Gender Differences in the Presentation of Emotion Dysregulation in Individuals with Borderline Personality Disorder

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The American Psychiatric Association defines borderline personality disorder (BPD) as a severe and complex disorder characterized by instability in interpersonal relations, behavior, and emotions (2013). The defining features of BPD are considered to be the diagnostic characteristic of emotion dysregulation (ED), relational dysfunction, and impulsivity (Chapman, 2019). The diagnosis of BPD requires five of nine criteria as listed in the DSM-V. These criteria largely encapsulate difficulties throughout relationships, self-damaging or impulsive behaviors, affective instability, and mood disturbances (Chapman, 2019). The symptoms of Borderline Personality Disorder fall in the range of an "emotionally unstable personality disorder" and, in turn, include significant issues in regulation of emotions, cognition, relationships, and behavior (Chapman, 2019). This instability can be seen especially in the significant emotional suffering, behavioral issues, and reliance on mental health resources that individuals with BPD experience. See below for a chart of the 9 criteria listed in the DSM-V for borderline personality disorder diagnosis:

9 Criteria for Diagnosis of Borderline Personality Disorder:
1. frantic efforts to avoid real or imagined abandonment
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. identity disturbance: markedly and persistently unstable self-image or sense of self
4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. chronic feelings of emptiness
8. inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

9. transient, stress-related paranoid ideation or severe dissociative symptoms

(American Psychiatric Association, 2013; DSM-V)

According to Chapman (2013), approximately 70-80% of individuals with BPD have a history of nonsuicidal self-injury and approximately 10% of die by suicide. Additionally, BPD has high comorbidity rates with anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders.

A Personality Disorder (PD) is characterized by an individual's rigid and inflexible style of interaction with the environment around them. These individuals may have difficulty adapting to changes or instability throughout their lives (DeShong et. al., 2019). These individuals may be more likely to react to this lack of order through maladaptive coping mechanisms which will result in emotional instability, instability in interpersonal relationships, and issues with their self-image. BPD is a PD generally characterized by increased instability and it is often characterized by instability in the areas mentioned above, so when individuals begin to have issues with instability, this is when we see a diagnosis of BPD.

