*Empirical Article*

Clinical Psychological Science
1–19

DOI: 10.1177/21677026241267954
www.psychologicalscience.org/CPS

# Bias in the Diagnosis of Borderline Personality Disorder Among Sexual- and Gender-Minority Persons: Results From a Vignette-Based Experiment

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## Abstract

Sexual- and gender-minority (SGM) individuals are diagnosed with borderline personality disorder (BPD) more than cisgender heterosexuals. Using a large sample of mental-health practitioners in the United States and Canada ($N$ = 426), we examined bias in the diagnosis of BPD. Mental-health practitioners were randomly assigned to receive one of three clinical vignettes (cisgender heterosexual man, cisgender gay man, or transgender woman) and asked to provide psychiatric diagnoses based on the vignette. Mental-health practitioners demonstrated a predilection to diagnose BPD when presented with the transgender vignette (odds ratio [$OR$] = 1.99, $p$ = .01) but not the cisgender-gay vignette ($OR$ = 1.34, $p$ = .29) compared with practitioners presented the cisgender-heterosexual vignette. Psychiatrists, mental-health counselors, and clinical social workers were significantly more inclined to diagnose BPD than psychologists, although reasons for underdiagnosis differed across groups. These findings bear important implications for future training given the nature of the mental-health workforce in the United States.

## Keywords

borderline personality disorder, diagnostic bias, LGBTQ+ mental health, clinician bias

Received 8/1/23; Revision accepted 6/21/24

Borderline personality disorder (BPD) is a psychiatric condition, the diagnosis of which is associated with a host of detrimental outcomes, including high comorbidity with other psychiatric disorders (B. F. Grant et al., 2008; Zimmerman & Mattia, 1999), functional disability (Gunderson et al., 2011), burden on caregivers (Bailey & Grenyer, 2013), and stigma from both the general public and health-care providers (Aviram et al., 2006; Ring & Lawn, 2019). The prevalence of BPD diagnosis is higher among sexual- and gender-minority (SGM) populations compared with cisgender heterosexuals (Denning et al., 2022; Rodriguez-Seijas et al., 2021b; Zimmerman et al., 2022). Emerging evidence suggests that mental-health-care providers might be predisposed to diagnose BPD among SGM patients in clinical settings (Rodriguez-Seijas et al., 2021a; Rodriguez-Seijas, Morgan, & Zimmerman, 2023). However, it is unclear if the elevated BPD diagnosis is due to different clinical presentations between SGM and cisgender-heterosexual patients rather than a function of clinician bias per se. We examined how patient sexual orientation and gender identity and the training background of providers themselves were related to differences in the diagnosis of BPD using a clinical-vignette experiment.

## BPD Prevalence as a Function of SGM Status

BPD prevalence estimates vary from approximately 1.2% in the general population to 12% in outpatient settings and 22% in inpatient settings (Ellison et al., 2018; Rodriguez-Seijas et al., 2021b). Among sexual-minority samples specifically, prevalence estimates vary

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widely, from 7% to 58% (Dulit et al., 1993; Paris et al., 1995; Reich & Zanarini, 2008; Singh et al., 2011; Zubenko et al., 1987). Several studies have also documented high proportions of SGM status among BPD clinical samples (J. E. Grant et al., 2011; Reuter et al., 2016). Emerging evidence further suggests that transgender and gender-diverse patients are diagnosed with BPD more frequently than cisgender patients (Zimmerman et al., 2022). Together, evidence suggests elevated BPD prevalence among SGM populations relative to cisgender heterosexuals.

SGM individuals are typically excluded from or underrepresented in large, epidemiological samples, making it difficult to understand population-based prevalence patterns. Indeed, the fields of personality disorder and SGM psychosocial science appear to have developed independent of one another. Many population-based data sets that contain assessment of BPD or related domains—such as the National Survey on American Life (Jackson et al., 2004), the Midlife in the United States Study (Brim et al., 2004), and the National Comorbidity Survey (Kessler et al., 1994)—either exclude measurement of SGM status or possess samples restrictively small to preclude analysis of SGM individuals. Simultaneously, data sets focused squarely on understanding the mental health of SGM individuals typically include relatively superficial measurements of psychopathology domains (I. H. Meyer, 2023; Sterzing & Edleson, n.d.; TransPop, n.d.); their focus is more often on granular assessment of structural and social predictors of mental and physical health among SGM individuals. It is particularly noteworthy that experiences of trauma and victimization are associated with BPD psychopathology and are also more frequently experienced by SGM individuals. Yet assessment of BPD-related symptoms or proxies of such are excluded from most SGM-specific data-collection efforts at this time.

However, results from one study demonstrated that the prevalence of BPD among sexual-minority individuals depends on appropriately adjudicating impairment. Using data from the National Epidemiologic Study on Alcohol and Related Conditions III (B. F. Grant et al., 2014), Rodriguez-Seijas and colleagues (2021b) found that sexual-minority individuals more frequently endorsed behaviors associated with all nine of the diagnostic criteria for BPD compared with heterosexuals. If distress/impairment was ignored, the prevalence of BPD among sexual-minority individuals was 19.2%. However, accounting for distress/impairment when adjudicating criterion threshold reduced the prevalence of BPD among the sexual-minority population to 1.7%—on par with that of the heterosexual population. The heightened prevalence of BPD among SGM individuals, therefore, might be associated with an elevation in the endorsement of nonclinical (i.e., independent of distress/impairment) behaviors among SGM individuals that are typically considered indicators of the BPD diagnosis. Personality-disorder theory, research, and treatment have excluded considerations of SGM populations in its epistemology, which might explain such an oversight (Rodriguez-Seijas, Rogers, & Asadi, 2023).

## Sociocultural Context and BPD Among SGM Populations

The sociocultural context in which SGM individuals exist might predispose them to more frequently endorse behaviors consistent with the diagnosis of BPD compared with their cisgender heterosexual peers. The criteria of interpersonal difficulties and fears of abandonment map onto the deleterious interpersonal effects of rejection sensitivity (Feinstein, 2020; Mendoza-Denton et al., 2002; Pachankis et al., 2008); rejection sensitivity is related to common mood and anxiety psychopathology (Cohen et al., 2016) and the diagnosis of BPD (Gao et al., 2017). SGM individuals may face actual experiences of rejection, or threats thereof, that can be quite extreme (e.g., excommunication from church, alienation from family of origin) or knowledge that these experiences happen to other SGM persons. Such experiences can lead to a threat-sensitive orientation (Feinstein, 2020), which can thwart efforts of interpersonal intimacy (Downey & Feldman, 1996). Internalized stigma related to SGM identity can also be a barrier to healthy interpersonal relationships; for instance, shame can act as a barrier to interpersonal connection and worsen mental-health outcomes (Puckett et al., 2017). For a more in-depth discussion of how the sociocultural context is associated with conceptualization of personality disorders, see Rodriguez-Seijas, Rogers, and Asadi (2023).

