Psychiatry Research 257 (2017) 197–202

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Borderline personality disorder in men: A literature review and illustrative case vignettes

Adam Bayes[a,*], Gordon Parker[a,b]

[a] School of Psychiatry, University of New South Wales, NSW 2050, Australia
[b] Black Dog Institute, Hospital Rd, Randwick, NSW 2031, Australia

ABSTRACT

The aim is to review the salient literature on borderline personality disorder (BPD) in men and link those findings with case vignettes. We provide a literature review and then report case examples of those who met DSM and clinical BPD criteria, and consider the extent to which the small male sub-set corresponded developmentally and phenomenologically with prototypic BPD in women. The review considered phenomenological, epidemiological, biological and developmental BPD factors, finding BPD men evidence elevated substance abuse, and 'externalising' patterns of behavior, antisocial personality traits, violent self-harm and interpersonal aggression, whereas women display more 'internalising' strategies. The five male vignettes enriched the literature review providing support for gender differences reported in our review. The literature and case vignette findings should assist clinicians in recognising that BPD in men may not be as rare as generally viewed, and which may reflect BPD being commonly viewed as weighted to women and being misdiagnosed as an antisocial personality disorder (ASPD) in men.

1. Introduction

Borderline personality disorder (BPD) has been judged as distinctly understudied compared to most other psychiatric conditions (Zimmerman, 2015). Studies are heavily weighted to females (Paris et al., 1994b) or involve males and females considered together. These factors have largely disallowed gender comparisons (Paris et al., 1994b) and any consideration as to whether the phenotypic expression and determinants of BPD in men and women correspond. In this paper we first review the salient literature for BPD in men and then report illustrative male vignettes.

1.1. Prevalence rates

The prevalence rate of BPD in males compared to females has been debated, with several community estimates finding non-significantly different rates in men and women, such as 0.4% vs 0.9% in a Norwegian study by Torgersen et al. (2001) with the highest rates of 5.6% vs 6.2% found in a study by Grant et al. (2008), while Lenzenweger et al. (2007) reported no statistically significant gender differences in their analysis of National Comorbidity Survey data. There is seemingly only one community study reporting a female preponderance with Swartz et al. (1990) quantifying prevalence rates of 0.5% vs 1.3% for men and women respectively – though this study used an instrument not primarily designed to measure personality disorders. By contrast, in the majority of clinical settings, BPD is less frequently diagnosed in males (Johnson et al., 2003; American Psychiatric Association, 2013; Gunderson, 1984), with a meta-analysis of 75 clinical studies by Widiger and Trull (1993) quantifying that only one in four (24%) so diagnosed were males. The equality of male and female prevalence rates found in the majority of community samples – compared to the differing rates in clinical settings – might in part be the result of less precise methods of data acquisition, including use of self-report measures and less experienced raters.

Widiger (1998) suggested six potential biases towards making a BPD diagnosis in women rather than in men, and reflecting: sampling, diagnostic constructs, diagnostic criteria, diagnostic thresholds, application of diagnostic criteria and assessment instruments. Skodol and Bender (2003) reviewed the evidence in relation to these potential biases and concluded that the differing prevalence rates are largely an artefact resulting from sampling biases – that is fewer men present to treatment settings – with the other potential forms of diagnostic bias not of sufficient magnitude to account for the observed disparity in prevalence. In certain clinical populations, such as forensic and prison settings, studies have found high prevalence rates in men. Wetterborg et al. (2015) quantified a BPD prevalence rate of 20% in men on

* Correspondence to: School of Psychiatry, University of New South Wales, Hospital Rd, Randwick, NSW 2031, Australia.
E-mail address: a.bayes@unsw.edu.au (A. Bayes).

http://dx.doi.org/10.1016/j.psychres.2017.07.047
Received 27 February 2017; Received in revised form 26 June 2017; Accepted 25 July 2017
Available online 26 July 2017
0165-1781/

probation or parole while, in prisons, Singleton et al. (1997) quantified a rate of 19% and Black et al. (2007) a rate of 27% in men, with Blackburn and Coid (1999) quantifying a rate of 57% amongst violent male offenders. Such data indicate that BPD is not necessarily a rare condition in men and that its prevalence rate varies, being particularly high in those with a forensic history.

1.2. Relationship to antisocial personality disorder (ASPD)

The frequently quoted 1:3 male to female ratio quantified for BPD in clinical populations has been contrasted with the reverse ratio of 3:1 quantified for ASPD (Skodol and Bender, 2003) with that author positing that ASPD and BPD are two disorders that reflect 'multifinal' outcomes of a single aetiology. Both disorders have similar features including trait impulsivity, emotional lability, a history of child abuse/neglect, and with such a view further supported by elevated rates of ASPD in first-degree relatives of those with BPD (Schulz et al., 1989). Manifestations of aggression, mood and impulsivity have been linked to a number of different genes – with their phenotypic expression moderated by gender effects (Beauchaine et al., 2009). Examples include the Monoamine Oxidase A (MAOA) gene polymorphism which confers vulnerability to externalising behaviors among males and internalising behaviors among females, the Val/Val Catechol-O-methyltransferase (COMT) genotype – which is associated with the risk of psychopathology after stressful life events – and may be more likely to lead to depression in females and antisocial behavior in males, and finally the short allele of the 5-HTT gene which appears to confer a vulnerability to deliberate self-harm (DSH) in women and aggression in men. Thus, a gene-gender interaction model has been used to explain the similar overall prevalence of BPD and ASPD (Beauchaine et al., 2009). Paris (1997) also judged that ASPD and BPD reflect the same underlying trait characteristics with different behavioural expressions in males versus females, but later (Paris et al., 2013) rejected this explanation, largely on the basis of there being a predominance of affective instability in BPD and, as such, at variance with ASPD.

