, 1360) = 14.495, p < .01$. We also replicated it at the diagnostic threshold level, treating the syndrome as present or absent, $F(1, 1360) = 4.246, p < .05$. These discrepancies across both gender and perspective suggest that whether one finds gender differences across the BPD continuum will depend on the perspective of the assessment (see Figure 1).

Criterion-level analyses identified particular criteria that were found to have statistically significant interactions: efforts to avoid abandonment, $F(1, 1360) = 48.37, p < .01$, identity disturbances, $F(1, 1360) = 13.61, p < .01$, and impulsivity, $F(1, 1360) = 11.04, p < .01$. The patterns of these item-level interactions parallel the overall interaction—self-report tends to reveal a gender difference, whereas informant report reveals relative stability. This item-level information underscores these features as relevant subjects of inquiry for future studies and provides direction for future research on the mechanisms behind the overall trends in the data.

Further analysis of the items revealed particular features that have statistically significant main effects for gender or perspective (without a significant Gender $\times$ Perspective interaction). For the six items that lacked a significant interaction, only the item intense anger revealed a gender difference. Specifically, men had higher levels whereas women had lower levels (see Table 1 for values). For these same six items, four revealed a perspective difference (see Table 1 for values). Informants, in all instances, reported higher levels of relationship instability, affective instability, chronic emptiness, and paranoia than was observed in self-report.

DISCUSSION

Overall, findings indicated that in a carefully selected epidemiological sample, the relative level of BPD severity across gender differed based on whether one considered the self-report or informant-report perspective. Specifically, men relative to women more strongly endorsed BPD features. However, informants indicated no significant differences across target gender. This trend illustrates the fact that the gender distribution of BPD depends not only on the nature of the sample (e.g., community vs. clinical) as shown in previous research, but also on which assessment perspective one considers (self vs. informant report). Previous investigations have generally focused only on the self-reported perspective and as a result of this are missing key information provided by informant reports that could expand our understanding of BPD symptom expression.

Beyond providing this perspective of the informant, this study also adds to the literature through efforts to avoid sampling bias that may have hampered previous studies. Specifically, the previous literature has mainly included studies that use either clinical or convenience community samples (such as college students), each of which are limited in their ability to provide generalizable results. This study utilized a carefully selected epidemiological sample that has a proportional representation of men and women and represents well the broader community population. Thus, the results of this study may be more aptly suited to generalize to the community population.

Along with the inclusion of multiple assessment techniques and the use of an epidemiological sample, this study also reported BPD features dimensionally. This approach evaluates the net tendency for people to endorse the set of BPD items, information that goes beyond simply distinguishing between the members of a group categorically defined (Widiger & Trull, 2007). This information is significant and potentially useful. It can, for instance, help quantify significant but potentially subthreshold levels of BPD pathology. Lastly, research that reports dimensional information is formatted in such a way that conceptually fits within the dimensional models of psychopathology the field is moving towards (Kreuger et al., 2011). This makes information from these studies more aptly suited to meaningfully contribute to the body of literature surrounding BPD as it is understood dimensionally, similar to previous investigations that have used dimensional measures of BPD, such as the borderline subscale of the Personality Assessment Inventory (PAI; Morey & Boggs, 1991; see Moor, Distel, Trull, & Boomsma, 2009).

This study also included criterion-level information. Including this information provides a window into the features that contribute to the overall trends in the data. For instance, in this study, efforts to avoid abandonment, identity disturbances, and impulsivity were identified as criteria that received differential endorsement across gender depending on the assessment perspective (self vs. informant report). This study also identified intense anger as an item that was more frequently observed in men, regardless of assessment source. Further, a number of criteria, including unstable relationships, affect instability, chronic emptiness, and transient paranoia, demonstrated significant effects across perspective, with informant reports demonstrating higher levels of each of these features than self-report. Finally, the results also illustrate prevalence differences among the criteria themselves, with (for

example) “avoids abandonment” being much more common than “suicidal/self-injurious behaviors.”