SGM individuals are overwhelmingly exposed to known predictors of the BPD diagnosis, such as traumatic events of discrimination and violence (Mizock & Lewis, 2008; Stotzer, 2009; White Hughto et al., 2015; Wyss, 2004). SGM populations experience elevated prevalence of suicidal ideation and deaths by suicide (Barnett et al., 2019; Bolton & Sareen, 2011; De Graaf et al., 2006; Haas et al., 2010; King et al., 2008). Although identity disturbance may be developmentally normative for SGM individuals, it is also a diagnostic criterion of BPD. In addition, transgender and gender-diverse identities have historically been equated with the diagnosis of BPD in the psychiatric literature (Kavanaugh & Volkan, 1978; Lothstein, 1980, 1984; J. K. Meyer, 1982; Volkan & Berent, 1976). For instance, J. K. Meyer (1982) theorized that transgender and gender-diverse identities shared common features with the diagnosis of BPD,

such as identity disturbance, engagement in impulsive behavior, and emotion-regulation difficulties. This theorizing was largely based on his and colleagues' clinical observations from the 1970s to 1980s. Transgender men have even been described as a separate subgroup within the BPD diagnosis (Murray, 1985). More recent evidence suggests that the psychiatric profiles of transgender and gender-diverse individuals are more similar to that of healthy control subjects than that of cisgender individuals diagnosed with a personality disorder (Haraldsen & Dahl, 2000).

Taken together, previous research documents associations between various minority stress processes that SGM individuals face and BPD symptoms, making it possible that SGM individuals are more inclined to demonstrate mental-health challenges congruent with the diagnosis of BPD. On the other hand—and perhaps more specific to transgender and gender-diverse individuals—historical equating of gender-diverse identity with the diagnosis of BPD could also result in a predilection to diagnose BPD among SGM individuals that is not explained by presenting symptoms (i.e., provider bias).

## Previous Studies of BPD Diagnostic Bias Among SGM Samples

Four previous studies have attempted to disentangle bias in the diagnosis of BPD among SGM populations. Results from two studies examining patterns of BPD diagnosis in actual clinical data suggest that providers are more inclined to diagnose BPD among SGM patients regardless of maladaptive personality that purportedly underlies the BPD diagnosis. Rodriguez-Seijas and colleagues (2021a; Rodriguez, Morgan, & Zimmerman, 2023) found elevated prevalence of BPD diagnosis among SGM patients compared with heterosexual patients; the observed disparity was not explained completely by group differences in maladaptive personality traits that underlie the diagnosis of BPD. It is noteworthy that—unlike the case for SGM patients—any observed differences in BPD diagnosis among ethnoracial minority groups in the same sample of psychiatric patients were explained by group differences in maladaptive personality traits (Becker et al., 2022). When considered in light of previous evidence suggesting that sexual-minority individuals are more likely to endorse behaviors congruent with all nine BPD diagnostic criteria, the inability to control diagnostic presentation in these two studies limits the conclusions that diagnostic differences were due to clinician bias versus differences in clinical presentations.

Only two studies to date have examined bias in the diagnosis of BPD for SGM populations by experimentally controlling for clinical presentation to equivocal ends (Assaad & Samuel, 2022; Eubanks-Carter & Goldfried, 2006). Whereas Eubanks-Carter and Goldfried (2006) found that clinicians more frequently diagnosed BPD among vignettes reflecting a gay/bisexual man, Assaad and Samuel (2022) found no significant differences in BPD diagnosis based on sexual-minority status. However, the nature of the vignettes used in these studies differed substantially. Eubanks-Carter and Goldfried used a vignette that reflected typical behaviors and experiences that are common among both sexual-minority and BPD populations, including efforts to avoid abandonment, unstable and intense relationships, unstable self-image, impulsivity, suicidality, affective instability, feelings of emptiness, and difficulty controlling anger; however, that vignette was not designed as a definitional depiction of BPD. In comparison, Assaad and Samuel adapted a standard vignette from the Wiggins (2003) text, *Paradigms of Personality Assessment*, that has been rated as between just under or just over threshold for the diagnosis of BPD (Samuel & Widiger, 2006). Thus, Assaad and Samuel used a vignette that appears more congruent with a personality-disorder diagnosis, whereas Eubanks-Carter and Goldfried described a case that was created as a depiction of common psychosocial experiences sexual-minority individuals might face. In addition, both studies of diagnostic bias exclusively focused on cisgender patients or vignettes. Given the historical equating of transgender identity and gender diversity with the diagnosis of BPD, it is important to expand such research to include transgender and gender-diverse samples.

## The Current Study

The goal of the current study was to examine BPD diagnostic bias based on SGM status using a sufficiently powered vignette-based experimental design, expanding the previous research done by Eubanks-Carter and Goldfried (2006). That is, we purposefully created a clinical vignette that illustrates several clinical domains that could be expected among SGM individuals presenting for psychiatric treatment and that map onto our aforementioned theoretical connections between SGM minority stress processes and the BPD diagnostic domains. Thus, the current study is not an examination of the accuracy of clinical providers' adjudication of the BPD diagnosis as a function of SGM status in a situation in which the BPD diagnosis is certainly warranted. Instead, we were interested in understanding whether health-care providers presented with identical clinical information that reasonably describes clinical domains related to the impact of minority stress processes that might be common to SGM individuals and to the BPD

diagnosis as described above would be more inclined to view that information through a lens consistent with the BPD diagnosis as a function of the SGM identity of the individual in the clinical case being described. If so, we would consider that indicative of bias. However, if we found no differences based on SGM status, then it would suggest that it might not be SGM identity per se related to elevated prevalence of BPD diagnosis but instead that that confluence of behavioral presentations and potential differences in those presentations as a function of SGM status drive the observed prevalence disparities rather than bias as we operationalize it here. Using a large, diverse sample of mental-health-care providers who were randomly assigned to one of three clinical-vignette conditions (i.e., cisgender heterosexual man, cisgender gay man, heterosexual transgender woman), our primary goal was to compare the proportion of individuals who believed that the diagnosis of BPD was appropriate across the three vignette conditions. Given that all vignettes depicted identical case presentations, any differences in the prevalence of diagnosed BPD would be considered a function of the SGM status depicted in the vignette: clinician bias.

## Transparency and Openness

### *Preregistration*

We preregistered our hypotheses and initial analytic plan, which can be reviewed at https://aspredicted.org/je47r.pdf. Following preregistration, however, we received additional funding that allowed us to expand the study. With the additional funding, we expanded data collection to include licensed master's-level mental-health counselors and clinical social workers. We reconducted a power analysis using a 3 (SGM Status) × 4 (Professional Status: PhD/PsyD-level clinical/counseling psychologists, MD-level psychiatric residents or attendings, clinical-psychology trainee, and master's-level mental-health counselor/master's- or doctoral-level clinical social worker) factorial design with 80% power to detect a medium effect size ($F$ = 0.25) for the main effects of interest, which suggested a minimum sample size of 225; our final sample comprised 426 participants. We used a medium effect size for power calculations based on the Eubanks-Carter and Goldfried (2006) design.

### *Data, materials, code*

For code for all analyses and a copy of the preregistration document, see https://osf.io/z2vbj/?view_only=3b083e0a2d5f445192c829607279b986.

