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Gender differences in outpatients affected by Borderline Personality Disorder

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ABSTRACT

Introduction: Borderline Personality Disorder (BPD) is a prevalent mental health condition associated with prominent disability. The existing literature on gender differences in BPD is fragmented and data are conflicting.

Methods: 152 patients followed up by community psychiatry services were compared according to gender by independent sample t tests and χ^2 tests. Statistically significant variables at univariate analyses were then inserted in a binary logistic regression model to identify the variables associated with specific gender.

Results: Women resulted to have more previous suicide attempts ($p<0.01$) and more probability to have past history of suicide attempts ($p=0.01$) than men. Women had more frequently multiple family history of psychiatric disorders ($p=0.02$) and post-onset psychiatric poly-comorbidity ($p=0.02$), while males had more frequent substance use disorders before the onset of BPD ($p<0.01$). Binary logistic regression confirmed that previous suicide attempts ($p=0.04$), post-onset psychiatric poly-comorbidity ($p=0.04$) and less frequency of substance use disorders before the onset of BPD ($p<0.01$) were associated with female gender.

Conclusions: Women can have a more complicated course of illness with more suicidal behaviour and psychiatric comorbidity than men. Preventive strategies should be implemented for males with substance use disorders as these conditions could be a sign of future development of BPD.

Keywords: Borderline Personality Disorder (BPD); gender; precision medicine

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INTRODUCTION

Borderline personality disorder (BPD) is a mental health condition characterized by a pervasive pattern of affective, emotional, and behavioral dysregulation associated with instability in personal identity and in interpersonal relationships (Gunderson et al., 2018). An epidemiological study estimated a lifetime prevalence of 5.9%, with no significant difference between males and females (Grant et al., 2008). On the contrary, the Diagnostical and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (American Psychiatric Association, 2013) indicated that the disorder is more frequently diagnosed in females, with a gender ratio of approximately 3:1. As it is easy to imagine, the prevalence of BPD, as well as of other personality disorders, is even higher in people in contact with health-care services (Zimmerman et al., 2008). In clinical settings women affected by BPD are over-represented than men (Leichsenring et al., 2024), probably because women are more prone to seek psychiatric help, as reported by previous studies (Tyrer et al., 2015; Buoli et al., 2019). It is important to note that male patients with BPD are often misdiagnosed as affected by anti-social personality disorder and this could partially explain the data discrepancies (Skodol and Bender, 2003).

To our knowledge, until now the scientific literature about gender differences in BPD is fragmented and contradictory (Bozzatello et al., 2024). Moreover, research in the field generally focuses the attention on females more than males (Bozzatello et al., 2024), and this introduces a selection bias in the studies (Qian et al., 2022). Nonetheless, there are some significant gender differences in the clinical presentation of the disorder that are acknowledged by multiple studies (Sansone and Sansone, 2011).

In particular, some authors highlighted the fact that males with BPD tend to display more externalizing symptoms such as impulsivity and aggressiveness (Qian et al., 2022). Interestingly, an association between anger-related aggressions and deficits in lateral prefrontal emotional control in male BPD patients was found by different authors (Sharp et al., 2014; Bertsch et al., 2019). On the other hand, females are more likely to present internalizing symptoms such as affective instability,

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unstable relationships and suicidal or self-harm behaviours (Hoertel et al., 2014; Sharp et al., 2014). With regard these latter, the difference in suicidal behaviours between males and females is of particular interest and clinical importance (Reichl and Kaess, 2021). Of note, suicide represents the cause of death for up to 10% of patients affected by BPD (Paris, 2019). The factors, that were identified to increase the risk of suicide in BPD patients, include: the presence of substance use disorders (Skinstad and Swain, 2001) in turn associated with a longer duration of untreated illness (Esposito et al., 2023), previous suicidal behavior (Lee et al., 2020) and male gender (Sher et al., 2019). In fact, the proportion of suicide attempters and the number of suicide attempts was reported to be similar in men versus women suffering from BPD, but it seems that men are more at risk of dying by suicide compared to women (Kullgren, 1988; Sher et al., 2019), probably as a result of using violent methods (Tsirigotis et al., 2011; Capuzzi et al., 2022).