ASPD and BPD demonstrate significant diagnostic overlap as detailed by Becker et al. (2005) in a study of male Hispanic outpatients with substance abuse disorders. Study findings showed that DSM-IV criteria for ASPD (and in particular the conduct disorder criterion) were useful in discriminating the disorders whereas the DSM-IV BPD criteria were not useful in differentiating. Shorey et al. (2016) studied young men in treatment for substance use disorders and showed ASPD features were associated with multiple forms of aggression – including physical, verbal and attitudinal – while BPD features were only associated with physical aggression. Hatzitaskos et al. (1997) compared males with BPD versus a group with ASPD, finding the BPD group had higher overall levels of psychopathology, depression and introverted hostility while the ASPD group had more extroverted hostility, with both groups having equal levels of anxiety. In a Chinese study of abusive men, Liu et al. (2012) reported that BPD and ASPD features serve a mediating role between experiencing childhood maltreatment and perpetrating intimate partner violence, thus leading to intergenerational transmission of violence. Differential patterns of partner violence have been associated with BPD and comorbid BPD/ASPD compared to ASPD alone, with the former being more reactive versus the latter a combination of reactive and proactive violence (Ross and Babcock, 2009). Bateman and Fonagy (2008) described comorbid BPD and ASPD as presenting a particular clinical challenge, as DSH and suicidality common to BPD must be managed along with consideration of potential violence towards others arising from ASPD.

1.3. Clinical features

In a study of male offenders, Gardner et al. (2016) reported that 24% engaged in deliberate self-harm (DSH), and this group showed higher BPD and lower ASPD traits, with a preference for intrapersonal (particularly affect regulation) over interpersonal reasons given for DSH. Additionally, a majority described more severe forms of DSH (e.g. swallowing dangerous substances and cutting). Scheidell et al. (2016) reported that, after controlling for ASPD, being in the top quartile of BPD symptom severity was associated with sexual risk behaviors (possibly mediated by substance use) in incarcerated African-American men.

A number of studies have investigated sexual orientation in individuals with BPD, with rates of homosexuality in BPD males found to range from 16% to 58% (Zubenko et al., 1987; Stone, 1990; Dulit et al., 1993), with Paris et al. (1995) as well as Reich and Zanarini (2008) also finding an over-representation of same-sex attraction in BPD men compared to men with other personality disorders. Paris et al. (1995) also found that compared to heterosexual BPD participants, same-sex attracted men had higher rates of childhood sexual abuse (CSA), reported decreased maternal affection, and increased maternal and paternal control.

Gilbert et al. (2015) studied a sample of mostly male convicted offenders finding a BPD diagnosis predicted increased self-reported aggression and internal representations of violent scenarios. Peters et al. (2016) studied undergraduate males and reported that BPD profile scores were associated with both general violence and intimate partner violence, and with the latter associated with negative urgency (regrettable behavior in response to distressing emotions). Additionally, male perpetrators of domestic violence have been assessed as showing higher rates of BPD compared to non-abusive men (Else et al., 1993; Hastings and Hamberger, 1988).

A number of studies have assessed men with BPD in substance abuse settings, with Hatzitaskos et al. (1999) quantifying a rate of 76% of substance users in hospitalised BPD patients. In substance abusing males, BPD features are associated with negative affect, alexithymia and dissociative experiences (Evren et al., 2012a). In another substance dependent group, Evren et al. (2012b) found self-mutilators (SMs) scored more highly on the Borderline Personality Inventory compared to non-SMs with the severity of BPD features and emotional neglect predictive of SM behavior and, within the SM group, physical neglect and BPD features predicted the number of SM episodes. In another study, Evren et al. (2011) found severity of anger and borderline personality features predicted a history of suicide attempts while Tull and Gratz (2012) reported that those with BPD were significantly more likely to drop out of or be expelled from residential treatment services – thus impacting on effective treatment of their substance-related problems.

1.4. Clinical comparisons in males versus females

Several studies have reported similar clinical features in BPD men and women including meeting the nine individual DSM-IV BPD diagnostic criteria (Johnson et al., 2003; Banzhaf et al., 2012) and overall impairment (Zlotnick et al., 2002). Past suicide attempts and deliberate self-harm have been found to be similar in some studies (McCormick et al., 2007; Sansone et al., 2010), while Stone (1993) found men but not women with co-morbid unipolar depression or bipolar disorder had twice the rate of suicide. Gender differences have been noted in other studies, with BPD men being more likely to display 'intensive anger' (Tadic et al., 2009), whereas females show greater paranoia and dissociation (McCormick et al., 2007), identity disturbance (Johnson et al., 2003) and affective instability (Tadic et al., 2009). Men compared to women with BPD have elevated levels of trait impulsivity, lifetime aggression and anger-hostility (Soloff et al., 2003). Zanarini et al. (1998a) hypothesised that gender differences in BPD may be a function of differing manifestations of impulsivity – with more internalising behaviors in females (e.g. eating disorders) – as against externalising behaviors in men (e.g. drug misuse).

Johnson et al. (2003) reported largely similar rates of comorbid psychiatric disorders across genders, while other studies have reported