The differential prevalence of BPD features observed across different sources of assessment dovetails nicely with findings from Hopwood and colleagues (2008), who compared self-reported and interview assessments of BPD and found that in certain instances the two perspectives provided different information about BPD features. In particular, self-report provided greater predictive validity than clinical interviews regarding experiential symptoms such as “identity disturbance.” In our study, we found that self-reported identity disturbance was more strongly endorsed than was informant-reported identity disturbance, and this gulf between self- and informant report was larger for men than it was for women. This finding from our study supports the notion that the assessment of this particular feature is significantly influenced by perspective, now having been shown in both a clinical and an epidemiological sample, and across self-report, interview, and informant-report perspectives.

Analyzing how BPD features (items) function across perspective and gender opens new avenues for inquiry, specifically by considering findings from studies that have not considered both variables together. For example, our feature-level analyses revealed that attachment, in as much as it is captured by the item “avoids abandonment,” differed across perspective and gender. This trend raises empirical questions about whether findings from well-conducted attachment studies (e.g., Choi-Kain, Fitzmaurice, Zanarini, Laverdière, & Gunderson, 2009) or other studies that rely largely on self-reported information collapsed across gender would differ if additional perspectives and gender were considered.

Attempts to consider both perspectives have often been met with challenges and limitations, including availability of time, availability of reliable informants, and availability of measures with both self-report and informant-report versions. However, as technology develops, these barriers seem less formidable. For one, today informant report measures could be filled out online, which wouldn't require much of the clinician's time. Similarly, people have become more interconnected and accessible, making it possible that clients could easily generate a list of potential trusted informants and their contact information (e-mail addresses). Conceivably, multiple informant-report assessments could be solicited, filled out, turned in, and scored automatically before the end of the first session. In another development, measures that assess multiple perspectives are becoming more common, such as the newly created Personality Inventory for the *DSM-5* (Krueger, Derringer, Markon, Watson, & Skodol, 2012), which includes a self- and informant-report version. Assessment of multiple perspectives provides valuable information that helps to develop a more complete understanding of disorder and should continue to be used as research and treatment in psychology continue to grow.

A notable characteristic of the sample is that it consists of individuals from the community who were experiencing a spectrum of BPD problems ranging from none, to very mild, to severe. For the most part, individuals tended to endorse very few BPD symptoms. Findings indicate, however, that meeting very few BPD symptoms may be clinically meaningful. A recent study revealed that the number of below-threshold BPD features endorsed is significantly related to six different psychosocial morbidity outcomes, including psychiatric

hospitalizations and suicidal ideation (Zimmerman, Chelminski, Young, Dalrymple, & Martinez, 2013). In fact, the presence of just one BPD symptom has been found to be significantly related to clinical impairment (Ellison, Rosenstein, Chelminski, Dalrymple, & Zimmerman, 2015).

One might wonder whether having only one of the BPD criteria rated as positive can be assumed to reflect borderline psychopathology. For example, if intense anger was the only criterion endorsed, can anger be assumed to be an indicator of borderline psychopathology? Or could endorsing anger reflect another disorder? The current research cannot answer this question. Whereas endorsement of subthreshold BPD pathology items in related research has found that the BPD criteria share significant correlations with the BPD scale as a whole (Balsis, Cooper, & Oltmanns, 2014), research also has indicated that BPD symptoms share associations with a variety of disorder constructs (Trull, 1995). Our results do not directly speak to this issue. Rather, our results more concretely indicate that community members commonly indicate a subthreshold number of symptoms on the BPD scale, a degree of symptom expression that is somewhat common and significantly related to clinically relevant outcomes.

