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Borderline personality disorder: Gender bias and diagnostic disparities

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Abstract
Borderline Personality Disorder (BPD) is a DSM-5 Cluster B mental health condition. One of the lesser understood mental health conditions, BPD is marked by a multi-symptom profile such as high levels of emotional dysregulation, distorted self-image, volatile and unstable relationships, emotional instability, and higher levels of suicidality. Symptoms are often intense and enduring, causing significant chaos and stress in an individual's life as well as those closest to them. Because there is a significant overlap of symptomology and diagnosis with other psychiatric disorders, BPD was at one time a contested diagnosis, thus research and treatment options remained limited. Currently, BPD is one of the more widely researched conditions, which has informed evidenced-based treatment, however, individuals carrying the diagnosis report difficulty accessing treatment and difficulty feeling understood by mental healthcare providers. The development of BPD remains unclear, although consistent with other mental health conditions there is a genetic constituent, and with BPD in particular a history of trauma. This research manual will explore current evidence-based practices and assessment methods to inform best practices when working with BPD.

Keywords: Borderline Personality Disorder (BPD), mental health assessment and research, BPD treatment methods, BPD assessment tools, BPD and vulnerable populations

Introduction

Brief History and Prevalence

Although the language of one having a "borderline personality type" was used as early as the late 1930s, it was not until 1980, that it was recognized as a diagnosable condition and listed for the first time in the Diagnostic and Statistical Manual for Mental Disorders; the then third Edition (DSM-3), now DSM-5 (American Psychiatric Association, 2013; New & Triebwasser, 2017) [1, 19]. Borderline Personality Disorder (BPD) was granted its name in the late 1960s when research was first established to help with diagnostic protocols. It was not recognized as a disorder featured in the DSM until much later when a greater empirical foundation was established. Earlier research described the condition as a milder version of schizophrenia though the advent of ego psychology began to describe patients meeting what is now recognized as part of the BPD symptom profile as being in borderline states. Language inclusive of "borderline" seemed fitting as it appeared individuals suffering from acute symptoms were on the "borderline" of neurotic and psychotic (Perotta, 2020) [22]. Research continues to develop and is still considered rather young because BPD continues to be one of the more treatment-resistant thus difficult personality disorders to manage. As expanded upon in Perotta, 2020 [22], BPD is frequently comorbid with other mental health conditions, e.g., 85% of individuals carrying a diagnosis of BPD have co-occurring conditions making identification challenging with the symptom profile diverse and varying from case to case. Furthermore, it is also quite common for individuals carrying a diagnosis of BPD to have trauma histories (Ford & Courtois 2021) [11].

BPD was at one time thought by mental healthcare providers to be a catchall bridge between individuals with acute conditions and those considered relatively well.

Because research and diagnostic criteria were lacking, individuals carrying a diagnosis of BPD were inaccurately diagnosed with conditions ranging from anxiety, depression, bipolar disorder, and schizophrenia (Craighead *et al*., 2013) [7], abroad range indeed. Because the condition is so mercurial and mimicking of other disorders, it is still rather common for BPD to be misdiagnosed, most often as Bipolar 2 disorder. Though both share overlapping symptoms and are part of the Cluster B category of personality disorders, there are distinct differences. Because BPD can present as depressive in the same way an episode of depressive or bipolar disorder can it is important for the symptoms of comorbid disorders to be long-standing and early onset (Fowler *et al*., 2019) [12]. As outlined by Bayes & Parker (2019) [2], the more distinct features of BPD are a pervasive pattern of instability in relationships, an unstable sense of self and self-image, poor impulse control, and emotional instability. The most defining feature is often an intense fear of abandonment and whether perceived or real, individuals with BPD will commonly understand the slightest rejections or criticisms as a form of abandonment. Dichotomous, i.e., black-and-white thinking is another enduring feature of BPD with idealization and devaluation, known clinically as splitting, being pervasive in interpersonal relationships.