As for other clinical factors that underline gender differences, there are evidence showing a specific comorbidity pattern in BPD males versus females: while males are more likely to have comorbid substance use disorders and cluster A/B personality disorders, females would present more frequently comorbid anxiety and eating disorders (Tadić et al., 2009; Sher et al., 2019; Qian et al., 2022). In the light of the gender differences in the clinical presentation of BPD, it is not surprising that females are more likely to receive combined therapy with antidepressants/anxiolytics and psychotherapy (Dehlbom et al., 2022; Goodman et al., 2010) , while males are mostly treated with antipsychotics (Pascual et al., 2007). In agreement with these considerations, men (compared to women) are also more likely to have their first BPD diagnosis in specialized clinic for the management of substance abuse disorders (Dehlbom et al., 2022).

On the other hand, the literature about biochemical and neuroimaging differences between genders in BPD is scarce. A study reported abnormal cortisol responses upon awakening in women, but not in male patients with BPD (Rauch et al., 2015). Of note, dysfunction of hypothalamic-pituitary-adrenal (HPA) axis was documented in subjects affected by BPD in particular in case of comorbidity with depression, post-traumatic stress disorder, dissociative symptoms, and history of

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childhood abuse (Zimmerman and Choi-Kain, 2009). A functional magnetic resonance imaging study showed that males with BPD, compared with the female counterpart, had a higher activation in some brain regions, including the left amygdala, the lateral orbitofrontal (LOFC) and dorsolateral prefrontal cortex (DLPFC). This occurs while imagining interpersonal rejection and acting out aggressively, explaining potential gender differences in brain mechanisms underlying emotional dysregulation (Bertsch et al., 2019; Herpertz et al., 2017).

Although some studies in the literature highlight gender differences in the clinical presentation and course of BPD (Leichsenring et al., 2024), more data are needed to obtain a broader precise view and to suggest personalized treatment (Stone, 2022; Buoli, 2023). In this framework, purpose of the present study is to identify, in a cohort of outpatients with BPD, gender-related clinical characteristics.

METHODS

This is a retrospective cross-sectional study. A sample of 152 outpatients (51 males and 101 females, no patient reported gender incongruence) with a diagnosis of BPD according to DSM criteria (APA, 2013) was included. All the subjects were followed up by community psychiatry services in Milan (N=107) and Monza (N=45). The diagnosis of BPD as well as of main psychiatric comorbidities was made by a psychiatrist of outpatient clinic staff through a clinical interview. Clinical and socio-demographic data were obtained through a screening of the clinical charts and Lombardy electronic database, as well as with interviews with patients and their relatives and transcriptions of previous contacts. Patients with the following criteria were included: (1) age $\geq$ 18 years, (2) diagnosis of BPD according to DSM-5 criteria, (3) contact at the outpatient psychiatric services for at least three months. In case of psychiatric comorbidity, BPD represented the disorder that affected the patients for a longer time or/and was responsible for more disability.

The protocol of this study was approved by the Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico Ethical Committees (identification number of the study: 2064) and it is conformed to the provisions of the Declaration of Helsinki.

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The following variables were collected:

- Demographic variables: age, gender, working condition, marital status;

- Clinical variables: age at onset, duration of untreated illness DUI (years), duration of illness (years), family history of psychiatric disorders, multiple family history of psychiatric disorders, pre-onset and post-onset psychiatric comorbidity and poly-comorbidity, pre-onset and post-onset medical comorbidity and poly-comorbidity, pre-onset and post-onset substance use disorders, pre-onset and post-onset multiple substance use disorders, presence and number of previous suicide attempts, presence and number of previous psychiatric hospitalizations, history of obstetrical complications, main pharmacological treatment with dosage, duration of last pharmacological treatment (months), current poly-pharmacotherapy, presence of pharmacotherapy side effects, current or lifetime psychotherapy and type, history of criminal offenses.

Duration of untreated illness was considered as the time elapsing between the onset of the disorder and the prescription of a proper treatment (pharmacotherapy with antidepressants, mood stabilizers, antipsychotics or dynamic/cognitive psychotherapy or a combination of both, according to predominant psychopathological dimension or biological vulnerability) (Esposito et al., 2023).