The implications of these findings have important clinical utility given the sampling techniques used in this study. The use of a representative epidemiological sample of a common U.S. city allows these results to be well generalized to the community population. Consistent with existing data from community samples, our results suggest that the base rate of full threshold BPD is relatively low. However, while most previous studies only provide information on the base rate of full threshold BPD, our results are reported dimensionally to provide information on the base rate of subthreshold BPD features. The results indicate that the base rate of subthreshold BPD features in a community sample is relatively high, which suggests that a client from the community presenting for treatment has a relatively high probability of endorsing subthreshold BPD features. Due to the probability of such an endorsement and the clinically relevant problems found to be associated with endorsement of even one criterion, it becomes increasingly important for clinicians to assess BPD features of their clients. Assessing BPD features can provide important information to guide treatment planning and help the therapist address and prevent negative clinical outcomes related to subthreshold BPD, such as potentially damaging impulsivity and self-harm. Given that the prevalence of BPD features differs according to the gender of the target and the perspective of the assessment (self vs. informant), it is also important for clinicians to consider these variables in tandem.

There are several limitations of this study. For example, the fact that participants selected their own informant, whom they reported knowing for longer than 30 years on average, is potentially both a strength and a weakness of the current study. It could be a strength, in that the average duration of these relationships assures that the informants most likely knew the participants very well and could base their responses on years of evidence. On the other hand, the fact that the self-selected informants had known the targets for so long could be a limitation in that they may have had biases that affected their reporting (Leising, Erbs, & Fritz, 2010; Oltmanns & Turkheimer, 2006). The extent to which the number of years acquainted affects self- and informant-report ratings is an empirical question that could be

examined in future studies. Another potential limitation involves the nature of the sample, which was limited to individuals aged 55 to 64 years. It is not clear whether these results would generalize to younger samples. Although the generalizability to younger samples remains unknown, results highlight the importance of using multiple assessment perspectives and considering gender differences when assessing BPD features in adults approaching later life, which is an important time to assess BPD pathology (Oltmanns & Balsis, 2011). At the same time, there is a trend suggesting that as age increases, the likelihood that a person endorses BPD symptoms decreases (Paris & Zweig-Frank, 2001), and so the findings here might underestimate the endorsement found in younger populations. To complement these findings, future studies should seek to replicate the methods used in this study within other sample types, particularly clinical samples and younger populations.

Despite such limitations, the study provides meaningful information about gender differences in BPD, at both the diagnostic and criterion levels, with a well-selected epidemiological sample assessed using two important and contrasting perspectives. Future efforts to quantify and understand the amount of BPD severity across gender would ideally incorporate multiple techniques and limit selection bias, thus increasing the amount of relevant information gathered, and delineate factors that might lead to different estimates of gender distributions. The addition of this and similarly structured studies to the current body of literature can uncover information that has historically been understudied, discover and define trends underlying past conclusions, and generate a substantial body of data that is well suited to generalize to the population as a whole.

Acknowledgments

This work was supported in part by RO1-MH077840 awarded to Thomas F. Oltmanns.

REFERENCES

- Akhtar S, Byrne J, Doghramhi K. The demographic profile of borderline personality disorder. *Journal of Clinical Psychology*. 1986; 47:196–198.
- American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed.. text rev.. Author; Washington, DC: 2000.
- Balsis S, Cooper L, Oltmanns T. Are informant reports of personality more internally consistent than self reports of personality? *Assessment*. 2014 Advance online publication. doi: 10.1177/1073191114556100.
- Barzega G, Maina G, Venturello S, Bogetto F. Gender-related distribution of personality disorders in a sample of patients with panic disorder. *European Psychiatry*. 2001; 16:173–179. doi:10.1016/S0924-9338(01)00560-0. [PubMed: 11353596]
- Bernstein DP, Cohen P, Velez CN, Schwab-Stone M, Siever LJ, Shinsato L. Prevalence and stability of the DSM-III-R personality disorders in a community-based survey of adolescents. *American Journal of Psychiatry*. 1993; 150(8):1237–1243. [PubMed: 8328570]
- Carter JD, Joyce PR, Mulder RT, Sullivan PF, Luty SE. Gender differences in the frequency of personality disorders in depressed outpatients. *Journal of Personality Disorders*. 1999; 13(1):67–74. [PubMed: 10228928]
- Choi-Kain LW, Fitzmaurice GM, Zanarini MC, Laverdière O, Gunderson JG. The relationship between self-reported attachment styles, interpersonal dysfunction, and borderline personality disorder. *Journal of Nervous and Mental Disease*. 2009; 197(11):816–821. doi:10.1097/NMD.0b013e3181bea56e. [PubMed: 19996719]