## Method

### *Participants*

Participants ($N$ = 466) were practicing mental-health professionals in the United States and Canada recruited between November 2021 and September 2022. Practicing professionals for the purpose of this study included psychiatrists (with an MD, DO, or equivalent degree [e.g., MBBS]), clinical and counseling psychologists (with a doctoral-level degree or a terminal master's degree), and clinical social workers (with an MSW, DSW, or PhD). Students enrolled in clinical-psychology doctoral-training programs who were in their fourth year of training or beyond were also eligible to participate in the study. Additional criteria included a license to practice—this was not required of clinical-psychology graduate students—and the status of currently providing mental-health treatment to clients.

To uphold the fidelity of the sample, a preliminary screener survey was disseminated that inquired about potential participants' licensure. License numbers were verified against official records before participants were invited to complete the study. Participants ($n$ = 22) were excluded if they failed two or more (over 50%) of the four attention-check questions. This deviated from our original preregistered exclusion criterion if participants failed three or more (75%) attention-check questions because we felt that this more conservative exclusion criterion was better for ensuring validity of the data. Finally, participants ($n$ = 18) were omitted from analyses if they completed only the demographic questions or if they took fewer than 5 min to complete the survey. The analytic sample, therefore, consisted of 426 participants. All participants were compensated $10 for their time. For demographic information about the analytic sample, see Table 1. This study was approved by the University of Michigan Institutional Review Board.

### *Measures*

***Clinical vignettes.*** Three clinical vignettes—each describing a fictional, treatment-naive patient (Jesse) who presented for an intake—were developed based on a modified version of the vignette used by Eubanks-Carter and Goldfried (2006). The vignette was specifically designed to reflect commonly experienced forms of psychosocial dysfunction among young-adult SGM populations, including history of identity concealment (Camacho et al., 2020; Pachankis et al., 2020), social isolation (Garcia et al., 2020), rejection sensitivity (Cohen et al., 2016; Feinstein, 2020), heavy alcohol use (Hughes et al., 2016), and suicidal thoughts and past behavior (de Lange

**Table 1.** Demographic Information About the Sample of Mental-Health Practitioners, *n* (%)

| | Doctoral-level clinical/counseling psychologists | Psychiatry attendings/ residents | Clinical-psychology trainees | Mental-health counselors/clinical social workers |
|---|---|---|---|---|
| *N* | 86 (20.2) | 74 (17.4) | 108 (25.4) | 158 (37.1) |
| Age, *M* (*SD*) | 40.84 (12.90) | 39.88 (12.71) | 29.51 (3.91) | 37.59 (11.21) |
| Gender | | | | |
| Man | 28 (32.6) | 31 (41.9) | 13 (12.0) | 69 (43.7) |
| Woman | 58 (67.4) | 42 (56.8) | 92 (85.2) | 86 (54.4) |
| Nonbinary/gender fluid | 0 | 0 | 3 (2.8) | 2 (1.3) |
| Not listed | 0 | 1 (1.4) | 0 | 1 (0.6) |
| Race/ethnicity | | | | |
| White | 78 (90.7) | 49 (66.2) | 91 (84.3) | 104 (65.8) |
| Black or African American | 2 (2.3) | 3 (4.1) | 7 (6.5) | 45 (28.5) |
| Hispanic | 0 | 9 (12.2) | 8 (7.4) | 11 (7.0) |
| American Indian or Alaska Native | 0 | 1 (1.4) | 1 (0.9) | 1 (0.6) |
| Asian | 6 (7.0) | 14 (18.9) | 11 (10.2) | 6 (3.8) |
| Middle Eastern or North African | 1 (1.2) | 1 (1.4) | 1 (0.9) | 0 |
| Not listed | 0 | 3 (4.1) | 1 (0.9) | 1 (0.6) |
| Relationship status | | | | |
| In a relationship: living together | 71 (82.6) | 53 (71.6) | 51 (47.2) | 93 (58.9) |
| In a relationship: living separately | 4 (4.7) | 11 (14.9) | 30 (27.8) | 22 (13.9) |
| Widowed | 0 | 0 | 0 | 5 (3.2) |
| Separated | 0 | 0 | 0 | 3 (1.9) |
| Divorced | 4 (4.7) | 5 (6.8) | 2 (1.9) | 3 (1.9) |
| Single/not in a relationship | 8 (9.3) | 7 (9.5) | 25 (23.1) | 31 (19.6) |
| Not listed | 4 (4.7) | 4 (5.4) | 8 (7.4) | 3 (1.9) |
| Sexual orientation | | | | |
| Straight or heterosexual | 66 (76.7) | 63 (85.1) | 76 (70.4) | 133 (84.2) |
| Gay or lesbian | 10 (11.6) | 7 (9.5) | 1 (0.9) | 12 (7.6) |
| Bisexual | 7 (8.1) | 3 (4.1) | 25 (23.1) | 9 (5.7) |
| Not listed | 3 (3.5) | 1 (1.4) | 6 (5.6) | 4 (2.5) |
| Therapeutic orientation | | | | |
| Psychodynamic | 10 (11.6) | 38 (51.4) | 15 (13.9) | 70 (44.3) |
| Feminist | 9 (10.5) | 4 (5.4) | 10 (9.3) | 26 (16.5) |
| Cognitive-behavioral therapy | 71 (82.6) | 59 (79.7) | 79 (73.1) | 108 (68.4) |
| Interpersonal | 13 (15.1) | 18 (24.3) | 20 (18.5) | 73 (46.2) |
| Not listed | 18 (20.9) | 2 (2.7) | 37 (34.3) | 25 (15.8) |
| Vignette condition | | | | |
| Cisgender heterosexual man | 29 (33.7) | 24 (32.4) | 35 (32.4) | 56 (35.4) |
| Cisgender gay man | 29 (33.7) | 26 (35.1) | 39 (36.1) | 49 (31.0) |
| Transgender woman | 28 (32.6) | 24 (32.4) | 34 (31.5) | 53 (33.5) |
| BPD diagnosis | | | | |
| Primary diagnosis | 17 (19.8) | 23 (31.1) | 27 (25.0) | 54 (34.2) |
| Combined diagnosis | 21 (24.4) | 31 (41.9) | 29 (26.9) | 87 (55.1) |
| BPD diagnosis agreement | | | | |
| Strongly disagree | 22 (25.6) | 8 (10.8) | 21 (19.4) | 20 (12.7) |
| Disagree | 29 (33.7) | 15 (20.3) | 28 (25.9) | 24 (15.2) |
| Agree | 18 (20.9) | 29 (39.2) | 34 (31.5) | 44 (27.8) |
| Strongly agree | 14 (16.3). | 17 (19.8) | 14 (13.0) | 66 (41.8) |

Note: BPD = borderline personality disorder.

et al., 2022). The vignettes differed only in the gender identity, pronouns, and sexual orientation of the patient and the gender of their romantic partners, resulting in the three distinct vignette conditions: a heterosexual cisgender man, a gay cisgender man, and a heterosexual transgender woman, hereafter referred to as the "transgender

condition" (see Appendix). These specific vignette conditions were chosen for practicality. The inclusion of several other vignette conditions reflecting sexual-minority women, transgender men, and nonbinary individuals would have necessitated a sample size that we would not have been able to support for the interested comparisons between respondents' professional group statuses.