Statistical analyses were performed through The Statistical Package for Social Sciences (SPSS) for Windows (version 26.0). Descriptive analyses of the total sample were initially performed, then groups identified according to gender were compared using Student's t test for continuous variables and $\chi 2$ tests for qualitative variables (with odds ratio-OR calculation and 95% confidence interval-CI where appropriate). Finally, statistically significant variables from these univariate analyses were inserted in a binary logistic regression model as predictors, with gender as dependent variable. The goodness of the model was assessed by the Omnibus and Hosmer-Lemeshow tests.

The level of statistical significance was set at $p<0.05$

RESULTS

The total sample included 152 patients whose 33.6% (N=51) were males and 66.4% N=101) females. None of the subjects declared transgender condition. Descriptive analyses and a summary

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of the results of univariate analyses are reported in Table 1 (qualitative variables) and Table 2 (continuous variables).

With regard to main pharmacological treatment, 16 patients were not treated with pharmacological compounds, 10 were treated with venlafaxine (mean dosage-MD 135 mg/day), 1 with mirtazapine (MD 30 mg/day), 6 with citalopram (MD 23.3 mg/day), 3 with sertraline (MD 66.7 mg/day), 2 with pregabalin (MD 225 mg/day), 23 with quetiapine (MD 99.2 mg/day), 4 with gabapentin (MD 800 mg/day), 34 with valproic acid (MD 873.5 mg/day), 1 with lamotrigine (MD 75.0 mg/day), 10 with lithium (MD 631.8 mg/day), 4 with haloperidol (MD 3.0 mg/day), 2 with paliperidone (MD 6.2 mg/day), 7 with olanzapine (MD 11.8 mg/day), 1 with quetiapine (MD 75.0 mg/day), 3 with asenapine (MD 11.7 mg/day), 10 with aripiprazole (MD 11.7 mg/day), 4 with clozapine (MD 146.3 mg/day), 4 with clotiapine (MD 80.9 mg/day), 3 with zuclopenthixol (MD 23.8 mg/day), 1 fluvoxamine (MD 100.0 mg/day), 1 levosulpiride (MD 32.0 mg/day), 1 lurasidone (MD 74 mg/day), 1 fluoxetine MD (20 mg/day). No gender differences were identified with regard to gender distribution of main pharmacological treatment ($\chi2=31.07$, $p=0.15$).

In relation to univariate analyses, female versus male BPD patients resulted: to have more frequently a multiple family history of psychiatric disorders ($\chi2=5.15$, $p=0.02$), to show more often post-onset psychiatric poly-comorbidity ($\chi2=5.73$, $p=0.02$), to suffer less frequently from pre-onset substance use disorders ($\chi2=13.05$, $p<0.01$), to have more often a history of suicide attempts ($\chi2=6.13$, $p<0.01$) and more past suicide attempts ($t=3.83$, $p<0.01$), but to have less frequently a history of obstetrical complications ($\chi2=4.65$, $p=0.03$). In contrast, male patients showed a significantly higher prevalence of criminal offense history ($\chi2=4.75$, $p=0.04$) than the counterpart. No further statistically significant differences were indentified between the two groups (Table 1 and Table 2).

With regard to the binary logistic regression model (Table 3), the goodness-of-fit test results (Hosmer and Lemeshow Test: $\chi2=5.10$, $p=0.65$) showed that the model was reliable, allowing for a correct classification of 70.5% of the cases. In addition, the model was overall significant (Omnibus

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test: $\chi 2=27.97$, $p<0.01$). Female patients (with respect to male ones) resulted to have more frequently previous suicide attempts ($p=0.040$), more often post-onset psychiatric poly-comorbidity ($p=0.04$), but less frequently pre-onset substance use disorders ($p<0.01$).

DISCUSSION

The results of the present study show that patients suffering from BPD have different clinical characteristics according to gender.

First of all, female versus male patients seem to come from families with multiple members suffering from mental pathologies. This finding could indicate that women are more at risk of developing BPD in the presence of genetic vulnerability or that they are more susceptible to the stress of having family members with mental health problems. Of note, some authors demonstrated that women versus men have a higher risk to develop mental disorders in case of parental neglect (Pallier et al., 2022). Furthermore, maladaptive parenting was identified as a factor facilitating the development of BPD in adulthood (Steele et al., 2019). On the other hand, the protective role of estrogens in women may counterbalance the familial predisposition that would express itself in a full-blown BPD only in case of multiple family members affected by mental disorders (Kulkarni, 2023).