- Ellison W, Rosenstein L, Chelminski I, Dalrymple K, Zimmerman M. The clinical significance of single features of borderline personality disorder: anger, affective instability, impulsivity, and chronic emptiness in psychiatric outpatients. *Journal of Personality Disorders*. 2015 _Advance online publication. doi:pedi_2015_29_193.
- Furnham A. Knowing and faking one's five-factor personality score. *Journal of Personality Assessment*. 1997; 69(1):229–243. doi:10.1207/s15327752jpa6901_14.
- Hartung CM, Widiger TA. Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the DSM-IV. *Psychological Bulletin*. 1998; 123(3):260–278. doi: 10.1037//0033-2909.123.3.260. [PubMed: 9602559]
- Henry KA, Cohen CI. The role of labeling processes in diagnosing borderline personality disorder. *American Journal of Psychiatry*. 1983; 140(11):1527–1529. [PubMed: 6625010]
- Hopwood CJ, Morey LC, Edelen MO, Shea MT, Grilo CM, Sanislow CA, Skodol AE. A comparison of interview and self-report methods for the assessment of borderline personality disorder criteria. *Psychological Assessment*. 2008; 20(1):81–85. doi:10.1037/1040-3590.20.1.81. [PubMed: 18315403]
- Hyler SE, Rieder RO, Williams JB, Spitzer RL, Lyons M, Hendler J. A comparison of clinical and self-report diagnoses of DSM-III personality disorders in 552 patients. *Comprehensive Psychiatry*. 1989; 30(2):170–178. doi:10.1016/0010-440X(89)90070-9. [PubMed: 2920552]
- Jackson HJ, Burgess PM. Personality disorders in the community: A report from the Australian National Survey of Mental Health and Wellbeing. *Social Psychiatry and Psychiatric Epidemiology*. 2000; 35:531–538. doi:10.1007/s001270050276. [PubMed: 11213842]
- John OP, Robins RW. Accuracy and bias in self-perception: Individual differences in self-enhancement and the role of narcissism. *Journal of Personality and Social Psychology*. 1994; 66(1):206–219. doi:10.1037/0022-3514.66.1.206. [PubMed: 8126650]
- Krueger RF. The structure of common mental disorders. *Archives of General Psychiatry*. 1999; 56(10): 921–926. doi:10.1001/archpsyc.56.10.921. [PubMed: 10530634]
- Krueger RF, Derringer J, Markon KE, Watson D, Skodol AE. Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine*. 2012; 42:1879–1890. [PubMed: 22153017]
- Krueger RF, Eaton N, Clark L, Watson D, Markon K, Derringer J, Livesley W. Deriving an empirical structure of personality pathology for DSM-5. *Journal of Personality Disorders*. 2011; 25(2):170–191. doi:10.1521/pedi.2011.25.2.170. [PubMed: 21466248]
- Leising D, Erbs J, Fritz U. The letter of recommendation effect in informant ratings of personality. *Journal of Personality and Social Psychology*. 2010; 98(4):668–682. doi:10.1037/a0018771. [PubMed: 20307137]
- Meehl PE, Rosen A. Antecedent probability and the efficiency of psychometric signs, patterns, or cutting scores. *Psychological Bulletin*. 1955; 52(3):194–216. [PubMed: 14371890]
- Miller JD, Pilkonis PA, Clifton A. Self and other-reports of traits from the five-factor model: Relations to personality disorder. *Journal of Personality Disorders*. 2005; 19(4):400–419. doi:10.1521/pedi.2005.19.4.400. [PubMed: 16178682]
- Möller-Leimkühler AM. Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders*. 2002; 71(1–3):1–9. doi:10.1016/S0165-0327(01)00379-2. [PubMed: 12167495]
- Moor MH, Distel MA, Trull TJ, Boomsma DI. Assessment of borderline personality features in population samples: Is the personality assessment inventory–borderline features scale measurement invariant across sex and age? *Psychological Assessment*. 2009; 21(1):125–130. doi: 10.1037/a0014502. [PubMed: 19290772]
- Morey, LC.; Alexander, GM.; Boggs, C. Gender. In: Oldham, JM.; Skodol, AE.; Bender, DS., editors. *Textbook of personality disorders*. American Psychiatric Publishing; Arlington, VA: 2005. p. 541–560.
- Morey, LC.; Boggs, C. Personality assessment inventory (PAI). PAR; Lutz, FL: 1991.
- Morey LC, Warner MB, Boggs CD. Gender bias in the personality disorders criteria: An investigation of five bias indicators. *Journal of Psychopathology and Behavioral Assessment*. 2002; 24(1):55–65. doi:10.1023/A:1014005308914.

