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In a previous study of primary care outpatients, the authors found a significant relationship between a history of domestic violence and borderline personality symptomatology. In the present study, they explore this relationship in a sample of women psychiatric inpatients. They use the Severity of Violence Against Women Scale (SVAWS) to assess a history of domestic violence and two self-report measures, the Self-Harm Inventory (SHI) and the Personality Diagnostic Questionnaire–4 (PDQ-4), to assess borderline personality symptomatology. Both measures of borderline personality symptomatology were highly related to each other ($r = .63$, $p < .001$) as well as to the SVAWS ($r = .31$, $p < .001$ for the SHI; $r = .37$, $p < .001$ for the PDQ-4). Using the recommended diagnostic cutoff scores on the measures for borderline personality symptomatology, 90.2% of those with histories of domestic violence scored in the positive range on either or both measures, compared to 65.1% of nonabused women. The authors discuss the clinical implications of these findings.

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

According to the available empirical data, an unexpectedly high percentage of women experience domestic or intimate-partner violence. For example, through telephone interviews, Weinbaum et al. (2001) found that 6% of women in a community sample reported physical violence or threats from intimate partners. Compared with community prevalence rates, one would expect the lifetime prevalence rates of such experiences to be considerably higher among women presenting for medical services. Current empirical data support this impression. For example, Ernst, Nick, Weiss, Houry, and Mills (1997) and Krishnan, Hilbert, and Pase (2001) found that about one third of women patients in emergency rooms reported histories of violence from intimate partners. In addition, Abbott, Johnson, Koziol-McLain, and Lowenstein (1995) found that nearly one half of women who were seen in an emergency department or walk-in clinic acknowledged assaults, threats, or intimidation by a partner at some point in their lives. Finally, according to the findings of Fairchild, Fairchild, and Stoner (1998); M. Johnson and Elliott (1997); and Richardson et al. (2002), approximately half of the women participants surveyed in these investigators' respective primary care settings reported violence at some point in their lives from an intimate partner.

Given the relatively high frequency of domestic violence in clinical samples, we wondered if there might be a possible relationship between a history of domestic violence and borderline personality symptomatology (BPS). This relationship is suggested by the criteria sets of several measures for borderline personality disorder (BPD). For example, one of the diagnostic criteria for BPD in the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition;

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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?" and another explores whether "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) the "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)?" Thus, several measures of BPD suggest that such individuals have unstable, intense, victimizing, masochistic, and stormy relationships with others.

An additional area of research complements the preceding research findings. Childhood sexual abuse is one of several variables that demonstrate a correlation with BPS (Goodman & Yehuda, 2002; D. M. Johnson et al., 2003; McLean & Gallop, 2003; Sansone, Gaither, & Songer, 2002; Zanarini et al., 2002). In addition, childhood sexual abuse has been associated with revictimization in adulthood (Beitchman et al., 1992; Gladstone et al., 2004) and appears to be a risk factor for intimate-partner abuse in adulthood for women but not for men (Desai, Arias, Thompson, & Basile, 2002).

As for studies that have explicitly examined the relationship between domestic violence and BPS, there are only two. In the first, 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 contrast to the preceding findings, we (Sansone, Reddington, Sky, & Wiederman, in press) examined 52 internal medicine outpatients for histories of domestic violence and BPS. Using the established cutoff scores on two administered measures for BPS, 64.0% of the domestic violence group compared to only 11.1% of the control group scored positively on either or both measures—a significant difference.

In the current study, using the same assessment tools as in our previous study, we examined the relationship between a history of domestic violence and BPS/BPD in a sample of women psychiatric inpatients.

Method

Participants

Study candidates were women, aged 18 years or older, unaccompanied by a partner at the time of recruitment, who were hospitalized in the psychiatric unit of a local community hospital. The hospital is located in an urban area of a midsized midwestern city. Both residents and faculty in the Department of Psychiatry are treatment providers in this setting. 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 131 candidates were approached; 113 agreed to participate, for a response rate of 86.3%.

