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J. Michael Bailey & Amy Shriver

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Does Childhood Sexual Abuse Cause Borderline Personality Disorder?

J. MICHAEL BAILEY and AMY SHRIVER
Department of Psychology, Northwestern University, Evanston, Illinois, USA

Several studies have found that women with borderline personality disorder are more likely than controls to report a history of childhood sexual abuse. Researchers have generally assumed that childhood sexual abuse causes borderline personality disorder, but there are other possible interpretations of the association. We surveyed psychologists about the likelihood that patients with various personality disorders would engage in behaviors relevant to several alternative interpretations. Relative to patients with other personality disorders and to the "typical outpatient," patients with borderline personality disorder were rated as especially likely to misinterpret or misremember social interactions, to lie manipulatively and convincingly, and to have voluntarily entered destructive sexual relationships, possibly even at young ages. We discuss the plausibility of relevant alternative interpretations of the association between childhood sexual abuse and borderline personality disorder.

Borderline personality disorder (BPD) is characterized by a pervasive pattern of instability of interpersonal relationships, self-image, and emotion and by marked impulsivity. By definition, personality disorders emerge by early adulthood, and some may manifest during childhood. BPD is approximately three times more common in women than in men (American Psychiatric Association, 1994).

Etiologic research on BPD has begun only recently, and some common paradigms (e.g., twin studies) have not yet been used. In this context, the attention given to one particular issue has been rather remarkable. A number of recent studies have demonstrated associations between BPD, or BPD symptoms, and self-reported childhood sexual abuse (Atlas, 1995; Brown & Anderson, 1991; Ellason, Ross, Stanton, & Mayran, 1996; Guzder, Paris, Zelkowitz, Marchueault, 1996; Links & Van Reekum, 1993; Paris, Zweig-Frank, & Guzder, 1994; Silk, Lee, Hill, & Lohr, 1995;
Wagner & Linehan, 1994; Waller, 1994; Weaver & Clum, 1993). These studies have generally compared rates of reported childhood sexual abuse (CSA) in female patients with and without BPD. It is noteworthy that some of these studies include abuse occurring well into adolescence as CSA (Brown & Anderson, 1991; Paris et al., 1994; Weaver & Clum, 1993). The commonly used criteria of Finkelhor (1979) include as CSA any sexual contact before the age of 16 with an individual at least 10 years older.

Researchers in this area have tended to conclude from their results that CSA is a cause of BPD. For example, consider the following passages from the recent edited book, *Role of Sexual Abuse in Etiology of Borderline Personality Disorder*, published in conjunction with the American Psychiatric Association (Zanarini, 1997b):

> Taken together, the available empirical evidence suggests that for some borderline patients, childhood sexual abuse . . . is an important factor in the development of their subjective pain and objective psychopathology. (Zanarini, 1997a, p. 12)

> For about half of our borderline patients, childhood sexual abuse appears to be an important etiological factor. (Zanarini, Dubo, Lewis, & Williams, 1997, p. 42)

> [O]ur findings suggest that the etiological factors associated with BPD in women prisoners [include] childhood sexual abuse. . . . (Jordan, Schlenger, Caddell, & Fairbank, 1997, p. 65)

> Awareness of the role of childhood abuse and neglect in the etiology of self-destructive behavior in borderline patients can help treaters to be empathic . . . . (Dubo, Zanarini, Lewis, & Williams, 1997, p. 125)

> Ongoing severe sexual abuse may be such a strong risk factor for BPD that a wide range of biological predispositions give rise to BPD in the presence of such trauma. . . . (Silk, Nigg, Westen, & Lohr, 1997, p. 158)

Because of the relevant evidence is necessarily correlational, an etiologic inference requires the absence of alternative interpretations. Several alternatives seem plausible to us, however. For example, relatives of BPD patients are at increased risk for both BPD and alcoholism (Loranger, Oldham, & Tulis, 1982; Loranger & Tulis, 1985), and both of those conditions plausibly raise the probability of committing incest. Thus, BPD and CSA could be linked due to familial–genetic factors. Alternatively, some individuals with BPD may be especially likely to misconstrue or misremember past events in a way that increases their rate of reported abuse. BPD symptoms include transient, stress-related paranoid
ideation or severe dissociative symptoms in times of stress, and these symptoms would facilitate neither the encoding nor the reporting of objective events. BPD patients are frequently manipulative, and thus may be more likely than other patients to fabricate a history of sexual abuse in order to gain sympathy or escape responsibility. Finally, it is possible that symptoms of BPD may put children and adolescents at greater risk of CSA. For example, with BPD are sexually impulsive and may be more likely than other patients to enter into inappropriate or destructive sexual relationships. Other symptoms of BPD, such as unstable evaluations of others, including periodic overidealization, as well as concerns about attachments with significant others, might also render children vulnerable to sexual predators.