- Mount MK, Barrick MR, Strauss JP. Validity of observer ratings of the big five personality factors. *Journal of Applied Psychology*. 1994; 79(2):272–280. doi:10.1037//0021-9010.79.2.272.
- Oltmanns TF, Balsis S. Personality disorders in later life: Questions about the measurement, course, and impact of disorders. *Annual Review of Clinical Psychology*. 2011; 7:321–349.
- Oltmanns TF, Rodrigues MM, Weinstein Y, Gleason ME. Prevalence of personality disorders at midlife in a community sample: Disorders and symptoms reflected in interview, self, and informant reports. *Journal of Psychopathology and Behavioral Assessment*. 2014; 36:177–188. doi:10.1007/s10862-013-9389-7. [PubMed: 24954973]
- Oltmanns, TF.; Turkheimer, E. Perceptions of self and others regarding pathological personality traits. In: Krueger, RF.; Tackett, JL., editors. *Personality and psychopathology*. Guilford; New York, NY: 2006. p. 71-111.
- Oltmanns TF, Turkheimer E, Strauss ME. Peer assessment of personality traits and pathology in female college students. *Assessment*. 1998; 5(1):53–65. doi:10.1177/107319119800500108. [PubMed: 9458342]
- Paris J, Zweig-Frank H. A 27-year follow-up of patients with borderline personality disorder. *Comprehensive Psychiatry*. 2001; 42(6):482–487. [PubMed: 11704940]
- Skodol AE, Bender DS. Why are women diagnosed borderline more than men? *Psychiatric Quarterly*. 2003; 74(4):349–360. doi:10.1023/A:1026087410516. [PubMed: 14686459]
- Torgersen S, Kringlen E, Cramer V. The prevalence of personality disorders in a community sample. *Archives of General Psychiatry*. 2001; 58:590–596. doi:10.1001/archpsyc.58.6.590. [PubMed: 11386989]
- Trull TJ. Borderline personality disorder features in nonclinical young adults: 1. Identification and validation. *Psychological Assessment*. 1995; 7(1):33–41.
- Trull TJ, Jahng S, Tomko RL, Wood PK, Sher KJ. Revised NESARC personality disorder diagnoses: Gender, prevalence, and comorbidity with substance dependence disorders. *Journal of Personality Disorders*. 2010; 24(4):412–426. doi:10.1521/pedi.2010.24.4.412. [PubMed: 20695803]
- Vazire S, Mehl MR. Knowing me, knowing you: The accuracy and unique predictive validity of self-ratings and other-ratings of daily behavior. *Journal of Personality and Social Psychology*. 2008; 95:1202–1216. [PubMed: 18954202]
- Widiger TA, Trull TJ. Plate tectonics in the classification of personality disorder: Shifting to a dimensional model. *American Psychologist*. 2007; 62(2):71–83. doi:10.1037/0003-066X.62.2.71. [PubMed: 17324033]
- Widiger, TA.; Trull, TJ. Borderline and narcissistic personality disorders. In: Sutker, PB.; Adams, HE., editors. *Comprehensive handbook of psychopathology*. 2nd ed.. Plenum; New York, NY: 1993. p. 371-394.
- Zimmerman M, Chelminski I, Young D, Dalrymple K, Martinez J. Is dimensional scoring of borderline personality disorder important only for subthreshold levels of severity? *Journal of Personality Disorders*. 2013; 27(2):244–251. [PubMed: 23514187]
- Zimmerman M, Coryell W. DSM-III personality disorder diagnoses in a nonpatient sample. *Archives of General Psychiatry*. 1989; 46:682–689. [PubMed: 2751402]