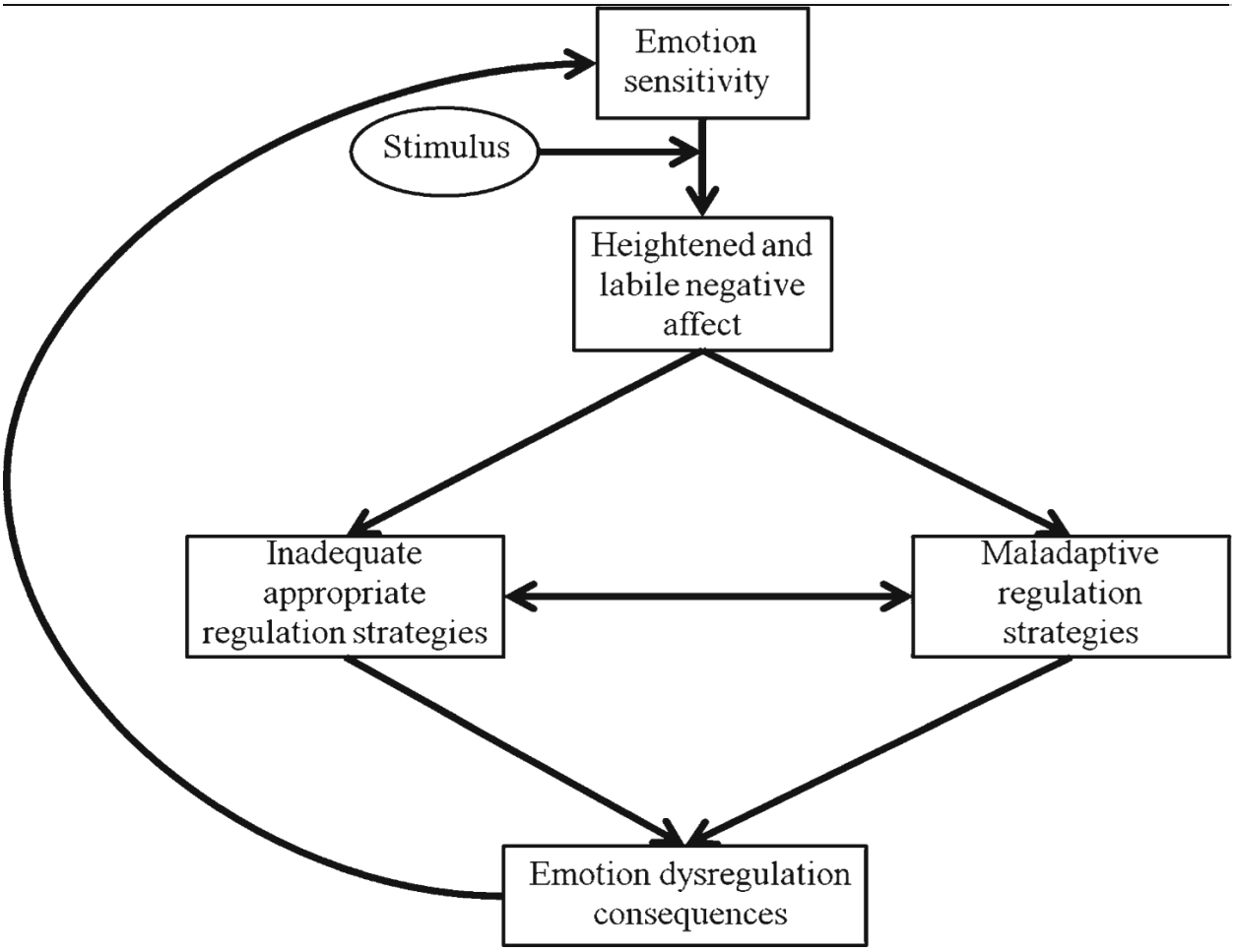
Personality Disorders in general are complicated concepts to diagnose and take multiple steps to diagnose. Many have suggested looking at BPD and other PDs from a dimensional standpoint instead of a categorical perspective. The five-factor model (FFM), as presented by McCrae and Costa (2003) is one of the most commonly used dimensional models. The FFM "assesses the adaptative and maladaptive variants of general personality traits" (DeShong et al., 2019) in order to look at diagnosis from a dimensional standpoint. The five domains of the FFM include neuroticism, agreeableness, extraversion, openness to experience, and conscientiousness. Each domain was then broken down into a subsequent set of 30 facets within the original five domains. These facets are later used for diagnosis of different PDs. Specific to BPD, there are 11 facets that correlate to the diagnosis of an individual with BPD. Six of these facets fall under

neuroticism, one to openness to experience, three facets of agreeableness, and one facet of conscientiousness. Based on these facets, the FFM would characterize BPD as a disorder of neuroticism/emotional instability and dysregulation (DeShong et al., 2019). This study will examine the presentation of emotion dysregulation in BPD, and in particular, the differences in presentation of ED between males and females.

Emotion dysregulation (ED) is transdiagnostic, causes significant distress and is associated with serious negative outcomes, including self-injury, suicide, and substance misuse (Gratz et. al., 2008; Klonsky, 2007; Law et. al., 2015; Jahng et. al., 2011). ED is a core component of borderline personality disorder (e.g., self-injury, risky impulsive behaviors; American Psychiatric Association, 2013). Due to the relationship of ED and borderline personality disorder (BPD) with negative outcomes, BPD provides an ideal context for examining ED mechanisms within the context of psychopathology. The significance of ED and maladaptive behaviors warrant empirical examination with the goal of guiding targeted interventions. Despite the significant implications of ED, there is a noteworthy gap concerning the mechanisms of ED, thus limiting effective interventions. There are data regarding components of ED in BPD; however, there is limited research examining how ED components interact to produce significant negative outcomes. In the absence of such knowledge, the development of efficacious and targeted interventions for emotional and behavioral dysregulation is severely restricted.