***Psychiatric-disorder diagnosis.*** Participants selected a primary and any comorbid psychiatric disorder(s) that they believed were appropriate for Jesse from a list of 14 psychiatric diagnoses—major depressive disorder, social anxiety disorder, generalized anxiety disorder, dysthymia, posttraumatic stress disorder, adjustment disorder, obsessive compulsive disorder, alcohol use disorder, BPD, antisocial personality disorder, avoidant personality disorder, dependent personality disorder, histrionic personality disorder, and obsessive compulsive personality disorder.

***BPD.***

*BPD diagnostic criteria.* Participants were also asked to rate their agreement on a 4-point Likert scale (*strongly disagree*, *disagree*, *agree*, *strongly agree*) with the extent to which Jesse met the diagnostic threshold for each of the nine BPD diagnostic criteria. Agreement about BPD diagnostic criteria was always asked after participants had selected primary and comorbid diagnoses to avoid affecting their diagnostic decisions.

*BPD diagnosis agreement.* Participants were also asked to rate their agreement on a 4-point Likert scale (*strongly disagree*, *disagree*, *agree*, *strongly agree*) with the statement that Jesse should be diagnosed with BPD. Agreement about BPD diagnosis was asked after participants selected primary and comorbid diagnoses and following agreement with BPD diagnostic criteria to avoid affecting participants' responses.

## *Analytic design*

***Preregistered analyses.*** All analyses were conducted using IBM SPSS (Version 28). Using logistic regressions, we regressed the binary outcome of BPD diagnosis for primary and combined (i.e., if BPD was diagnosed as either primary or comorbid diagnosis) on vignette condition for Hypothesis 1.1. Logistic regressions of the binary BPD outcome with simple effects coding using PhD-level clinical/counseling psychologists as the reference group were conducted to examine differences in BPD diagnosis based on professional status (i.e., comparing clinical-psychology trainees, psychiatry attendings and residents, and mental-health counselors and clinical social workers) and vignette condition for Hypotheses 1.2 to 4. We did not initially preregister analyses including mental-health counselors and clinical social workers.

We used linear regression with simple effects coding using doctoral-level clinical and counseling psychologists as the reference group to examine group differences in agreement with the BPD diagnosis based on professional status and vignette condition (Hypothesis 5.1).

***Additional exploratory analyses.*** Three one-way analyses of variance (ANOVAs) comparing agreement with the nine BPD diagnostic criteria between participants in (a) the cisgender-heterosexual and the combined SGM vignette conditions, (b) the cisgender-heterosexual and the cisgender-gay-man vignette conditions, and (c) the cisgender-heterosexual and the transgender vignette conditions were performed. Any significant findings were unpacked using all pairwise comparisons. We also did not preregister examination of interaction effects in the diagnosis of BPD. Thus, we included them as exploratory analyses in the Results section.

In addition, given the sizeable proportion of participants who reported SGM identity in the current sample, we also repeated the major analyses examining BPD diagnosis and diagnostic agreement using only the subsample of participants who reported cisgender-heterosexual identities (i.e., individuals whose reported sex assigned at birth was congruent with their current gender identity and who reported heterosexual orientation) as a sensitivity analysis ($n$ = 336). Finally, although we have focused primarily on the potential predilection to diagnose BPD based on the vignette condition, these data might also provide some information about the extent to which BPD was under- or overdiagnosed among participants. As an exploratory analysis, we calculated the number of participants in each condition and professional grouping who agreed with (selection of either agree or strongly agree with the diagnostic criterion) five or more of the BPD diagnostic criteria—corresponding with the diagnostic threshold necessary for the provision of the BPD diagnosis—and compared this with the frequency that participants actually selected the BPD diagnosis as either primary or comorbid in each condition. A lower frequency of assignment of the BPD global diagnosis as primary or comorbid than the frequency of assigning five or more BPD diagnostic criteria would suggest a problem of underdiagnosis of BPD. The converse would suggest a problem of overdiagnosis of BPD.

# Results

## *Prevalence of psychiatric-disorder diagnoses*

Approximately 39.4% ($n$ = 168) of the sample selected BPD as either primary or comorbid diagnosis. The most common primary diagnoses selected by participants

were major depressive disorder (29.8%, $n = 127$), BPD (28.4%, $n = 121$), and adjustment disorder (19.7%, $n = 84$). The most common comorbid diagnoses selected were alcohol use disorder (22.1%, $n = 94$), generalized anxiety disorder (21.4%, $n = 91$), none (18.3%, $n = 78$), BPD (16.7%, $n = 71$), and major depressive disorder (16.2%, $n = 69$).

## Primary BPD diagnosis

***Main effect of primary BPD diagnosis by vignette.*** Participants that received the SGM vignettes selected BPD as the primary diagnosis significantly more frequently than participants that received the cisgender-heterosexual vignette (odds ratio [*OR*] = 1.64, $p = .04$). However, this result was driven by the significantly higher frequency of BPD diagnosis among participants in the transgender condition ($OR = 1.99$, $p = .01$) compared with participants in the cisgender-heterosexual condition. Participants in the cisgender-gay-man condition did not differ in the diagnosis of BPD from participants in the cisgender-heterosexual-man condition ($OR = 1.34$, $p = .29$; see Table 2).

***Main effect of primary BPD diagnosis by professional status.*** Mental-health counselors and social workers selected BPD as the primary diagnosis significantly more than the reference group, doctoral-level clinical and counseling psychologists ($OR = 2.13$, $p = .02$). There were no other significant differences in primary diagnosis by professional status (see Table 2).

***Interaction effect of BPD diagnosis by professional status and vignette condition.*** No significant interaction effects on primary diagnosis were observed. Because there were no interaction effects, we presented results from models excluding the interaction above because they are not conditional on interaction effects. Thus, our preregistered hypotheses (Hypotheses 2–4) of differences in BPD diagnosis based on vignette condition and professional status were not supported.

## Combined (primary and comorbid) BPD diagnosis

***Main effect of combined BPD diagnosis by vignette.*** When considering primary and/or comorbid diagnosis together, there were no significant vignette group differences in the diagnosis of BPD. That is, although significantly more participants in the transgender condition selected BPD as the primary diagnosis, there was no significant difference in the frequency of BPD diagnosed as either primary or comorbid among participants (see Table 2).

***Main effect of combined BPD diagnosis by professional status.*** Logistic regression with simple effects coding revealed that mental-health counselors and social workers selected BPD as the combined diagnosis more frequently than the reference group, doctoral-level clinical and counseling psychologists ($OR = 3.80$, $p < .001$). Likewise, psychiatry residents and attendings also selected BPD more frequently than doctoral-level clinical and counseling psychologists ($OR = 2.23$, $p = .02$; see Table 2).

***Interaction effect of combined BPD diagnosis by professional status and vignette condition.*** Logistic regressions revealed no significant interactive effects of vignette group and professional status on the combined diagnosis of BPD. Because there were no interaction effects, we presented results from models excluding the interaction above because they are not conditional on interaction effects. Thus, our preregistered hypotheses (Hypotheses 2–4) of differences in BPD diagnosis based on vignette condition and professional status were not supported.