We emphasize that we are not arguing here that the conventional wisdom that CSA causes BPD is implausible. Rather, we have raised several plausible alternatives that need to be ruled out or controlled for before the validity of the etiologic alternative (CSA causes BPD) can be established. Finally, we note that in principle, any combination of these alternatives, as well as the etiologic alternatives, might be simultaneously true.

In this study we surveyed a small sample of clinical psychologists and clinical psychologists in training regarding several aspects of BPD patients that are germane to alternative interpretations of the link between BPD and CSA. Specifically, we asked how likely BPD patients are, compared with other personality disordered patients, to misinterpret interpersonal interactions, to misremember prior events, to lie manipulatively and believably, to manifest symptoms early, and to voluntarily enter into destructive sexual relationships.

METHOD AND RESULTS

Participants

We recruited two subsamples of practicing clinical psychologists and psychology interns. The first sample was recruited by placing questionnaires in the mailboxes of psychologists and psychology interns at a VA hospital. The return rate was 45.2% (N = 14 out of 31 possible), and 6 of the respondents were interns. The second sample was recruited from the InterPsych clinical psychology email discussion list. This list includes approximately 600 clinical psychologists and is devoted to discussions about the profession of clinical psychology. An initial solicitation was sent to the list requesting participants for a study of personality traits of “outpatients with various forms of psychopathology.” Neither borderline personality disorder nor sexual abuse was mentioned. Twenty-two people responded, of whom 19, all clinical psychologists, eventually returned questionnaires.

The two subsamples were similar in their average levels of experience. Over the entire sample, years of clinical experience ranged from 1 to 30, with a mean of 10.5. Outpatients seen during the past 5 years ranged
from 0 to 100, with a mean of 41.9. The number of patients with personality disorder seen during the past 5 years ranged from 0 to 100, with a mean of 12.7.

Although the two subsamples were recruited from different sources, they provided very similar data. Each participant provided 60 ratings as the primary data of this study, and the two subsamples did not differ significantly on any of them. Furthermore, the 60 mean ratings correlated .96 between the two subsamples.

Questionnaire

The six items of the questionnaire focused on tendencies related to three alternative interpretations of the association between CSA and BPD: (a) some BPD patients may have inaccurately encoded or recalled experiences as CSA, (b) some may falsely claim a history of CSA in order to manipulate others, and (c) early sexual impulsivity of some children or adolescents with BPD may be a causal factor in their experience of CSA.

Each item asked respondents to rate how characteristic a behavior is of outpatients with each of the following personality disorders: borderline, antisocial, avoidant, dependent, histrionic, narcissistic, obsessive-compulsive, schizoid, and schizotypal. Furthermore, for each item respondents rated "the typical outpatient." We queried about outpatients to reduce the effect of differences between diagnoses' typical severity (e.g., BPD is probably more likely to require hospitalization than avoidant personality disorder). Participants were asked to provide ratings only for those disorders for which they had adequate experience.

Five of the items used the following scale: [the behavior is] 1 = less true of this kind of patient than for the typical normal person, 2 = neither more nor less true of this kind of patient than of the typical normal person, 3 = slightly truer of this kind of patient than of the typical normal person, 4 = somewhat truer of this kind of patient than of the typical normal person, 5 = much truer of this kind of patient than of the typical normal person. (We defer discussion of the sixth item's scale to that section.)

For each item, we focus on the comparison of the BPD rating with two others: the average of the ratings for the other personality disorders and the rating for the typical outpatient. Significance tests were paired t tests. Table 1 contains the mean ratings for the relevant comparisons.