Of the 113 participants, 80 (70.8%) indicated White as their race, 24 (21.2%) African American, 7 (6.2%) Native American, 1 Asian, and 1 Other. Participants ranged in age from 18 to 57 years (M = 35.98, SD = 10.43). With regard to marital status, 15.9% were married, 15.9% separated, 32.7% divorced, 29.2% never married, 2.7% widowed, and 3.5% did not indicate marital status. The majority of participants either did not graduate high school (18.8%) or earned only a high school diploma (45.5%). A minority had some college experience (27.7%) or a bachelor's degree (4.5%), and only 3.6% had a graduate degree.

Procedure

Each candidate was approached by a single investigator (J.C.) as time permitted (i.e., a sample of convenience). After an introductory explanation to the project, participants were given a research booklet to complete. The research booklet explored demographic information and contained the following three measures (one for domestic violence and two for BPS/BPD).

Severity of Violence Against Women Scale (SVAWS). The SVAWS (Marshall, 1992) 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). Because of the sensitive nature of the queries on sexual aggression, we modified the SVAWS for this study by eliminating these items (i.e., we used only those items related to threats and acts of violence), which resulted in a 40-item scale. In addition, 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 α were .97 for the Threats subscale, .97 for the Acts subscale, and .98 for the overall total scale.

Self-Harm Inventory (SHI). The SHI (Sansone, Wiederman, & Sansone, 1998) is a 22-item, yes/no, self-report questionnaire 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 scored in the pathological direction, and the total number of "yes" responses constitutes the total SHI score. In addition to serving as a face-valid measure of self-harm behavior, the SHI is predictive of BPS/BPD. Using a cutoff score of 5, in comparison with the DIB (Kolb & Gunderson, 1980), the SHI correctly identified 85% of women with regard to a diagnosis or not of BPD (Sansone et al., 1998).

Borderline Personality Subscale of the Personality Diagnostic Questionnaire-4 (PDQ-4). The borderline personality subscale of the PDQ-4 (Hyler, 1994) 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 (J. G. Johnson & Bornstein, 1992) settings, including the use of the freestanding borderline personality subscale (Patrick, Links, Van Reekum, & Mitton, 1995).

Completion of the research booklet by participants was assumed to function as informed consent. The institutional review boards of both the community hospital and the university approved this project.

Results

Scores on the SHI exhibited the full possible range from 0 to 22, with a mean score of 7.90 (SD = 5.05). Scores on the PDQ-4 exhibited the full possible range from 0 to 9, with a mean of 5.65 (SD = 2.38). Scores on the SHI and the PDQ-4 were moderately correlated (r = .63, p < .001). Using a cutoff score of 5 or greater on each scale to indicate a substantial likelihood of BPS, 69.0% of the women met such criteria according to their scores on the SHI, and 70.8% met such criteria according to their scores on the PDQ-4. Of the total sample, 64.5% exceeded the cutoff score for BPD according to both the SHI and PDQ-4; 16.8% exceeded the cutoff score on one measure but not the other; and the remaining 19.6% did not exceed the cutoff score on either the SHI or the PDQ-4.

With regard to the SVAWS, scores on the Threats subscale exhibited the full possible range of scores (19-45), with an average score of 48.02 (SD = 21.32). Scores on the Acts subscale also exhibited the full range of possible scores (21-105), with a mean score of 23.84 (SD = 22.18). Scores on the two subscales of the SVAWS were highly correlated (r = .84, p < .001), leading us to use the combined score for further analyses. The possible score on the overall measure of experienced violence could range from 40 to 200, and actual scores ranged from 40 to 187 (M = 91.85, SD = 41.67).