The other aspect that differentiates male versus female patients is that the latter are more likely to develop multiple psychiatric comorbidity after the onset of BPD. Our findings are in agreement with a previous study that showed that women affected by BPD were more frequently affected by anxiety disorders compared to men (McCormick et al., 2007). This means that in women BPD could represent the first sign of a more complex pathology that requires a careful monitoring and a combined treatment (Ceresa et al.2021; Esposito et al., 2024). In addition some authors reported that psychiatric comorbidity is often the principal reason for seeking care in BPD patients, resulting in a delay of proper treatment and management (Zimmerman et al., 2017).

Women resulted to have a more frequent history of suicide attempts than men. Available literature is concordant in identifying female gender as associated with more suicide attempts in

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BPD in different cultural contexts (Yang et al., 2022; Bozzatello et al., 2024), however males seem to experience more premature death both for suicidal or non-suicide-related causes (Temes et al., 2019). Suicidal behavior causes discomfort in clinicians also due to medical-legal repercussions, but current guidelines discourage hospitalizations for chronic suicidality, while supporting a collaboration between hospital and outpatient care (Goodman et al., 2012; Besch et al., 2020). A determining factor in the management of suicidal behavior is lethality and male gender was identified as a predictor of violent attempted suicides (Giner et al., 2014). Other factors that were found to be associated with violent suicide attempts include low cholesterol levels (Capuzzi et al., 2022) and the presence of substance use disorders (López-Goñi et al., 2018). In this regard, it was observed in our sample that in males substance use disorders precede the diagnosis of BPD. The higher frequency of substance use disorders in male versus female BPD patients has been already reported by previous studies (Sher et al., 2019; Tadić et al., 2009). In addition to more violent suicidal behavior, early substance misuse triggers criminal behavior and for this reason addictive behaviors should be carefully monitored in young males (Bradford et al., 1992; Gordon et al., 2004). Male BPD patients are likely to be involved in criminal acts than females also because substance use disorders can exacerbate violence and aggressiveness (Bertsch et al., 2019), and this gender difference was also found to be statistically significant in our sample.

Finally, with regard to obstetrical complications observed in 2 male patients of our sample, few data have been published till now in BPD: one study reported that premature birth was more frequent in BPD patients versus controls (Bandelow et al., 2005). Further research is needed to clarify if obstetrical complications may represent a risk factor for the future development of BPD similarly to what happens for mood disorders (Serati et al., 2020).

The results of the present study enrich the few available literature about gender differences in BPD. From a practical point of view, female patients will have to be managed considering that BPD can be complicated by the onset of other psychiatric disorders (especially mood, anxiety and eating disorders). In this framework, it is necessary to choose the ideal therapeutic approach on the basis of

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the prevailing psychopathological dimension (e.g. emotional dysregulation), also taking into account the family history of mental conditions or the effectiveness of treatments on family members affected by psychiatric disorders (Bozzatello et al., 2020). As regards males, it will be necessary to focus on the possible presence of substance use disorders with the prescription of focused interventions or reliance on specialized services on the topic in order to prevent self- or hetero-aggressive behavior (Bohus et al., 2021).

Finally, the main study limitations consist of:

1) some variables were collected retrospectively and this might have made some data less accurate than in controlled studies;

2) the study did not include a follow-up monitoring due to the cross-sectional nature of the study;

3) the fact that outcome variables are limited to the available data (substance use disorders, medical and psychiatric comorbidity, psychotherapy) routinely collected in clinical practice.

Further studies with larger samples are needed to confirm the results of the present study.

DECLARATIONS

1) All the authors declare that there are no conflicts of interest regarding the publication of this article.

2) All data are accessible upon request by writing to the following email address: luigi.piccirilli@gmail.com.

3) This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

KEY POINTS

- **Familial vulnerability and gender:** Women seem to have greater genetic or environmental vulnerability to developing BPD.
- **Psychiatric comorbidities:** Women more frequently develop anxiety, mood, and eating disorders, complicating diagnosis and treatment.

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- **Suicidal behaviors:** Women have more suicide attempts, while men show greater lethality and violence in their attempts.

- **Substance abuse in men:** Substance use disorders often precede the diagnosis of BPD in men, contributing to aggression and criminal behavior.

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Table 1. Qualitative demographic and clinical variables of the total sample and of the two groups divided according to gender.