Interpersonal Perception and Memory Distortion. The first two items asked about the tendency to misperceive or misremember interpersonal situations:

1. Some people are prone to interpret interpersonal interactions in an objectively inaccurate manner. As a result, their accounts of interpersonal interactions tend to be distorted. Rate the accuracy of clients with each disorder in providing accurate accounts of interpersonal events and situations.
TABLE 1
Mean Ratings for Borderline Patients, Other Personality Disordered Patients, and Typical Outpatients

<table>
<thead>
<tr>
<th>Behavioral tendency</th>
<th>Type of patient</th>
<th>BPD M (SD)</th>
<th>Other personality disorders M (SD)</th>
<th>Typical outpatient M (SD)</th>
<th>BPD’s rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpret interpersonal interactions inaccurately</td>
<td>BPD</td>
<td>4.4 (0.8)</td>
<td>3.8 (0.7)</td>
<td>2.9 (0.7)</td>
<td>1</td>
</tr>
<tr>
<td>Have unreliable memories</td>
<td>Other personality disorders</td>
<td>3.5 (1.2)</td>
<td>3.2 (1.3)</td>
<td>2.6 (0.7)</td>
<td>1</td>
</tr>
<tr>
<td>Lie manipulatively</td>
<td>Typical outpatient</td>
<td>3.8 (0.9)</td>
<td>2.8 (0.3)</td>
<td>2.3 (0.5)</td>
<td>2</td>
</tr>
<tr>
<td>Lie believably</td>
<td>BPD’s rank</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter voluntarily into destructive sexual relationships</td>
<td>Other personality disorders</td>
<td>3.1 (1.1)</td>
<td>2.4 (0.3)</td>
<td>2.1 (0.3)</td>
<td>3</td>
</tr>
<tr>
<td>Symptomatology begins early</td>
<td>Typical outpatient</td>
<td>4.8 (0.4)</td>
<td>2.9 (0.3)</td>
<td>2.5 (0.6)</td>
<td>1</td>
</tr>
</tbody>
</table>

Rank refers to the rank of BPD’s mean rating among all the personality disorders and the “typical outpatient.”
The first five items used the following scale: 1 = less true of this kind of patient than for the typical normal person, 2 = neither more nor less true of this kind of patient than of the typical normal person, 3 = slightly truer of this kind of patient than for the typical normal person, 4 = somewhat truer of this kind of patient than for the typical normal person, 5 = much truer of this kind of patient than for the typical normal person. For the final item, the rating scale ranged from 1 = extremely unlikely to have had symptoms during childhood or early adolescence to 5 = extremely likely to have had symptoms in childhood or early adolescence. BPD’s rank refers to the rank order of BPD’s item mean compared with those of the other personality disorders and the typical outpatient.

2. Some people have personality characteristics or defensive styles that make their memories rather unreliable. Although they are not necessarily lying, their memories are distorted. Rate the following disorders on the following 1–5 scale comparing the memory accuracy of a client with each disorder to that of the typical normal person.

For the first item BPD patients ($M = 4.4$) were rated significantly more likely to misinterpret interpersonal interactions than both patients with other personality disorders ($M = 3.8$), $t(32) = 4.9$, $p < .001$ and the typical outpatient ($M = 2.9$), $t(32) = 8.4$, $p < .001$. Patients with BPD were also rated as relatively likely to have inaccurate memories ($M = 3.5$) compared with both patients with other personality disorders ($M = 3.2$), $t(32) = 2.6$, $p < .05$ and the typical outpatient ($M = 2.6$), $t(32) = 4.1$, $p < .001$. Average ratings for BPD patients exceeded those of all other personality disorders.

Manipulative Lying. The third and fourth items inquired about the tendency to lie manipulatively and convincingly:

3. Some people lie in order to avoid responsibility, gain sympathy, or otherwise manipulate others. Rate the following disorders on the following 1–5 scale comparing the likelihood that a client with each disorder would lie for these reasons, compared to the typical normal person.
4. Some people are especially believable when they lie, and thus are especially likely to convince others that they are telling the truth. Rate the following disorders on the following 1–5 scale comparing the ability of a client with each disorder to lie convincingly to that of the typical normal person.

Patients with BPD were rated as more likely to lie manipulatively ($M = 3.8$) compared with both patients with other personality disorders ($M = 2.8$), $t(32) = 6.9, p < .001$, and the typical outpatient ($M = 2.3$), $t(32) = 8.7, p < .001$. They were also rated as being able to lie more convincingly ($M = 3.1$) compared with both patients with other personality disorders ($M = 2.4$), $t(32) = 3.8, p < .001$ and the typical outpatient ($M = 2.1$), $t(32) = 4.8, p < .001$. The average ratings for BPD for these items ranked second and third, respectively, among the personality disorders.