Statistics and Data

The median population prevalence of BPD is approximated between 4-6% with a mean of 5.9%. In primary care settings, an estimated 6% carry the diagnosis, in outpatient settings an estimated 10%, and inpatient settings an estimated 20%. Prevalence appears to decrease as age increases, and the more acute symptoms experienced in adolescence and young adulthood often decrease with age (Daros & Williams, 2019) [8]. Because mental healthcare remains inaccessible, it is not uncommon for individuals to seek mental health treatment from general practitioners. Despite the prevalence, general healthcare practitioners are not abreast nor able to discern and identify the different symptom profiles of disorders and remain unaware of BPD as opposed to the more familiar depressive and bipolar disorders. Misdiagnosis and an ineffective treatment plan exacerbate symptoms and inaccuracy in statistical data (Rameckers *et al*., 2021) [24]. With 75% of individuals diagnosed with BPD being female, men are often underrepresented. Research surrounding BPD often elicits a higher frequency of females in clinical samples. It is also theorized that because males and females present differently and BPD is a more histrionic disorder, it is likelier to be attached to a female than a male, whereas a male is more likely to be attached to what might be considered a more masculine diagnosis such as posttraumatic stress disorder (PTSD), or narcissistic personality disorder (NPD) (Masland & Null, 2022) [17].

It is believed that multiple factors, including genetic vulnerabilities, trauma, particularly in early childhood, and the type of psychosocial factors that interfere with the development of social cognitive abilities that regulate behavior contribute to the multifaceted causes of BPD (Ford & Courtois 2021) [11]. Distinguished as an epigenetic expression, exposure to childhood trauma appears to be a great mediator of the genetic marker for BPD expressing itself and is one of the most consistent features in individuals carrying the diagnosis McEwen, 2017) [18]. Current research (Sharp & Kim, 2015) [26] supports the complex interactions between biology, life events, and one's environment that contributes to the development of BPD. In addition to a history of trauma, an insecure attachment style has a considerable association with BPD, which is consistent with relational instabilities, both with self and others- a tenor of the condition (Sharp & Kim, 2015) [26]. Although difficult to treat, with adequate treatment and commitment to treatment on the individual's part, there is a fair prognosis. For example, one longitudinal study with a sample size of 290 found healthy remission rates ranging from 35% after 2 years, 91% after 3 years, and 99% after 16 years (Chapman *et al*., 2022) [6]. However, a noted gap in Chapman *et al*., (2022) [6], is whether remission was at the cost of interpersonal relationships, i.e., did individuals remit because of relationship avoidance as opposed to progressive improvement in interpersonal abilities?.

Review of Population and Dominant Groups

Validated by empirical data, disparities of race prevail in diagnosing acute types of psychopathologies (Becker *et al*., 2022) [4]. Haeri *et al*., 2011 [14], indicated a higher prevalence of more severe personality disorders in individuals identifying as ethnic or racial minorities, while (Garb, 2021) [13] evidences different mental health conditions are diagnosed with racial bias. No exception, bias in BPD diagnosis can be marked within certain minority populations. Becker *et al*, 2022 [4], discovered differences in the diagnosis of BPD though greater research is needed surrounding considerations of population differences in maladaptive behaviors and measurements of baseline personality. Prior to the study organized by Becker *et al*., 2022 [4], the relationship between racial prejudice and BPD had not been studied with great consideration. A diagnosis of BPD is apparent among certain minority groups, though specific research focusing on prevalence within racial minorities remains scant. As highlighted by the research of DeGenna & Feske, 2013 [9], a cross-sectional sample of 83 females with BPD (42 black American women and 41 white American women) endorsed that black American women reported more acute externalizing symptoms while white women reported more acute internalizing symptoms. It is important to note that socioeconomic status was a mediator in understanding the connection between race and externalizing/internalizing symptoms. DeGenna & Feske, 2013 [9] concluded a probability of black American women with BPD being inaccurately diagnosed because of poor access to quality care thus receiving at best ineffective at worst detrimental treatment. The stated results in black American women presenting with more acute and explicit symptoms such as lacking emotional and impulse control while white women with BPD are more likely to present with more illicit symptoms such as suicidal ideations/actions and self-harming behaviors. Consistent with the prognosis and treatment of healthcare conditions, factors such as race, socioeconomics, and the ensuing discriminatory encounters one endures, are often cause for the stated consequences of misdiagnosis and poor fit treatment practices to be marked with more frequency in populations with less power (Becker *et al*., 2022; Haeri *et al*., 201) [4, 14].