Variables		Total sample N=152	Males N=51 (33.6%)	Females N=101 (66.4%)	$\chi 2$	OR (95% CI)	p
Working status: employed*	*Yes*	73 (48.0%)	27 (52.9%)	46 (45.5%)	0.74	0.74 (0.38-1.46)	0.39
	No	79 (52.0%)	24 (47.1%)	55 (54.5%)			
Marital Status: single	*Yes*	95 (62.5%)	34 (66.7%)	61 (60.4%)	0.57	1.31 (0.65-2.66)	0.45
	No	57 (37.5%)	17 (33.3%)	40 (39.6%)			
Family history of psychiatric disorders Missing n=5	*Yes*	75 (51.0%)	26 (52.0%)	49 (51.0%)	0.00	1.00 (0.51-1.98)	0.99
	No	72 (49.0%)	25 (48.0%)	47 (49.0%)			
Multiple family history of psychiatric disorders Missing n=3	*Yes*	30 (20.1%)	5 (9.8%)	25 (25.5%)	5.15	3.15 (1.13- 8.81)	**0.02**
	No	119 (79.9%)	46 (90.2%)	73 (74.5%)			
Pre-onset psychiatric comorbidity Missing n=1	*Yes*	43 (71.5%)	12 (24.0%)	31 (30.7%)	0.74	1.40 (0.65-3.04)	0.39
	No	108 (28.5%)	38 (76.0%)	70 (69.3%)			
Post-onset psychiatric comorbidity	*Yes*	67 (44.1%)	18 (35.3%)	49 (48.5%)	2.40	1.73 (0.86-3.46)	0.12
	No	85 (55.9%)	33 (64.7%)	52 (51.5%)			
Pre-onset psychiatric poly-comorbidity	*Yes*	7 (4.6%)	1 (2.0%)	6 (5.9%)	1.22	3.16 (0.37- 26.96)	0.27
	No	145 (95.4%)	50 (98.0%)	95 (94.1%)			
Post-onset psychiatric poly-comorbidity	*Yes*	20 (13.2%)	2 (3.9%)	18 (17.8%)	5.73	5.31 (1.18-23.88)	**0.02**
	No	132 (86.8%)	49 (96.1%)	83 (82.2%)			
Pre-onset medical	*Yes*	35 (23.3%)	10 (20.0%)	25 (25.0%)	0.47	1.33 (0.58-3.05)	0.50

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comorbidity Missing n=2	*No*	115 (76.7%)	40 (80.0%)	75 (75.0%)			
Post-onset medical comorbidity Missing n=5	*Yes*	51 (34.7%)	17 (35.4%)	34 (34.3%)	0.02	0.95 (0.46-1.96)	0.90
	No	96 (65.3%)	31 (64.6%)	65 (65.7%)			
Pre-onset medical poly-comorbidity Missing n=2	*Yes*	10 (6.7%)	1 (2.0%)	9 (9.0%)	2.63	4.85 (0.60-39.38)	0.11
	No	140 (93.3%)	49 (98.0%)	91 (91.0%)			
Post-onset medical poly-comorbidity Missing n=2	*Yes*	22 (14.7%)	6 (12.0%)	16 (16.0%)	0.43	1.40 (0.51-3.82)	0.51
	No	128 (85.3%)	44 (88.0%)	84 (84.0%)			
Pre-onset substance use disorders Missing n=4	*Yes*	56 (37.8%)	29 (58.0%)	27 (27.6%)	13.05	0.28 (0.14-0.56)	**<0.01**
	No	92 (62.2%)	21 (42.0%)	71 (72.4%)			
Post-onset substance use disorders Missing n=5	*Yes*	89 (60.5%)	33 (67.3%)	56 (57.1%)	1.42	0.65 (0.32-1.33)	0.23
	No	58 (39.5%)	16 (32.7%)	42 (42.9%)			
Pre-onset multiple substance use disorder Missing n=3	*Yes*	35 (23.5%)	16 (32.7%)	19 (19.0%)	3.41	0.48 (0.22-1.05)	0.07
	No	114 (76.5%)	33 (67.3%)	81 (81.0%)			
Post-onset multiple substance use disorder Missing n=4	*Yes*	52 (35.1%)	21 (43.8%)	31 (31.0%)	2.31	0.58 (0.28-1.18)	0.13
	No	96 (64.9%)	27 (56.2%)	69 (69.0%)			
Previous suicide attempts	*Yes*	66 (56.6%)	15 (29.4%)	51 (50.5%)	6.13	2.45 (1.19-5.02)	**0.01**
	No	86 (43.4%)	36 (71.6%)	50 (49.5%)			
Previous psychiatric	*Yes*	111 (73.0%)	38 (74.5%)	73 (72.3%)	0.09	0.89 (0.42-1.92)	0.77