**Impulsive Early Sexuality.** The final two items assessed psychologists' opinions about the likelihood of patients to be sexually impulsive and to have manifested symptoms during childhood and adolescence. In combination, the two items were intended to assess the perceived likelihood that children and adolescents with BPD (or who will later be diagnosed with BPD) would behave in a sexually impulsive manner:

5. Some people are sexually impulsive or seductive and as a result, enter into destructive sexual relationships. Rate the following disorders on the following 1–5 scale comparing the likelihood that a client with each disorder would voluntarily enter a destructive sexual relationship to that of the typical normal person.

6. Some people with mental disorders show symptoms quite early, in early adolescence or even childhood. Rate the following disorders on the following 1–5 scale comparing the likelihood that a client with each disorder had symptoms of the disorder during childhood or early adolescence to that of the typical normal person.

BPD patients ($M = 4.8$) were rated as much more likely than both other personality disordered patients ($M = 2.9$), $t(32) = 25.3, p < .001$, and the typical outpatient ($M = 2.5$), $t(32) = 18.6, p < .001$ to voluntarily enter destructive sexual relationships. BPD patients were ranked highest of all disorders on this item.

The final item concerning the early presence of symptoms, used a different rating scale than the other items. The scale ranged from 1 (extremely unlikely to have had symptoms during childhood or early adolescence) to 6 (extremely likely to have had symptoms during childhood or early adolescence). The mean for BPD patients ($M = 4.2$), indicates that psychologists believed they were likely to have had early symptoms, and was higher than those for both other personality disorders ($M = 3.9$), $t(32) = 2.8, p < .05$, and the typical outpatient ($M = 3.0$), $t(32) = 8.3, p < .001$. BPD patients ranked second highest on this item.
DISCUSSION

Clinical psychologists believe that BPD patients are especially susceptible to several tendencies that, we contend, could account for the association between CSA and BPD. We consider further the plausibility of these alternative interpretations of the BPD-CSA link.

Alternative Interpretations of the CSA–BPD Association

Psychologists in our survey believed that BPD patients are more likely than other kinds of patients to misinterpret or misremember social interactions. Thus, to the extent that a report of CSA could result from distorted interpersonal perception or memory, the association between BPD and CSA could be exaggerated. (On the other hand, the wording of our items concerns accuracy of social interpretation and memory, and is therefore also consistent with the possibility that BPD patients may underreport CSA.) Indirect evidence supports the role of subjective interpretation in reports of sexual abuse. In one survey of the incidence of rape at 32 colleges (Koss, Gidycz, & Wisniewski, 1987), 73% of participants whom the investigators believed had been raped apparently disagreed with that assessment. We know of no equivalent evidence concerning CSA, but suspect that there is sometimes or perhaps even often subjectivity in the labeling of a childhood experience as CSA. If so, then BPD patients' interpretations may be especially untrustworthy.

The validity of memories of childhood sexual abuse, especially so-called "repressed memories," is controversial (Bowers & Farvolden, 1996; Loftus & Ketcham, 1994; Pope & Brown, 1996), but evidence supports the possibility that false memories concerning sexual abuse can be induced. Two studies have shown that participants will sometimes report detailed memories of events that never occurred (Hyman, Husband, & Billings, 1995; Loftus & Pickrell, 1995). Outside the laboratory, there is convincing evidence that reported traumatic memories are sometimes false. For example, some people have reported memories of events such as being abducted by space aliens or being molested in a prior life (Spanos, Burgess, & Burgess, 1994). Many individuals who originally claimed to have uncovered repressed memories of CSA have later changed their minds and claimed that those memories were false (Lief & Fetkewicz, 1995). We do not know how common false memories of CSA are. Because both subjective interpersonal interpretation and memory can influence reports of CSA, reports of BPD patients should be treated especially cautiously.

Our participants also rated BPD patients as especially likely to lie manipulatively and convincingly. If falsely claiming CSA is sometimes advantageous (e.g., because it evokes sympathy and attention), then BPD patients may be especially likely to do so convincingly. At least one study suggests that such intentional misreporting of sexual abuse is not uncommon (Kanin, 1994). That study focused on a small metropolitan community and found that 41% of rape accusations made to police during a 9-year period were apparently false or at least distorted (i.e., the accuser
admitted that rape had not occurred). The authors concluded that false rape allegations "reflect impulsive and desperate efforts to cope with personal and social stress stimulations" (p. 81). Primary motives for false rape allegations included the need for an alibi, desire for revenge, and desire for attention or sympathy.