Measures with Vulnerable and Diverse Populations

It is frequently believed that white women alone suffer from BPD (Garb, 2021) [13]. Contrary to popular belief, findings from a sizable sample, inclusive of representing individuals with diverse racial and ethnic backgrounds revealed that BPD

affects minority groups more frequently than dominant groups (DeGenna & Feske, 2013) [9]. For example, Becker *et al*, (2022) [4] highlighted that both black and Native Americans experience higher rates of BPD than white Americans. This runs counter to most of the current research based on clinical samples, as most clinical samples do not adequately represent racial minority groups. Lack of inclusion in research sampling has likely been the greatest limitation in understanding how BPD impacts racial minorities and why it is frequently missed in assessment processes, consequently preventing those part of racial and ethnic minority groups from receiving adequate treatment (Sanches, 2019) [25]. Whereas racial and ethnic minority groups appear to be underrepresented, as previously articulated, women seem to be overrepresented, yet data from a broader epidemiological sample demonstrated little variation in the prevalence of BPD in women vs. men (Masland & Null, 2022) [17]. Studies often assert gender as an important contributing factor, i.e., there is an implicit bias in assuming women are more likely to carry the diagnosis, though the contrast between males and females remains statistically insignificant in clinical trials equally representing both genders (Garb, 2021) [13]. Furthermore, when degrees of sexual, physical, and emotional trauma are considered, it was discovered that men had a considerably higher risk of developing BPD (Masland & Null, 2022) [17]. Arguably one can say that with the development of more inclusive research representing both genders equally, the gender disparities in BPD diagnosis may dissipate. The same can be said about more inclusive samples regarding racial and ethnic diversity. By comparison to more well-known and thus better-understood personality disorders, e.g., anxiety disorders or bipolar illnesses, BPD receives much less funding for research. This is the greatest contributor to the lack of knowledge and consequently lack of efficient and viable treatment options (Haeri *et al*, 2011) [14]. As evidenced by contemporary literature, there appears to be a significant disparity in gender and carrying a diagnosis of BPD, and it has been argued that because it is a disorder predominantly impacting women it is not given the resources or consideration it would if it was a disorder impacting men at a greater rate or both genders equally (Ellison *et al*., 2018) [10]. Although BPD is underdiagnosed in males, it is inaccurate to presume males are not as likely to carry the diagnosis, but they are less likely to be accurately diagnosed (Garb, 2021) [13]. Theories surrounding why women are overrepresented vary, though the cause could be correlated to stigma and stereotypes surrounding gender and gender roles (Becker, 2019) [3]. For example, as highlighted by Becker (2019) [3], men may be more reticent than women to speak of suicidality or childhood abuse, particularly sexual. The perception that men and women present symptoms differently is also thought to be a contributor to the gender disparity in BPD diagnosis, further compounded by gender-biased clinicians aligned with the belief that women are at greater risk and more likely to develop the disorder (Becker, 2019) [3].

When looking at symptoms stratified by race and gender, Ellison *et al*., 2018 [10], indicates a change in how symptoms present and the pervasiveness of symptoms. Although BPD is stereotyped as a disorder largely impacting white women, substantiating research is lacking. Refuting bias, research such as Sanches, 2019 [25], highlights variables that may explain racial disparities in diagnosis. For example, inconsistencies in research and available scholarship may support a greater number of white women being attached to the diagnosis with more frequency or accuracy as a byproduct of having better access to care and not because the disorder is simply more prevalent in white women. Additionally, a lack of cultural competence can impact an accurate diagnosis. As featured in the work of both Haliczer *et al*., (2020) [15] and Garb (2021) [13], black American women were more likely to be accurately diagnosed with BPD, thus receive suitable treatment, when working with a black American clinician. It is important to note that disparities notwithstanding individuals accurately diagnosed with BPD have a difficult time finding BPD-informed clinicians willing to treat them because they are often difficult cases and beyond the scope of practice for many (Sanches, 2019) [25]. This is a challenge exacerbated when one is part of a minority group. To better understand the identified disparities between BPD and minority groups, more inclusive, larger scales of measurement are needed to address sample limitations (Garb, 2021; Haliczer *et al*., 2020) [13, 15]. Additionally, the effects of sexual and emotional abuse histories appear consistent in the majority of BPD cases (Sharp & Kim, 2015) [26]. Because of pervasive abuse histories, comprehensive research is needed to address both the underrepresentation and overrepresentation of certain groups to accurately identify the genetic and social patterns of BPD that become obscured by gender stereotypes and racial disparities, i.e., giving due consideration to the role of trauma histories.