The biosocial model of BPD is an etiological theory asserting that BPD develops as a result of biological (predisposition) and environmental (invalidating environment) factors (Linehan, 1993). Specifically, emotion sensitivity (heightened reactivity to other's emotions) in childhood predisposes individuals to experience more negative and unpredictable affect in

response to emotional stimuli. With high emotional vulnerability and strong negative emotions, useful coping strategies are difficult to acquire and utilize. Therefore, maladaptive behaviors (e.g., nonsuicidal self-injury) are used to regulate mood (Klonsky, 2009; Selby & Joiner, 2009). Carpenter and Trull (2013) expanded the biosocial model of BPD as it pertains to ED to include the feedback cycle of this directional and continuous process. Specifically, according to the biosocial model of BPD, individuals experience greater emotion sensitivity, which leads to interpreting environmental stimuli and interactions negatively, thereby increasing negative affect across contexts. Negative and potentially labile affect interferes with the ability to develop healthy coping and regulation skills, resulting in inadequate strategies for tolerating distress. In order to regulate affect, maladaptive behaviors may be utilized as regulation strategies. These behaviors (e.g., binge drinking, nonsuicidal self-injury) often cause immediate short-term relief of negative affect, but may have long-term negative outcomes (Selby et. al., 2009). The consequences of this cycle reinforce emotion sensitivity and the ED process.



Biosocial Model of Borderline Personality Disorder (Carpenter & Trull, 2013)

Heightened negative and dysregulated affect are core components of BPD. Vulnerability to experience heightened negative emotions has been well documented within BPD samples (Ebner et. al., 2007; Linehan, 1993). Further, this negative affect also presents as unstable and labile. A number of studies have documented this component affect dysregulation in BPD in real time, using ecological momentary assessment (Schneider et. al., 2015; Trull et. al., 2008). Under conditions of negative affect, individuals with BPD may have more difficulties with emotion interpretation thus generating a negative feedback loop of emotion sensitivity and negative affect (Baer et. al., 2012). However, research has not directly examined how emotion sensitivity,

including negative interpretation bias and hypersensitivity to other's emotions directly affect negative and labile affect within the ED cycle of BPD. It is essential to establish this direct link prior to testing the subsequent aspects of the model given that these components are proposed to interact to directly lead to the subsequent steps (e.g., maladaptive coping behaviors). This theory's components have been empirically examined and outlined independently; however, how they explicitly interact to produce negative outcomes has not been studied (Carpenter & Trull, 2013). Extensive examination of the interaction of these components as they relate to behavioral dysregulation and maladaptive outcomes will advance our knowledge of the development of heightened negative affect.

Emotion Dysregulation is a complicated concept that has been debated throughout academic circles. There has been debate over whether it should be categorized as dysregulation or affective instability, two terms that you will see used interchangeably throughout this paper. While the title of the issue is debated, the core components within it are not. Emotion dysregulation is characterized by deficits in and the inability to regulate an individual's emotions especially in relation to intense or shifting emotion patterns. While studying this phenomenon there are many different approaches to take. Beauchaine (2012) suggests that the disorder used as a reference for ED prevalence is dependent on the gender of the individual being examined. While a number of individuals may struggle with some form of emotional instability throughout their life (albeit not all to the degree necessary to diagnose one with Borderline Personality Disorder), many studies tend to only focus on females in relation to ED presenting in BPD. Whilst looking at males with ED issues, the disorder that ED is attributed to are those such as ADHD in boys. According to Beuachaine (2012), males struggling with emotional regulation are likely to then have conduct issues throughout their life whereas issues with emotion regulation in

females are indicative of borderline personality traits (2012). Looking towards the future, this could put females at a disadvantage for accurate diagnosing later on if there is already a preconception of females with instable emotions being categorized as borderline whereas emotionally unstable boys are seen as a conduct issue.