## Agreement with the diagnosis of BPD

***BPD agreement by vignette condition.*** Preregistered *t* tests revealed that participants assigned the cisgender-heterosexual vignette ($M = 1.53$, $SD = 1.07$) reported significantly lower agreement with the diagnosis of BPD compared with participants in the combined SGM vignette groups ($M = 1.76$, $SD = 1.048$), $t(401) = -2.017$, $p = .04$. This finding was driven by participants in the transgender vignette condition reporting significantly more agreement with the BPD diagnosis ($M = 1.89$, $SD = 1.01$) than participants in the cisgender-heterosexual condition, $t(266) = -2.801$, $p = .005$. There were no significant differences in agreement with the BPD diagnosis between participants in the cisgender-gay-man ($M = 1.63$, $SD = 1.08$) and heterosexual conditions, $t(266) = -0.730$, $p = .47$. We also performed an exploratory linear regression between vignette condition and BPD agreement, and results again pointed to significantly elevated BPD agreement among participants assigned the transgender vignette relative to participants assigned the cisgender-heterosexual vignette (see Table 3).

***BPD agreement by professional status.*** Relative to doctoral-level clinical/counseling psychologists, both psychiatric residents and attendings and mental-health counselors and clinical social workers exhibited significantly greater agreement with the diagnosis of BPD (see Table 3).

**Table 2.** Results From Regression Analyses Examining Effects of Vignette Condition and Professional Status on the Diagnosis of BPD in the Current Study

| | Complete sample of respondents ($N = 426$) | | | | | Cisgender-heterosexual respondents only ($n = 336$) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Predictor | β | Odds ratio | 95% CI for odds ratio | | *p* | β | Odds ratio | 95% CI for odds ratio | | *p* |
| Principal BPD diagnosis | | | | | | | | | | |
| Vignette condition | | | | | | | | | | |
| Cisgender-gay vignette | 0.293 | 1.34 | 0.78 | 2.31 | .29 | 0.313 | 1.37 | 0.75 | 2.50 | .309 |
| Transgender-heterosexual vignette | 0.689 | 1.99 | 1.17 | 3.38 | .011 | 0.505 | 1.66 | 0.92 | 2.96 | .093 |
| Professional status | | | | | | | | | | |
| Clinical-psychology trainees | 0.308 | 1.36 | 0.68 | 2.72 | .383 | 0.405 | 1.50 | 0.66 | 3.39 | .332 |
| Psychiatry attendings/residents | 0.611 | 1.84 | 0.89 | 3.82 | .101 | 0.663 | 1.94 | 0.85 | 4.45 | .117 |
| Mental-health counselors/clinical social workers | 0.758 | 2.13 | 1.14 | 4.00 | .018 | 0.891 | 2.44 | 1.50 | 5.03 | .016 |
| Combined BPD diagnosis | | | | | | | | | | |
| Vignette condition | | | | | | | | | | |
| Cisgender-gay vignette | 0.093 | 1.10 | 0.69 | 1.80 | .713 | 0.063 | 1.07 | 0.61 | 1.86 | .824 |
| Transgender-heterosexual vignette | 0.229 | 1.26 | 0.77 | 2.06 | .366 | 0.066 | 1.07 | 0.61 | 1.86 | .815 |
| Professional status | | | | | | | | | | |
| Clinical-psychology trainees | 0.128 | 1.14 | 0.59 | 2.18 | .699 | 0.091 | 1.10 | 0.51 | 2.35 | .815 |
| Psychiatry attendings/residents | 0.803 | 2.23 | 1.14 | 4.39 | .02 | 0.702 | 2.02 | 0.95 | 4.31 | .069 |
| Mental-health counselors/clinical social workers | 1.336 | 3.80 | 2.12 | 6.82 | <.001 | 1.393 | 4.03 | 2.08 | 7.80 | < .001 |

Note: Cisgender-heterosexual-man vignette used as vignette-condition reference category. PhD/PsyD-level clinical/counseling psychologists used as the professional-status reference category. BPD = borderline personality disorder; CI = confidence interval.

**Table 3.** Results From Regression Analyses Examining Effects of Vignette Condition and Professional Status on Participant Agreement With the Borderline-Personality-Disorder Diagnosis in the Current Study

| | Complete sample of respondents ($N$ = 403) | | Cisgender-heterosexual respondents only ($n$ = 320) | |
|---|---|---|---|---|
| Predictor | β | $p$ | β | $p$ |
| Vignette condition | | | | |
| Cisgender-gay vignette | 0.049 | .376 | 0.058 | .354 |
| Transgender-heterosexual vignette | 0.158 | .004 | 0.117 | .061 |
| Professional status | | | | |
| Clinical-psychology trainees | 0.055 | .369 | 0.032 | .650 |
| Psychiatry attendings/residents | 0.180 | .002 | 0.126 | .063 |
| Mental-health counselors/clinical social workers | 0.332 | < .001 | 0.324 | < .001 |

Note: Cisgender-heterosexual-man vignette used as vignette-condition reference category. PhD/PsyD-level clinical/counseling psychologists used as the professional-status reference category.

***BPD agreement by vignette and professional status.*** No significant interactive effects of vignette group and professional status on the agreement with the BPD diagnosis were observed. Because there were no interaction effects, we presented results from models excluding the interaction above because they are not conditional on interaction effects.

## *BPD diagnostic criterion agreement*

Across three one-way ANOVAs measuring the effect of vignette assignment on BPD criteria agreement, no significant differences were found. Specifically, we observed a nonsignificant difference in criterion agreement between participants in the cisgender-heterosexual condition and participants in the combined (a) SGM vignette condition, (b) cisgender-man condition, or (c) the transgender condition. For agreement ratings for the nine BPD diagnostic criteria, see Table S1 in the Supplemental Material available online.

## *Sensitivity analysis: restricting sample of cisgender-heterosexual participants*

Eighty-nine participants reported SGM identities. We reexamined the effects of vignette condition and professional status on the primary and combined BPD diagnosis outcomes ($n$ = 336; Table 2) and on participant agreement with the BPD diagnosis ($n$ = 320; Table 3) using the subsamples of participants who reported cisgender and heterosexual identities. Using this subsample resulted in no differences in primary BPD diagnosis based on vignette condition. That is, respondents in the transgender vignette condition did not select BPD as primary diagnosis significantly more frequently ($OR$ = 1.66, $p$ = .09), nor did they report greater agreement (β = 0.12, $p$ = .06) with the BPD diagnosis than participants in the cisgender-heterosexual condition. However, the main effects for mental-health counselors and clinical social workers persisted ($OR$ = 2.44, $p$ = .02). Likewise, the main effect of elevated selection of BPD as either the primary or comorbid diagnosis persisted for mental counselors and clinical social workers ($OR$ = 4.03, $p$ < .001) but was attenuated for psychiatry residents/attendings ($OR$ = 2.02, $p$ = .07; see Table 2). Likewise, psychiatry attendings/residents and mental-health counselors and clinical social workers demonstrated greater agreement with the BPD diagnosis than clinical/counseling psychologists.