There are reasons to doubt that false reports of CSA are much less common than those of rape. False complaints by adults that they were abused as children are probably much more difficult to disprove than false allegations of rape because of the long delay between the alleged events and the accusations in the former case. Furthermore, allegations of much earlier CSA are less likely than rape allegations to result in any kind of formal investigation, especially in the context of psychiatric treatment, and so there would be fewer potential consequences of false CSA reports than of false rape reports.

Regarding false reports of CSA, per se, two studies provided estimates of between 3 and 8% for the incidence of false CSA allegations (Everson & Boat, 1989; Faller, 1984). However, these estimates probably tell more about how commonly child protective service workers will judge cases to be unfounded than they tell us about the actual rate of false allegations. No one knows how common intentional false reporting of CSA is, but our results suggest that patients with BPD may be especially susceptible. Furthermore, case reports have found some BPD patients prone to pathological lying (Snyder, 1986).

Our participants rated BPD patients as especially likely to voluntarily enter destructive relationships. Furthermore, they rated BPD patients as especially likely to have exhibited symptoms during childhood or adolescence. We contend that these tendencies, together, would make it especially likely that, as children or adolescents, BPD patients would be especially susceptible to sexual abuse. We recognize that this contention is likely to be controversial (and potentially offensive), and thus we emphasize two points: First, our argument concerns causal contributions to sexual abuse, and not moral responsibility for such abuse. We do not believe there is any inconsistency in holding both that a child or adolescent may be especially susceptible to sexual abuse and that the person who abuses her or him is morally responsible. Suppose, for example, a 12-year-old girl had a tendency to sneak out of her house at night and seek out the company of men. Such a child would surely be at increased risk of sexual abuse due to the conjunction of her own behavior and the predatory sexual behavior of some men. Even so, any man who took advantage of her vulnerability would surely be morally blameworthy. Furthermore, we believe that cases in which children or adolescents have had a causal role in their own CSA are as deserving of sympathy and clinical concern as cases in which the CSA was entirely out of their control. Indeed, it is plausible that the former situations could cause more psychological distress than the latter.

Our second point concerns the plausibility of our contention. Some studies of the CSA-BPD link have included as "childhood" ages as old as 18, and many included ages as old as 16, provided the contact was
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with a much older person. It seems obvious to us that the sexual experiences of adolescents are not always imposed on them regardless of their own behavior. For example, the degree to which such adolescents are impulsive, seductive, wary, or sexually arousable is likely to affect the number and types of sexual experiences they have. It is not difficult to imagine scenarios in which their own behavior might influence whether such adolescents are sexually abused. For example, two girls approached sexually by older men may react very differently, resulting in only one of them being sexually abused. (In any case, of course, the offending man would be morally blameworthy and legally responsible.)

The association between BPD and reports of CSA cannot entirely be due to high age limits, however, because studies using lower limits have also found the association. For example, one study found that most BPD patients who reported sexual abuse said it began by age 12 (Ogata et al., 1990). We do not know the lower age limit below which girls cannot plausibly contribute casually to their own sexual experiences, including abuse experiences. Recent research on the onset of puberty and sexual feelings suggests that it may be earlier than has typically been assumed. On average, both boys and girls experience their first sexual feelings at age 10 (McClintock & Herdt, 1997). A substantial minority of girls begin puberty by age 8 (Herman-Giddens et al., 1997), and probably experience their sexual feelings before age 10. It seems possible that children who experience sexual desire sometimes behave in ways that makes sexual contact more likely, and if so, impulsive children prone to inappropriate behavior should be especially likely to do so. BPD symptomatology has been identified in children below the age of 10 (Greenman, Gunderson, Cane, & Sultzman, 1986; Goldman, D'Angelo, DeMaso, & Mezzacappa, 1992; Guzder et al., 1996), but relevant studies have not reported rates of sexual impulsivity for these children. It is noteworthy that one study found that female BPD adolescents who reported CSA were substantially more impulsive and sexually promiscuous than those who did not report CSA (Westen et al., 1990). Although the authors suggested that the CSA caused the adolescent girls to act out sexually, the direction of causation is unclear. It is not implausible to us that these symptoms antedated, and contributed to, the CSA. U.S. culture is not accustomed to thinking of children as young as 8 or 10 as sexual beings, but this reflects the value that children so young should not be engaging in sex more than it reflects empirical findings on the numbers who do engage in sex.