A meta-analysis of clinical studies (Widiger & Trull, 1993) found that females make up 76% of the BPD diagnosis rate. However, more recent studies have found the diagnosis rate to be more evenly distributed (Benson et. al., 2017). Researchers have examined potential reasons why females may be over diagnosed with BPD in comparison to men. Previous studies have examined gender biases in the diagnosis of other personality disorders such as Histrionic PD, Narcissistic PD, and Antisocial PD and determined gender biases with clinician diagnoses based on diagnosis rates associated with name and gender (Samuel & Widiger 2009). This suggests that clinician bias would extend to other personality disorders as well, especially in PDs that exhibit specific criteria that individuals may determine a more specific towards one gender over another such as emotion dysregulation as exhibited in BPD.

Males are more likely to exhibit emotion dysregulation through conduct issues that are noted in disorders such as ADHD whereas emotion dysregulation in females has been more directly linked to borderline traits which could be attributed to later diagnoses of borderline personality disorder (Beauchaine, 2012). Additionally, females may already be at a higher risk of diagnosis due to a higher rate of diagnosed maladaptive behaviors or coping mechanisms associated with the diagnosis of BPD (Benson et. al., 2017). Females report higher rates of or risk of developing eating disorders as well as higher reports of “inner turmoil” in relation to the emotions they feel which then lead them to maladaptive behaviors that can be associated with BPD. Additionally, females report higher symptomology overall in relation to anxiety,

depression, and hostile thoughts or actions when compared to their male counterparts (Benson et. al., 2017). On the opposite side, males with BPD exhibit higher rates of narcissistic and antisocial personality traits when compared to females (Benson et. al., 2017).

This difference in presentation of BPD symptoms between males and females shows the difference in how the two express their symptoms. Females may "internalize" their symptoms whereas males "externalize" them (Benson et. al. 2017). This can be seen in the ways that females struggle with self-image issues, increased feelings of anxiety and depression, and heightened negative affect whereas males exhibit symptoms that can be seen in a more externalized manner such as narcissistic and antisocial tendencies (Benson et. al., 2017). Looking at the symptoms exhibited by males and females allows for clinicians and researchers to examine potential criterion bias in diagnosis as opposed to a perceived diagnosis bias. This is to say that before a diagnosis occurs there may be criteria in place to establish a diagnosis of borderline personality disorder that already puts females at a disadvantage to potentially receive higher diagnosis rates in comparison to males. Due to the prevalence in symptomology that is already seen within females related to emotionally dysregulated characteristics, clinicians are more likely to diagnose females at a higher rate in comparison to males given their lack of emotionally induced symptoms.

The differences in symptomology and presentation of emotion dysregulation and overall BPD behaviors can impact further treatment for individuals with BPD in the future. For example, if a female presents with BPD symptoms it has been noted that she is also more likely to present with an eating disorder, anxiety, or depression when compared to her male counterpart whereas the male is likely to present with narcissistic or antisocial PD. This would detail a completely different treatment plan for the individuals which means that their providing physician,

psychiatrist, or psychologist would have to be prepared and well equipped to understand the intricacies of both the proper prescriptions as well as all of the potential comorbidities associated with BPD in order to develop an accurate treatment plan for the patient in terms of prescriptions and therapy regimens.

Borderline personality disorder is an intricate and complicated diagnosis that weaves an intricate web of symptoms and emotions for clinicians, researchers, and individuals with BPD to discern. After conducting a literature review of current prevalent research, I believe it would be necessary for future research to be conducted regarding how the criteria for borderline personality disorder were established so that more research can occur to determine where biases in the development of the symptom criteria could have occurred. It is apparent from previous research studies that borderline personality disorder is one of the personality disorders that does have a higher diagnosis rate within females and this is likely due to the construction of diagnosis criteria within the DSM-5 and how the emotionally charged criteria are more often exhibited by females.

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