Assessment Methods

Although BPD was recognized as a diagnosis in the 1980s, specialized treatment remained scant and continues to be difficult to access (American Psychiatric Association, 2013; New & Triebwasser, 2017) [1, 19]. Because BPD is now more accurately identified, clinical settings have improved assessment methods and specialized treatment is available for individuals with BPD to help manage symptoms and reduce hospitalization. Despite advances in assessment and treatment options, a precise diagnosis of BPD remains difficult and time-consuming to assess due to its complexity and range of symptoms that overlap with other mental health conditions. (Craighead *et al*., 2013) [7]. Espoused in Rameckers (2021) [24], discernment is hard to measure, and symptoms must be marked over a healthy amount of time. An inaccurate diagnosis and subsequent inaccurate treatment plan can be detrimental, a conflict noted frequently with BPD. It is not uncommon for individuals affected by BPD to terminate treatment during the assessment process, i.e., before the ideal combination of treatment and resources has been discerned due to feelings of frustration and symptom exacerbation (Rameckers, 2021) [24].

The assessment tool most frequently used to screen for BPD is the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD) (Zimmerman & Balling, 2021) [28]. Other frequently employed tools and protocols used to measure BPD are the Structured Clinical Interview for DSM-IV Axis II Personality Disorders-Patient Questionnaire (SCID-5-PD), the Personality Diagnostic Questionnaire 4th Edition-BPD Scale (PDQ-4), and the Zaharini Rating Scale (ZAN-BPD) (American Psychiatric Association, 2013; Jordan & Franklin, 2016) [1, 16]. A 2017 study was conducted (Bloo *et al*., 2017) using the PDQ-4, MSI-BPD, and SCID-II to compare correlations and specificity in their effectiveness in determining a BPD diagnosis. The sample demographic was limited to adolescents and young adults although findings supported all

tools were equally accurate in determining a diagnosis. Because findings from an older study (Tan *et al*., 2016) [27] found that the PDQ-4 had a significant rate of false positives research facilitators advise against using the PDQ-4 as a personality disorder screening tool; of the more commonly employed tools it is the least used. BPD assessment protocols take approximately one hour. Clinicians will rarely if ever attach a concrete diagnosis after one session- the assessment tools help inform the course of treatment and evaluate symptoms. They are not able to measure an individual's behavioral patterns over a period, only at a specific point in time (Bloo *et al*., 2017; Zimmerman & Balling, 2021) [28]. The onus of accounting for patterns of behavior over longer periods is on the treating clinician (Bloo *et al*., 2017).

McLean Screening Instrument for Borderline Personality Disorder MSI-BPD

Description and Clinical Utility

Developed by Dr. Mary Zanarini and her clinical team at McLean Hospital in 2003, the MSI-BPD is a 10-item measuring system used to screen for BPD. The scaling system used to measure data from the MSI-BPD is aptly named the Zanarini scale. As stated, although other tools of measurement exist, the MSI-BPD is the most employed (Bloo *et al*., 2017; Jordan & Franklin, 2016) [16] and will be expanded upon in this section. The MSI-BPD is a written exam based on the diagnostic criteria listed in the DSM-IV, then, DSM-III (American Psychiatric Association, 2013) [1], and like other disorders of personality, a definitive diagnosis cannot be tested biologically. Diagnosis can be fluid and co-occurring with other personality disorders. Though diagnostic tools such as the MSI-BPD aid in determining the probability of BPD and the necessity for additional evaluation protocols, the fluidity of diagnosis and the possibility of co-occurring disorders are considerations to be mindful of during the evaluation process (Perotta, 2020; Pomeroy & Wombach, 2015) [22, 23]. The information acquired from the MSI-BPD will begin to outline and inform the treatment plan, but because BPD is mercurial and complex (Bayes & Parker, 2019; Chapman *et al*., 2022) [2, 6], the treatment plan must be frequently reassessed by the primary clinician/clinical team to accommodate the changing needs of the client.