## *Underdiagnosis versus overdiagnosis of BPD*

For frequencies of participants who agreed with five or more BPD diagnostic criteria and assigned BPD as either primary or comorbid diagnosis, see Table 4. Broadly, these results demonstrate that among all vignette conditions and professional statuses, the proportion of participants who selected BPD as either primary or comorbid diagnosis was much lower than the proportion of participants who agreed with five or more of the BPD diagnostic criteria. However, these differed based on the vignette condition and the professional status of participants. Clinical and counseling psychologists demonstrated a predilection to underdiagnose BPD as both primary and primary/comorbid diagnosis in the transgender condition relative to their agreement with the presented patient meeting five or more BPD diagnostic criteria. On the other hand, clinical-psychology trainees and psychiatry residents and attendings

**Table 4.** Proportions of Respondents Who Endorsed Sufficient Diagnostic Criteria to Meet Threshold for the Diagnosis of BPD Compared With the Frequencies That Respondents Selected the BPD Diagnosis

| Vignette condition | | Clinical/ counseling psychologists | Clinical-psychology trainees | Psychiatry attendings/ residents | Mental-health counselors and social workers |
|---|---|---|---|---|---|
| Complete sample of respondents ($N = 426$) | | | | | |
| *n* participants endorsed ≥ 5 BPD diagnostic criteria (%) | Cisgender heterosexual man | 21 (75.0) | 24 (77.0) | 14 (66.7) | 49 (92.5) |
| | Cisgender gay man | 19 (70.4) | 25 (71.4) | 20 (80.0) | 43 (89.6) |
| | Transgender heterosexual woman | 16 (57.1) | 25 (80.6) | 20 (87.0) | 48 (90.6) |
| *n* participants selected BPD as primary diagnosis (%) | Cisgender heterosexual man | 5 (17.2) | 10* (28.6) | 7 (29.2) | 10 (17.9) |
| | Cisgender gay man | 4 (13.8) | 8 (20.5) | 8 (30.8) | 19 (38.8) |
| | Transgender heterosexual woman | 8** (27.6) | 9 (26.5) | 8 (33.3) | 25 (47.3) |
| *n* participants selected BPD as principal or comorbid diagnosis (%) | Cisgender heterosexual man | 6 (20.7) | 10* (28.6) | 9* (37.5) | 29* (51.8) |
| | Cisgender gay man | 6 (20.7) | 10* (25.6) | 11* (42.3) | 28 (57.1) |
| | Transgender heterosexual woman | 9** (32.1) | 9 (26.5) | 11 (45.8) | 30 (56.6) |
| Cisgender-heterosexual respondents ($n = 336$) | | | | | |
| *n* participants endorsed ≥ 5 BPD diagnostic criteria (%) | Cisgender heterosexual man | 16 (76.2) | 20 (83.3) | 13 (65.0) | 39 (92.9) |
| | Cisgender gay man | 14 (73.7) | 17 (65.4) | 14 (73.7) | 37 (92.5) |
| | Transgender heterosexual woman | 12 (54.5) | 15 (75.0) | 17 (89.5) | 43 (89.6) |
| *n* participants selected BPD as primary diagnosis (%) | Cisgender heterosexual man | 3 (13.6) | 9 (33.3) | 7 (30.4) | 8 (18.6) |
| | Cisgender gay man | 4 (19.0) | 5 (18.5) | 6 (30.0) | 17 (41.5) |
| | Transgender heterosexual woman | 5 (22.7) | 5 (22.7) | 6 (30.0) | 22 (45.8) |
| *n* participants selected BPD as principal or comorbid diagnosis (%) | Cisgender heterosexual man | 4 (18.2) | 9 (33.3) | 9* (39.1) | 23* (53.5) |
| | Cisgender gay man | 6 (28.6) | 6* (22.2) | 7* (35.0) | 25 (70.0) |
| | Transgender heterosexual woman | 6 (27.3) | 5 (22.7) | 9 (45.0) | 27 (56.3) |

Note: Significance levels for chi-square proportional difference comparisons of proportion of respondents who selected BPD and primary or primary/comorbid compared with the proportion of respondents who agreed with five or more BPD diagnostic criteria. Comparisons are made to participants' own professional status and vignette condition (e.g., comparing the proportion of clinical/counseling psychologists who were presented with the cisgender-heterosexual vignette who endorse five or more BPD criteria with the proportion of those same clinical/counseling psychologists who selected BPD as a primary diagnosis). BPD = borderline personality disorder.
*$p < .05$. **$p < .01$.

demonstrated a predilection to underdiagnose BPD as primary/comorbid in the cisgender-heterosexual and gay conditions; mental-health counselors and clinical social workers demonstrated underdiagnosis of BPD as primary/comorbid only in the cisgender-heterosexual condition. A similar pattern of findings occurred when the sample was restricted to participants reporting cisgender-heterosexual identity.

Together, then, these results suggest that although psychologists seem more hesitant to select BPD when presented with a transgender patient relative to their agreement that the described patient meets the criterion threshold for the BPD diagnosis, trainees and psychiatrists are more inclined to do the opposite. When presented with a patient who is cisgender—be it a cisgender heterosexual or gay man—they seem more hesitant to select BPD as a diagnosis even if they report that the patient meets the criterion threshold; they do not demonstrate this apparent hesitation when the patient is transgender. On the other hand, mental-health counselors

and social workers evidence the opposite effect: They appear more hesitant to select BPD as a diagnosis even if they believe that diagnostic threshold is met only when the patient described is cisgender and heterosexual.

## Discussion

Using a vignette-based experimental design, we investigated differences in BPD diagnosis based on the sexual orientation and gender identity of the depicted clinical case in a large, diverse sample of practicing mental-health practitioners in the United States and Canada. Respondents provided with SGM vignettes more frequently selected BPD as the primary diagnosis. However, this effect was exclusively driven by (a) a specific bias to diagnose BPD among respondents in the transgender condition and (b) a predilection to diagnose BPD among psychiatrists, mental-health counselors, and clinical social workers. In addition, there were no observed differences in participants' agreement with the nine BPD diagnostic criteria as a function of their professional status or the vignette condition to which they were assigned. That is, observed differences in the diagnosis of BPD were not reflective of differences at the criterion level, which one could reasonably expect to be associated with the elevated BPD diagnosis. Finally, although psychologists showed some evidence of a predilection to underdiagnose BPD in the transgender condition, trainees and psychiatrists demonstrated some evidence of a tendency to underdiagnose BPD in the cisgender conditions; mental-health counselors and clinical social workers demonstrated a predilection to underdiagnose BPD in the cisgender-heterosexual condition exclusively.

These results suggest bias in the diagnosis of BPD among transgender and gender-diverse patients relative to cisgender-heterosexual and sexual-minority patients. Note that when analyses were restricted to only participants who reported cisgender-heterosexual identity, the only main effect that remained significant was the elevated diagnosis of BPD by mental-health counselors and clinical social workers. However, the patterns of underdiagnosis based on vignette condition and professional status remained consistent. These results bear important implications for future research aimed at understanding BPD among SGM populations and mental-health training most broadly.