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hospitalizations	*No*	41 (27.0%)	13 (25.5%)	38 (27.7%)			
Obstetrical complications Missing n=37	*Yes*	2 (1.7%)	2 (5.7%)	0 (0.0%)	4.65	**NA**	**0.03**
	No	113 (98.3%)	33 (94.3%)	80 (100.0%)			
Pharmacotherapy side effects Missing n=2	*Yes*	15 (10.0%)	6 (12.2%)	9 (8.9%)	2.70	NA	0.61
	No	135 (90.0%)	43 (87.8%)	92 (91.1%)			
Current poly-pharmacotherapy Missing n=1	*Yes*	103 (68.2%)	32 (64.0%)	71 (70.3%)	0.61	1.33 (0.65-2.73)	0.43
	No	48 (31.8%)	18 (36.0%)	30 (29.7%)			
Current psychotherapy Missing n=5	*Yes*	29 (19.7%)	6 (12.5%)	23 (23.2%)	2.35	2.12 (0.80-5.61)	0.13
	No	118 (81.3%)	42 (77.5%)	76 (76.8%)			
Lifetime psychotherapy Missing n=1	*Yes*	68 (45.0%)	17 (34.0%)	51 (50.5%)	3.68	1.98 (0.98-4.00)	0.06
	No	83 (55.0%)	33 (66.0%)	50 (49.5%)			
History of criminal offesenses Missing n=1	*Yes*	20 (13.1%)	11 (21.5%)	9 (8.9%)	4.75	0.36 (0.14-0.93)	**0.04**
	No	132 (86.9%)	40 (78.5%)	92 (91.1%)			

Legend:

*students and housewives are included in this group

CI: confidence interval

NA: not applicable

OR: odds ratio

p: p value

In bold statistically significant p (<0.05). OR refers to females versus males

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Table 2. Continuous demographic and clinical variables of the total sample and of the two groups divided according to gender.

Variables	Total Sample N=152	Males N=51 (33.6%)	Females N=101 (66.4%)	t	p
Age (years)	35.23 ± 12.01	36.33 ± 12.24	34.67 ± 11.99	0.80	0.43
Age at onset	22.82 ± 10.84	22.94 ± 10.57	22.76 ± 11.03	0.10	0.92
Duration of illness (years)	12.46 ± 9.83	13.45 ± 10.09	11.96 ± 9.71	0.88	0.38
Duration of untreated illness	3.50 ± 6.83	4.06 ± 7.42	3.22 ± 6.54	0.71	0.48
Duration of last pharmacological treatment (months)	35.16 ± 64.67	43.91 ± 70.23	31.01 ± 61.80	1.13	0.26
Number of previous suicide attempts	0.98 ± 1.67	0.76 ± 0.11	1.26 ± 1.92	3.83	**<0.01**
Number of previous psychiatric hospitalizations	3.37 ± 5.08	3.02 ± 4.98	3.54 ± 5.15	0.60	0.55

Legend:

p: p value

t: Student’s t

In bold statistically significant p (<0.05). Mean ± standard deviations are reported

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Table 3. Summary of the statistics of best-fit binary regression model for qualitative variables.

Variables	B	S.E.	Wald	P	EXP(B)	95% CI for OR
Multiple family history of psychiatric disorders Missing n=3	0.98	0.56	3.02	0.08	2.66	0.88-7.99
Post-onset psychiatric poly-comorbidity	1.60	0.80	4.04	**0.04**	4.98	1.04-23.76
Pre-onset substance use disorders	-1.25	0.39	10.33	**0.01**	0.29	0.13-0.61
Previous suicide attempts	0.82	0.40	4.23	**0.04**	2.28	1.04-5.00

Legend:

In this analysis the dependent variable was female gender versus male one. In bold statistically significant p.

B=regression coefficient; CI=confidence interval; EXP(B)=B exponential; P= p value S.E.=standard error of B; Wald=Wald statistics

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