Total scores on the SVAWS were positively related to scores on both the SHI (r = .31, p < .001) and the PDQ-4 (r = .37, p < .001). To examine the potential prevalence of BPD among those respondents indicating a history of personal violence compared to respondents without such a history, we decided to use a score of less than 70 on the SVAWS as the criterion. Again, actual scores on the SVAWS ranged from 40 (indicating no experiences of personal violence) to 187 (indicating a relatively extensive history of various forms of personal violence). The cutoff of 70 was substantially below both the mean (91.85) and median (90) scores on the SVAWS. Using the cutoff of 70, respondents with a history of personal violence (n = 64) were substantially more likely than respondents without a history of personal violence (n = 45) to exceed the cutoff for BPD according to both the SHI (83.9% vs. 53.5%,

$\chi^2 = 11.49$, $df = 1$, $p < .001$) and the PDQ-4 (84.1% vs. 55.6%, $\chi^2 = 10.68$, $df = 1$, $p < .001$). Using the more stringent criterion of exceeding the cutoff score for BPD on both the SHI and PDQ-4, 77.0% of the group who had experienced personal violence compared to 44.4% of the nonviolence group met such criteria ($\chi^2 = 11.84$, $df = 1$, $p < .001$).

Discussion

In this group of predominantly White, middle-aged women in an inpatient psychiatric setting, we found that (a) scores on two measures of BPS significantly and positively correlated with scores on a measure of domestic violence and (b) by dividing the sample into two subgroups based upon low versus high scores on the domestic violence measure, those with domestic violence histories were significantly more likely to score positively on either or both measures of BPS. As in our previous study (Sansone et al., in press), these findings suggest that there is an association between being a victim of domestic violence or abuse and reporting symptoms related to BPD.

As we pointed out in our previous article (Sansone et al., in press), these findings are highly relevant for clinicians. Specifically, for therapists treating victims of domestic violence, it would appear essential to initially assess for BPS/BPD. If BPS/BPD is not present, it would seem that the therapeutic focus would be the facilitation of the patient's departure from the abusive relationship (e.g., assist with physical relocation, job training, social support) via a relatively time-limited intervention, depending on the presence or absence of posttraumatic stress disorder symptoms. If BPS/BPD is present, we would anticipate a protracted course of psychotherapy, focusing on relationship issues, with an intensified effort to prevent the patient's reengagement in future abusive relationships.

Because the current study and our previous study strongly support a relationship between domestic violence and BPS, we wish to emphasize the importance of evaluating these individuals for BPS/BPD. In addition to clinical assessment using the *DSM-IV* criteria, we also suggest adjunctive self-report measures, such as the PDQ-4, the SHI, and/or the McLean Screening Instrument for Borderline Personality Disorder (Zanarini et al., 2003). All of these self-report measures are one page in length, easy to score, and without charge to use. From our experience with the first two measures, it is likely that each identifies a slightly different subpopulation with BPS/BPD; therefore, we recommend the use of two measures. However, in this study, note that the scores on the PDQ-4 and SHI were moderately correlated.

In this psychiatric inpatient study, nearly 65% of participants demonstrated BPS according to both self-report measures. This percentage seems surprisingly high, but given the setting, it may be reflective of the reasons that individuals are acutely admitted to psychiatric hospitals, specifically, suicidal ideation or attempts, other forms of self-harm behavior, threats to others, and/or the inability to care for oneself. Borderline patients are particularly prone to suicidal ideation, suicide attempts, and self-harm behavior and therefore would be expected to be overrepresented in an inpatient psychiatric setting. In addition, patients with borderline personality tend to undergo more frequent psychiatric admissions than individuals with other Axis I (Hurt, 2001; Zlotnick et al., 2003) or II (Zanarini, Frankenburg, Khera, & Bleichmar, 2001) disorders, heightening the probability of their overrepresentation in this setting.

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 externally corroborate histories of intimate-partner violence). However, the reasonable sample size and use of two measures of BPS/BPD, each with different constructs, strengthens these findings. In addition, one would expect the comparison group of psychiatric inpatients to be at heightened risk for domestic violence because of their psychological and economic vulnerability; however, even comparison with this high-risk subsample demonstrated a significant between-group difference. This is the second empirical study to confirm a relationship between BPS/BPD and domestic violence. The clinical implications of these findings appear both relevant and practical for clinicians in their treatment of victims of domestic or intimate-partner violence.

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