Each MSI-BPD item indicates a behavior pattern and is given a rating of zero or one. One indicating the behavioral pattern is identified as present, zero if it is not. For example, the question 'Have any of your closest relationships been troubled by a lot of arguments or repeated breakups' that appears on the MSI-BPD would be rated as one or zero, as would all successive questions. The items and their subsequent scoring are tabulated to provide a score ranging from 0-10. The sum of the score will indicate if and where one lies on the spectrum. A score of seven or higher is clinically indicative of an individual likely fitting the criteria of a BPD diagnosis. Whereas seven is traditionally deemed a reasonable clinical cutoff, some researchers and clinicians advise and employ a lower cutoff, while others, depending on the age and culture of the client, will employ a higher cutoff (Bloo *et al*., 2017; Zimmerman & Balling, 2021) [28]. The first eight items featured in the MSI-BPD are oriented to the first eight diagnostic criteria listed in the DSM-IV with the latter two items oriented to the last few diagnostic criteria, e.g., dissociation and paranoia (American Psychiatric Association, 2013) [1].

MSI-BPD Validity and Reliability

Critical practice in identifying individuals necessitating a more comprehensive evaluation is through screening. Findings from various studies support that employing the MSI-BPD as a screening instrument for BPD (in both non-clinical and clinical populations), has shown positive validity and reliability (Daros & Williams, 2019; Patel *et al*., 2011) [8, 21]. Because of the MSI-BPD's strong validity and reliability, it has become a frequently used evaluation tool in most cultures. Although indigenous to the United States, its protocol has been modified and standardized in other languages to accommodate other cultural norms to positive effect (Tan *et al*., 2016) [27]. Detailed evaluations and accurate assessments inform treatment protocols and research, allowing clinicians to be best informed and thus provide optimal service to their clients. While assessing for personality disorders, it is extremely important to conduct reliable screening protocols using the appropriate tools, for both preventative and clinical uses. Although it is possible to increase the external validity of measurements by looking at their psychometric characteristics in vulnerable and underrepresented populations, the MSI-BPD remains a trusted tool in the screening for BPD as it appears to be the most reliable (Noblin, 2014) [20].

The MSI-BPD and its subscales demonstrate a consistent, valid psychometric method of assessment (Perotta, 2020; Pomeroy & Wombach, 2015) [22, 23]. Its test-retest reliability and internal consistency are both satisfactory. When a score of seven is used to measure BPD during assessment protocols, the MSI-BPD has shown specificity and sensitivity in identifying BPD. Additional findings from Noblin *et al*., 2014 [20], supported the MSI-BPD's validity when applied to adolescents receiving inpatient care, though a clinical score of 5.5 was set as the baseline diagnostic measurement score. Although the clinical cutoff was 5.5, lower than the standard of seven, the research demonstrated adequate validity and reliability because convergent validity was reviewed with established screening tools for BPD in adolescents. For example, criterion validity was studied by applying 5.5 as a clinical cutoff to examine small-group differences in suicidal ideation, a common correlate of BPD. Findings supported the validity of 5.5 being a suitable clinical cutoff for the population and setting, thus establishing 5.5 as the clinical cutoff for the Noblin *et al*., 2014 [20] study. As well, findings from Rameckers (2021) [24], with a clinical cutoff score between 5-6, displayed higher sensitivity, while scores between 7-8 displayed lower sensitivity, i.e., positive diagnosis grew as the clinical cutoff score increased. Results broadly agreed that although a score of seven is recommended, a cutoff score of six appeared sufficient. In case-by-case circumstances, a clinical cutoff of seven may be preferred and should be carefully considered by the diagnosing clinician as scoring and clinical cutoff standards can be discretionary depending on case-by-case factors (Bloo *et al*., 2017; Zimmerman & Balling 2021) [28].

