

# Being bullied in childhood: correlations with borderline personality in adulthood

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## Abstract

**Objective:** This study was designed to explore correlations between a history of being bullied in childhood and borderline personality disorder (BPD) in adulthood, several externalizing behaviors, and mental health care utilization.

**Method:** Using a cross-sectional consecutive sample of internal medicine outpatients (N = 414), we examined the relationship between history of being bullied in childhood and 2 measures of BPD: the borderline personality scale of the Personality Diagnostic Questionnaire–4 and the Self-Harm Inventory. We also explored whether having ever been bullied was related to a number of externalizing behaviors (eg, rage reactions, road rage, excessive spending, alcohol and substance misuse, binge eating) as well as greater mental health care utilization.

**Results:** In this study, a history of being bullied in childhood demonstrated statistically significant correlations with both measures of BPD as well as a number of externalizing behaviors and the measures for mental health care utilization.

**Conclusions:** A history of being bullied in childhood demonstrates a positive correlation with BPD in adulthood, externalizing behaviors, and mental health care utilization. Although this does not necessarily imply causality, the nature of this relationship warrants further investigation.

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## 1. Introduction

Being bullied appears to encompass approximately 9% to 14% of children and adolescents. For example, in a nationally representative sample of more than 11,000 adolescents in grades 6 through 10, 9% of survey respondents reported being bullied, with an additional 3% describing themselves as both victims and bullies [1]. In another study of more than 2000 New York state high school students, 9% reported being the victims of bullies [2]. Finally, in a California study of more than 1300 boys in grades 7 through 12, 13.7% were classified by researchers as being bullied [3]. From these data, it appears that approximately 9% to 14% of children and adolescents in the United States are the victims of being bullied.

The phenomenon of being bullied clearly exists outside of the United States as well. Studies from other countries proffer various prevalence rates among children and adolescents, including Italy (7.1%) [4], Canada (6.1%) [5], Sweden (10%) [6], the United Kingdom (39.8%) [7], Norway (15%) [8], and Germany (10%) [9]. Despite the wide intercountry variation in prevalence rates, which is likely attributable to differing methodologies, the phenomenon of being bullied appears to be a universal phenomenon that affects a substantial minority of children and adolescents.

Existing data indicate that victims who are bullied may suffer a variety of psychological consequences (eg, social difficulties, internalizing symptoms, anxiety, depression, suicidal ideation/attempts, eating disorders, multiple psychiatric disorders) and somatic consequences (eg, sore throats, cough, colds, poor appetite, headaches, sleep disturbances, abdominal pain, musculoskeletal pain, dizziness, fatigue, greater medication use) [10]. Those who are bullied may also demonstrate behavioral problems [11], difficulty with anger control [12], and other externalizing behaviors [13–15]. According to Liu [16], *externalizing*

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behaviors refer to outward behaviors in which the child or adolescent negatively acts upon his or her environment. Examples of externalizing behaviors include aggression, delinquent behaviors, hyperactivity, and alcohol and substance misuse; and these behaviors may coalesce into conduct disorder, antisocial behavior, or simply undercontrolled behaviors. Note that some of these behaviors are similar to those encountered in borderline personality disorder (BPD; eg, aggression, undercontrolled behaviors, alcohol and substance misuse).

With regard to possible relationships between being bullied in childhood and adult BPD, this Axis II disorder is frequently associated with noxious experiences during childhood, including various forms of childhood trauma (eg, sexual, emotional, and physical abuses), failures in parenting, and dysfunctional family environments [17,18]. However, BPD is not entirely environmental in origin, as there may be genetic contributions to BPD in terms of temperamental vulnerability. Yet the similar features in both being bullied and BPD led us to hypothesize correlations between the two. Specifically, both being bullied and BPD are associated with noxious social experiences during childhood; and both may result in some of the same psychologic sequelae, namely, aggression, difficulty with anger control, and poorly controlled behaviors (ie, self-regulation difficulties manifesting as alcohol and drug misuse).

In reviewing the PubMed and PsycINFO databases, we found no empirical literature on a potential association or correlation between childhood victimization by bullies and adult indications of BPD. Therefore, the focus of the present study was to investigate such potential correlations between having ever been bullied in childhood and self-reported symptoms of BPD in adulthood.

## 2. Method

### 2.1. Participants

Participants were men and women between the ages of 18 and 65 years who were being seen at an outpatient primary care clinic for nonemergent medical care. The outpatient clinic is staffed by both faculty and residents in the department of internal medicine and is located in a midsized Midwestern city. We excluded participants who were unable to complete a brief survey—that is, those with compromising medical (eg, dementia, pain), intellectual (eg, mental retardation), or psychiatric disorders (eg, psychotic).

A total of 492 people were invited to participate in this study; 419 agreed, for a response rate of 85.2%. Of the 419 respondents, 130 were male, 287 were female, and 2 failed to indicate sex. Respondents ranged in age from 18 to 65 years ( $M = 49.48$ ,  $SD = 15.26$ ). Most participants were white (358; 85.4%); 35 participants were African American, 8 Native American, 2 Hispanic, 4 Asian, 11 “other,” and 1 failed to indicate race/ethnicity. With regard to educational attain-

ment, most (92.1%) had at least graduated high school, with 159 (37.9%) having attended some college and 110 (26.3%) having earned at least a 4-year college degree.

### 2.2. Procedure

During afternoon clinic hours, one of the authors (CL) positioned herself in the lobby of the outpatient clinic. She approached incoming patients and informally assessed exclusion criteria. With potential candidates, she then reviewed the focus of the project and invited each to participate. Each participant was asked to complete a 4-page survey, which took about 10 minutes. Participants were asked to place the completed surveys into sealed envelopes and then to place these into a collection box in the lobby.

The survey consisted of 5 sections. The first section was a demographic query, in which we asked participants about their sex, age, marital status, racial/ethnic origin, and educational level.

The second section of the survey briefly queried participants about their histories of being bullied. With a yes/no response option, we asked, “When you were growing up, were you ever a victim of bullying?” For positive endorsements, we further inquired about the duration of being bullied in years as well as the number of individual bullies.

The third section explored behaviors that might be described as externalizing and included, with yes/no response options, “Have you ever had ... rage reactions, road rages, excessive spending, alcohol abuse, substance abuse, binge eating behavior?” Note that these behaviors are also suggestive of self-regulation difficulties.

The fourth section of the survey queried participants about the use of mental health care services. Specifically, we queried participants about the following 4 items, allowing for yes/no responses: “Have you ever been seen by a psychiatrist?” “Have you ever been hospitalized in a psychiatric hospital?” “Have you ever been in counseling?” and “Have you ever been on medication for your nerves?”

The final section of the survey contained 2 measures for BPD—the borderline personality scale of the Personality Diagnostic Questionnaire–4 (PDQ-4) [19] and the Self-Harm Inventory (SHI) [20]. The borderline personality scale of the PDQ-4 is a 9-item, true/false, self-report measure that consists of the diagnostic criteria for BPD that are listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* [21]. A score of 5 or higher is highly suggestive of BPD. Previous versions of the PDQ have been found to be useful screening tools for BPD in both clinical [22,23] and nonclinical samples [24], including the use of the freestanding borderline personality scale [25].

The second BPD measure, the SHI, is a 22-item, yes/no, self-report inventory that explores participants’ histories of self-harm behavior. Each item in the inventory is preceded by the statement, “Have you ever intentionally, or on purpose,....” Individual items include “overdosed, cut yourself on purpose, burned yourself on purpose,” and “hit

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