### *Directions for BPD research on SGM populations*

Our findings qualify past research on the topic of BPD diagnostic bias. Rodriguez-Seijas and colleagues (2021a; Rodriguez-Seijas, Morgan, & Zimmerman, 2023) found that even after controlling for one measure of maladaptive personality that underlies the BPD diagnosis, mental-health-care providers more frequently diagnosed BPD among SGM patients. However, without criterion-level information in that study, it is entirely possible that SGM patients presented with different constellations of symptoms than heterosexuals; group differences in clinical presentations might have been responsible for the observed differences rather than clinician bias per se. Indeed, there are 256 different possible constellations of BPD criteria that can lead to the same BPD diagnosis (Hallquist & Pilkonis, 2012; Krueger & Eaton, 2010; Rodriguez-Seijas et al., 2015). These results would suggest that when patients present with identical clinical profiles, transgender women and patients seen by psychiatrists, mental-health counselors, and clinical social workers—regardless of sexual orientation or gender identity—are more likely to be given a BPD diagnosis or to have BPD viewed as the principal presenting concern. There were no differences among respondents in the endorsement of specific BPD diagnostic criteria that explained differences in the assignment of BPD based on vignette exposure. However, the potential reasons for this difference seem complex. Whereas diagnostic discrepancies among clinical and counseling psychologists seem to point to hesitancy to diagnose BPD in the transgender condition, psychiatrists, mental-health counselors, and clinical social workers demonstrate seeming hesitance to provide a BPD diagnosis if the presenting client is cisgender; when it comes to a transgender patient, however, their diagnosis of BPD better matches their agreement with the criterion threshold of five or more diagnostic criteria being met.

Note that we created the vignettes to reflect difficulties commonly experienced among SGM populations. Sexual-minority individuals are more inclined to endorse all nine BPD criteria compared with heterosexuals even if they are not associated with clinical distress/impairment (Rodriguez-Seijas et al., 2021b), data from SGM community samples show higher endorsement of six of the nine BPD criteria (Denning et al., 2022), and endorsement of BPD symptoms among sexual-minority individuals is positively associated with minority stressors such as discrimination (Chang et al., 2021). Furthermore, scholars have outlined how the constructs of BPD and other personality disorders bear similarities to the effects of stigma on the lives of SGM individuals (Goldhammer et al., 2019; Rodriguez-Seijas, Rogers, & Asadi, 2023). Given that there seems to be conceptual overlap between the theory of (borderline) personality disorder and experiences common to SGM populations, there are several potential future directions for understanding and unpacking the findings of elevated prevalence of BPD among SGM samples.

Although these results suggest bias might be an issue specific to providers when interacting with transgender populations, there might be other associations between various contextual and minority stress processes relevant to SGM populations and the BPD diagnosis. Future research might explore associations between minority stress processes and BPD diagnostic criteria and related domains. In addition, future scholarship might investigate how behavioral indicators that are commonly used to adjudicate the BPD diagnosis might differentially reflect underlying BPD criteria and how these associations might also differ among various SGM subpopulations, possibly in relation to different types of stigma experiences that differ within SGM populations themselves. For example, results from one recent study showed little associations between one sexual-risk behavior (i.e., use of alcohol and other drugs during sex) and transdiagnostic dimensions commonly associated with the BPD criterion of impulsivity among sexual-minority men (Rodriguez-Seijas, Rogers, et al., 2024). Even when considering dimensional models of personality pathology, emerging evidence suggests that there might be endorsement differences based on SGM status with specific impact on the measurement of domains associated with the BPD diagnosis (Asadi et al., 2024).

## *Implications for clinical training*

We hypothesized that psychiatrists would diagnose BPD more frequently than clinical/counseling psychologists. We were surprised to find that master's-level mental-health counselors and master's- and doctoral-level clinical social workers consistently diagnosed BPD at higher frequencies than respondents from other disciplines. This finding is noteworthy because mental-health counselors and clinical social workers comprise the majority of the mental-health workforce in the United States (Ellis et al., 2009; HRSA Health Workforce, n.d.; Polinsky et al., 2022; Weissman et al., 2006). Employment data from 2014 suggest social workers comprise 44% of the mental-health workforce, followed by mental-health counselors at 41%, compared with 10% for psychologists and 1.6% for psychiatrists (Polinsky et al., 2022). Furthermore, projections of the mental-health-care workforce into 2030 expect declines in the adult psychiatrist population by 20% compared with expected growth of the psychologist, mental-health-counselor, and social-worker populations of 13%, 17%, and 114%, respectively (HRSA Health Workforce, n.d.).

It is unclear the extent to which social-work training emphasizes competence in psychiatric diagnosis and assessment. According to one report, there are no state-level requirements for specific coursework across social-work programs (Polinsky et al., 2022). Indeed, in our examination of the course requirements for the five top-ranked master's of social work programs in the United States—according to the 2022 *U.S. News and World Report*—based on their program websites, four of the five programs appear to have at least one course in their curriculum devoted to the topic of assessment. However, these courses appear to vary considerably. In the top-ranked program at the University of Michigan, there are eight specific pathways of specialization during training. However, none of the required courses in each pathway requires training in psychiatric assessment. There is an applied assessment course that students may take. However, based on perusal of the course syllabus at this time, this course appears more focused on assessment screening without specific emphasis on any psychiatric diagnosis per se. This is not meant as carte blanche criticism of social-work training. Indeed, all eight pathways involve required course curricula devoted to topics of social justice, diversity, and oppression, which are topics that are not typically mandated or areas of focus in clinical-psychology training (Rodriguez-Seijas, McClendon, et al., 2024). Likewise, terminal master's-degree programs are shorter than doctoral programs with potentially less focus on assessment, less clinical supervision, and less exposure to more severe mental-health challenges—of which BPD is often described. In contrast, clinical-psychology graduate programs often include required courses on psychiatric assessment and differential diagnosis by virtue of accreditation standards set by such bodies as the American Psychological Association and the Psychological Clinical Science Accreditation System.

In contrast to mental-health counselors and social workers, wherein BPD was diagnosed more frequently as both primary diagnosis and generally, we found that psychiatrists in this study did not identify BPD as a primary diagnosis more frequently than clinical/counseling psychologists. However, they did identify BPD more frequently as a fitting diagnosis in general (i.e., when examining the combination of selecting BPD as primary and comorbid diagnosis) across vignette conditions than psychologists. Although conjecture on our part at this time, it is possible that relative differences in training between psychologists and psychiatrists might provide additional insight into this finding. For instance, greater adherence to a more medical model of BPD, assuming that signs and symptoms of BPD represent some specific disease process etiologically and qualitatively distinct from other psychosocial health conditions (Shah & Mountain, 2007), might be more common in psychiatrist than psychologist training and might explain this observed cross-discipline discrepancy.