Conclusion

BPD is one of the more difficult personality disorders to diagnose and treat due to the higher levels of emotional dysregulation and coexisting comorbidities with other conditions. Commonly misdiagnosed as other mental health disorders part of the Cluster B category such as bipolar disorder, though both conditions share overlapping symptoms, the course of treatment for BPD differs thus an accurate assessment is

critical. The higher risk of suicidal ideation and experimentation marked in those suffering from BPD can become exacerbated by a poorly informed assessment and treatment plan, making competent assessment tools such as the MSI-BPD paramount. The MSI-BPD is a screening instrument that aids in determining the probability of an individual carrying a diagnosis of BPD rather than an actual diagnostic tool. Semi-structured and structured interviews in conjunction with traditional therapeutic practices preferably with a clinician offering extensive experience in the diagnosis and treatment of BPD are necessary for a proper diagnosis. Thus, the MSI-BPD should not be used solitarily as it is one of several instruments employed during the diagnostic process.

Though stereotyped as a disorder primarily affecting white women, BPD is experienced consistently across the spectrum of dominant and minority groups. Because the greater majority of studies have been smaller in sample size and without much gender or racial diversity, findings have not represented much diversity which helps explain the overrepresentation of white women. It is not that BPD affects white women at a greater rate, but rather disparities of inclusion have created an inaccurate stereotype that has been adopted. The strongest predictor for BPD appears to be a history of childhood abuse, particularly sexual, gender, and race notwithstanding (Sharp & Kim, 2015) [26]. Even with an inclusive demographic sample, assessment tools such as the MSI-BPD only offer a point-in-time snapshot of a person's mental state in a specific setting. It captures a part of the individual being assessed and not a holistic comprehensive examination. Clinicians must be astute and consider the individual's behavioral patterns longitudinally and within context. Adequate and comprehensive treatment will be designed only with greater research representing diverse groups, though, in considering evidenced-based tools, the MSI-BPD provides clinicians with a viable assessment to discern the presence of BPD and inform the course of treatment.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed.), 2013. https://doi.org/10/1176/appi.books9780890425596.
2. Bayes A, Parker G. Differentiating borderline personality disorder (BPD) from bipolar disorder: Diagnostic efficiency of DSM BPD criteria. Acta Psychiatric Scandinavica, 2019, 141(2). https://doi.org/10.1111/acps.13133
3. Becker D. Through the looking glass: Women and borderline personality disorder. Routledge Press, 2019. https://doi.org/978-08133-3310-6.
4. Becker L, Asadi S, Zimmerman M, Morgan T, Rodriguez-Seijas C. Is there a bias in the diagnosis of borderline personality disorder among racially minoritized patients? Personality Disorder: Theory, Research, and Treatment, 2022. https://doi.org?10.1037/per0000579.
5. Boo J, Arntz A, Schouten E. The borderline personality disorder checklist: Psychometric evaluation and factorial structure in clinical and nonclinical samples. Annals of Psychiatry. 2017; 2:311-336. https://doi.org/10.18290/psych.2017.20.2-3en.
6. Chapman J, Jamil R, Fleisher C. Borderline Personality Disorder. In Stat-Pearls Publishing, 2022. https://www.ncbi.nlm.nhi.gov/books/NBK4308833/
7. Craighead W, Miklowitz D, Craighead L. Borderline Personality Disorder. In John Wiley and Sons Inc., Psychopathology: History, Diagnosis, and Empirical Foundations, 2013, (2nd ed., 562-511). https://doi:978-1-119-22173-9
8. Daros A, Williams G. A meta-analysis and systematic review of emotion-regulation, strategies in borderline personality disorder. Harvard Review of Psychiatry. 2019; 27(4):217-232. https://doi:10.1097/HRP.0000000000000212.
9. DeGenna N, Feske U. Phenomenology of borderline personality disorder: The role of race and socioeconomic status. Journal of Nervous and Mental Disorder. 2013; 212(201):1027-1034. https://doi:10.1097/NMD.0000000000000053.
10. Ellison W, Rosenstien L, Morgan T, Zimmerman M. Community and clinical epidemiology of borderline personality disorder. Psychiatric Clinics of North America. 2018; 4(41), 561-573. https://doi:10.1016/j.psc.2018.07.008.
11. Ford J, Courtois. Complex PTSD and borderline personality disorder. Borderline personality disorder and emotional dysregulation, 2021; 8(16). https://doi.org/10.1186/s40479-021-00155-9.
12. Fowler C, Madan A, Allen J, Oldham J, Freuh C. Differentiating bipolar disorder from borderline personality disorder: Diagnostic accuracy of the difficulty in emotion regulation scale and personality inventory for DSM-5. Journal of Affective Disorders. 2019; 245(15):856-860. https://doi.org/10.1016/j.jad.2018.11.079.
13. Garb H. Race bias and gender bias in the diagnosis of psychological disorders. Clinical Psychology Review, 2021, 90. https://doi.org/10.1016/j.cpr.2021.102087.
14. Haeri S, Williams J, Kopeykina I, Johnson J, Newmark A, Galynker I, *et al*. Disparities in diagnosis of bipolar disorder in individuals of African and European descent: A review. Journal OF Psychiatric Practice. 2011; 17(6):394-403. https://doi.org10.1097/01.pra.0000407962.49851.ef.
15. Haliczer L, Dixon-Gordon K, Keyne L, Anestis M, Rosenth M, Chapman A. Emotion regulation difficulties and borderline personality disorder: The moderating role of race. Personality Disorder: Theory, Research, and Treatment. 2020; 11(4):280-289. https://doi.org/10.1037/per0000355.
16. Jordan C, Franklin Clinical Assessment for Social Workers: Quantitative and Qualitative Methods (4th ed.). Lyceum Books, 2016. https://doi.org/978-1-935871-92-7.
17. Masland S, Null K. Effects of diagnostic label construction and gender on stigma about borderline personality disorder. Stigma and Health. 2022; 7(1):89-99. https://doi.org/10.1037/sah0000320.
18. McEwen B. Epigenetic interactions and brain-body communication. Psychotherapy and Psychosomatics. 2017; 86(1):1-4. https://www.jstor.org/stable/48516311.
19. New A, Triebwasser J. A History of Borderline Personality Disorder. In Barbara Stanley, and Antonia New (Eds), Borderline Personality Disorder. Oxford Academic, 2017. https://doi.org/10.1093/med/9780199997510.003.001.
20. Noblin L, Venta A, Sharp C. The validity of the MSI-