Although our study focused on sexual impulsivity, we note that there may be other ways in which early symptoms of BPD make children or adolescents vulnerable to sexual abuse. For example, extreme overidealization of significant others and sensitivity to threats of abandonment could both make children vulnerable to sexual exploitation.

One possible objection to our general argument that various alternative explanations should be considered is that it is unparsimonious because none of the alternatives we have raised can completely explain the CSA–BPD association. Although that may be so, the etiologic hypothesis
that CSA causes BPD is less simple than it seems. A wide variety of experiences are classified as CSA in relevant studies, from unwanted nongenital touching to sexual intercourse, from early childhood to well into adolescence, with perpetrators ranging from older children to parents. It is not obvious why such diverse experiences, happening at quite different developmental stages, should lead to the same outcome. The etiologic hypothesis seems more parsimonious than it is because it subsumes substantially diverse phenomena under the rubric of "childhood sexual abuse."

Methodological Implications

The fact that BPD patients report more CSA than either psychiatric or normal controls has been well established using retrospective studies. Because of the potential concerns we have documented, we doubt that retrospective studies can definitively resolve the meaning of this association. As a first step, however, researchers could make at least two methodological adjustments that would provide a more rigorous test of the hypothesis that CSA causes BPD. They could assess the degree to which the respondent may have contributed causally to each incident of CSA, and attempt to verify reports of CSA using other informants. The latter approach has already been attempted by some investigators (Silk, Weston, Lohr, & Ogata, 1991) who attempted to verify sexual abuse reports with caretakers.

Prospective studies of children with known and detailed abuse histories could provide much more definitive information. The potentially most informative subgroup is sexually abused children who were abused by nonrelatives, and those whose abuse could not plausibly have depended on characteristics of the children. If such children are at increased risk for BPD, this would rule out the alternative interpretations we have raised and increase the likelihood that CSA is a cause of BPD. Another potential design would be a multivariate twin study of BPD and CSA, which could resolve whether the covariation between them is entirely due to environment, as the hypothesis that CSA causes BPD should predict.

The general concern we have raised, that an association between apparent environmental stressors and psychopathology cannot merely be assumed to reflect a causal relation, has precedent in the psychopathology literature. (For a thoughtful discussion of this general issue, see Willerman & Cohen, 1990). Consider, for example, the association between stress and depression. That stress can cause depression is surely more consistent with intuitions than the analogous relation we have questioned, that CSA causes BPD. There is, in fact, a moderate correlation between self-report stress and depression (Munroe & Simons, 1991). However, careful research has shown that a substantial proportion of this correlation cannot be attributable to a straightforward model in which stress causes depression (Munroe & Simons, 1991). For example, people who are susceptible to depression often behave in ways that increase
their own life stress (Adrian & Hammen, 1993; Hammen, 1991). Depressed people may elicit social interactions that depress them further (Joiner, 1995; Joiner & Metalsky, 1995). Equating for actual experiences, depressed people are more likely than nondepressed people to report stress (Munroe & Simons, 1991). Precise estimates of the degree to which different types of stress cause depression remain unavailable, despite a relatively long history of interest in the topic and impressive methodological sophistication. Research on the link between BPD and CSA will need to become considerably more sophisticated before etiologic inferences can be confidently drawn.

Limitations

One potential limitation of this study concerns its sample, which was both small and potentially unrepresentative. We do not believe, however, that sampling bias was an important factor in our results. Our two subsamples were recruited very differently, but provided remarkably similar data. Moreover, we can think of no plausible scenario by which sampling bias could have led to spurious confirmation of our hypotheses.

A more serious limitation, and the primary one of this study, is that it is about clinical psychologists' judgments of types of patients rather than the actual behavior of patients. It would have been more persuasive to demonstrate, for example, that BPD patients are actually more likely than other kinds of patients to misinterpret social interactions rather than merely to document psychologists' opinions that this is so. On the other hand, some of the relevant behaviors about which we surveyed psychologists are closely linked to diagnostic criteria for BPD (e.g., sexual impulsivity). Future research should examine the tendencies we explored more directly by assessing BPD patients. Until such research has been completed, however, we believe that our results raise serious questions regarding the nature of the relation between CSA reports and BPD.

REFERENCES