FIGURE 1.

Mean differences in BPD scores across gender and perspective.

BPD = Borderline Personality Disorder, Mapp = Multisource Assessment of Personality

Pathology. Men self-report: $M = 4.55$, $SD = 3.73$. Women self-report: $M = 3.23$, $SD = 3.25$.

Men informant report: $M = 4.97$, $SD = 4.54$. Women informant report: $M = 5.01$, $SD = 5.09$.

Difference in gender: $F(1,1360) = 12.32$, $p < .01$.

Difference in perspective: $F(1,1360) = 60.91$, $p < .01$.

TABLE 1**Self-Versus Informant-Reported Borderline Personality Disorder Severity Across Gender**

Item		Men <i>n</i> = 604	Women <i>n</i> = 756	F for Gender	F for Perspective	F for G × P
(1) Avoids abandonment	Self	1.34 (.140)	.60 (.97)	74.88 *	14.27 *	48.37 *
	Informant	1.20 (1.32)	1.09 (1.27)			
(2) Unstable relationships	Self	.19 (.48)	.23 (.57)	—	49.655 *	—
	Informant	1.20 (1.32)	.42 (.82)			
(3) Identity disturbance	Self	.76 (.74)	.65 (.72)	—	32.80 *	13.61 *
	Informant	.50 (.71)	.60 (.79)			
(4) Impulsivity	Self	.55 (.77)	.31 (.60)	25.581 *	—	11.04 *
	Informant	.46 (.83)	.39 (.81)			
(5) Suicidal behavior	Self	.08 (.34)	.09 (.38)	—	—	—
	Informant	.07 (.34)	.10 (.43)			
(6) Affect instability	Self	.52 (.76)	.51 (.79)	—	127.16 *	—
	Informant	.82 (1.05)	.91 (1.09)			
(7) Chronic emptiness	Self	.43 (.74)	.38 (.67)	—	30.28 *	—
	Informant	.54 (.83)	.56 (.87)			
(8) Intense anger	Self	.40 (.67)	.26 (.54)	13.38 *	61.29 *	—
	Informant	.58 (.90)	.49 (.85)			
(9) Transient paranoia	Self	.28 (.66)	.20 (.54)	—	69.07 *	—
	Informant	.46 (.86)	.46 (.86)			
Total	Self	4.55 (3.73)	3.23 (3.25)	12.32 *	60.91 *	23.46 *
	Informant	4.97 (4.54)	5.01 (5.09)			
Criteria Present	Self	.94 (1.30)	.57 (1.06)	23.42 *	75.97 *	14.50 *
	Informant	1.18 (1.54)	1.18 (1.70)			
Diagnostic Threshold	Self	.02 (.15)	.01 (.11)	—	29.41 *	4.25
	Informant	.05 (.21)	.06 (.25)			

*
 $p < .01$.