BPD among inpatient adolescents. Assessment. 2014; 21(2):210-217. https://doi.org/10.1177/10731911112473177.
21. Patel A, Sharp C, Fongay P. Criterion validity of the MSI-BPD in a community sample of women. Journal of Psychopathology and Behavioral Assessment. 2011; 33:403-408. https://doi.org/10.1007/s10862-011-9238-5.
22. Perotta G. Borderline personality disorder: Definition, differential diagnosis, clinical contexts, and therapeutic approaches. Annals of Psychiatry and Treatment. 2020; 4(1):43-56. https://doi.org/10.17352/apt.000020.
23. Pomeroy E, Wombach K. The Clinical Assessment Workbook: Balancing Strengths and Differential Diagnosis (2nd ed). Pacific Grove, CA: Brooks/Cole-Thompson Learning, 2015.
24. Rameckers S, Verhoef R, Grasman Cox W, Emmerik A, Engelmoer I, Arntz A. Effectiveness of psychological treatments for borderline personality disorder and predictors of treatment outcomes: A multivariate multilevel meta-analysis of data from all design types/ Journal of Clinical Medicine. 2021; 10(23):5622. https://doi.org/10.3390/jcm10235622.
25. Sanches M. The limits between bipolar disorder and borderline personality disorder: A review of the evidence. Diseases. 2019; 7(3):49. https://doi.org/10.3390/diseases7030049.
26. Sharp C, Kim S. Recent advances in the developmental aspects of borderline personality disorder. Current Psychiatry Reports, 2015, 17(21). https://doi.org/10.1007/s11920-015-0556-2.
27. Tan Y. Liu Y, Wu L. Screening results correlating to personality disorder traits in a new employee population of the People's Republic of China. Neuropsychiatric Disease and Treatment. 2016; 12:2553-2560. https://doi.org/10.2147/NDT.S118668.
28. Zimmerman M, Balling C. Screening for borderline personality disorder with the McLean Screening Instrument: A review and critique of the literature. Journal of Personality Disorders, 2021, 35(2). https://doi.org/10.1521/pedi_2019_33_451.