Likewise, there might also be differences in the relative training in each discipline about the impact of

environmental context and stigma SGM individuals face and its concomitant impact on psychosocial health with ramifications for BPD diagnosis. For instance, the guidelines for psychological practice with SGM individuals from the American Psychological Association (2012, 2015) are large documents—each more than 30 pages in length—that include substantial focus on principles of understanding how environmental context and the associated stigma compromise psychosocial health of SGM individuals, including review of a host of relevant literature. In contrast, the guidelines produced by the American Psychiatric Association (Cabaj, n.d.) span only four pages with mention of the impact of stigma but substantially less attention devoted to explaining how stigma compromises SGM population health. It is possible that training models between psychiatry and psychology in addition to individual differences in competence working with SGM clients might affect clinicians' BPD ratings. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) does stipulate that a personality disorder should be distinguished from normative behavior expected within an individual's culture (p. 629) and in response to specific stressors experienced by the individual (p. 630). Thus, the relative difference in focus on understanding the detrimental impact of minority stress in each discipline's training might be associated with these differences. These could be fruitful avenues for future inquiry, particularly because our discrepancies across any groups exist only at the diagnostic level and not with respect to any specific diagnostic criterion.

On the basis of our results wherein mental-health-care providers are more inclined to assign a BPD diagnosis in the transgender vignette condition at the diagnostic level rather than in relation to any specific BPD diagnostic criterion itself, we believe that additional assessment training on the importance of focusing on meeting diagnostic criteria in making a diagnosis of BPD, and any psychiatric disorder, can be an intervention to counteract such bias. Indeed, this finding aligns with previous scholarship demonstrating discrepancy between providers' global diagnoses compared with criterion-based diagnoses (Morey & Benson, 2016; Morey & Ochoa, 1989). In addition, and specific to our finding of elevated BPD diagnosis among mental-health counselors, social workers and—to a lesser degree—psychiatrists increased diagnostic training in differential diagnosis and the importance of ensuring that evidence of specific diagnostic criteria is used in adjudicating any specific diagnostic presentation might also be beneficial for reducing observed diagnostic inequities because of clinician bias. Furthermore, reinforcing the use of explicit criteria consistently across groups might ameliorate some of the observed diagnostic disparities that appear to emanate from different places among different professional populations (i.e., discrepancy because of underdiagnosis of BPD for transgender clients among clinical/counseling psychologists vs. discrepancies because of underdiagnosis of BPD for cisgender patients among psychiatrists, mental-health counselors, and clinical social workers). What is missing from the current study is an understanding of the factors that might differentially affect respondents' decisions about the relevance of the BPD diagnosis and how these might relate to professional status and training type. Future research might examine how clinicians justify decisions about the diagnosis of BPD to better understand different factors affecting diagnostic decision-making.

## *Implications for BPD treatment*

It is arguable that an elevation in BPD diagnosis among SGM individuals might be beneficial in that it might more quickly route individuals experiencing distress for more intense psychosocial interventions, such as dialectical-behavior therapy (DBT). However, emerging evidence suggests that sexual-minority individuals might not benefit from DBT as much as heterosexual patients (Oshin et al., 2023). Although not always specific to BPD treatment, information from SGM respondents highlights the perceived utility of adopting a minority-stress-framed lens when conducting psychotherapy among SGM individuals (Iacono et al., 2022; Scheer et al., 2023; Tilley et al., 2022). Indeed, understanding the detrimental impact of minority stress processes on the lives of SGM individuals is a common principle in all SGM-affirming interventions (e.g., Burton et al., 2019; Pantalone et al., 2019; Rodriguez-Seijas et al., 2019; Rogers et al., 2022). It is unclear the extent to which this might be achieved in standard BPD treatment. In the most recent text from the American Psychological Association on personality disorders (Huprich, 2022), for instance, with several chapters relevant to BPD conceptualization and treatment, there is not any consideration of SGM populations. Thus, apart from an issue of diagnostic justice, it appears premature to assume that elevated BPD diagnosis among SGM individuals will result in a net positive by virtue of routing them for more intense psychosocial intervention when standard approaches to the conceptualization and treatment of BPD might not typically include sufficient SGM competence to ensure appropriate effectiveness.

## *Limitations*

This study is not without limitations. First, all vignettes used in this study depicted patients who were assigned

male at birth. Future study might manipulate sex assigned at birth. We did not create an exhaustive number of clinical vignettes representing all possible SGM identities because of practical concerns about ability to recruit a sufficiently large sample size to permit comparisons at the level of professional status. Previous research showed that BPD is diagnosed equally among transgender men and women patients regardless of sex assigned at birth (Rodriguez-Seijas, Morgan, & Zimmerman, 2023). Two epidemiological studies suggested no difference in the lifetime prevalence of BPD among cisgender women compared with men (B. F. Grant et al., 2008; Lenzenweger et al., 2007). However, greater proportions of women are represented among BPD clinical samples, suggesting that women are more likely to seek therapy than men. Nonetheless, it would be premature to assume that the bias observed in this study represents a broad bias to diagnose BPD among women. The literature on gender differences in BPD has exclusively pertained to cisgender women. Future research is tasked with examining whether similar bias occurs when clinicians are presented with vignettes/patients who are transgender men and who possess other gender-diverse identities. Second, we did not assess participants' experience of formal training in factors related to SGM psychosocial health or familiarity with things such as the American Psychological Association's guidelines for working with SGM persons (American Psychological Association, 2012, 2015).

Third, although we had a large, diverse sample of mental-health professionals, it may still be considered a convenience sample, and so there might be limitations in generalizability. Fourth, we did not collect data from respondents about how long they have been practicing, which might moderate the effect observed. Fifth, as noted before, the clinical vignette was designed to represent experiences that might be common among SGM populations who present for psychiatric treatment and that might conceivably overlap with the BPD diagnosis rather than designed to specifically reflect a prototypical BPD case. Thus, the current study is not one of diagnostic accuracy but, rather, one of whether clinical providers demonstrate a predilection to provide a BPD diagnosis when faced with a potential SGM patient versus when faced with a non-SGM patient presenting with identical clinical concerns. Sixth, given the nature of our vignette, it is possible that providers questioned the sexual orientation of the individual described in the heterosexual vignette. However, we did not assess participants' perceptions of the sexual orientation or gender identity of the individual described in the vignette.

Finally, we designed the current study to examine main effects of vignette condition and professional status. We included exploratory investigation of potential interaction effects. However, these effects might have been underpowered, limiting the conclusions that might be drawn from them. We also examined the results among respondents who reported cisgender-heterosexual identities. When we did this, some of the initial findings were no longer significant. We are cautious to interpret this change in the significance of results too much because gender identity and sexual orientation of respondents was not a manipulated variable. In our sensitivity analyses, the restriction in sample size to cisgender-heterosexual respondents differentially affected various professional-status groupings. Although there was only a 15% reduction in the sample size of psychiatry residents and attendings and a 16.5% reduction for mental-health counselors and social workers when this restriction was applied, there was a reduction of 25% among clinical and counseling psychologists (i.e., the reference group). So, although endorsement frequencies might also have been affected by the identities that respondents held, it might also be the relative reductions that differed among various respondent groupings that were responsible for changes in our initial results.

## Conclusion

Are mental-health practitioners biased to diagnose BPD among SGM persons compared with cisgender-heterosexual persons? Our results from a vignette-based experiment using a large, diverse sample of mental-health practitioners across the United States and Canada suggest that yes, they might be, but understanding bias is complex. A predilection to ascribe BPD was evident only when providers were presented with a transgender-woman patient vignette. In addition, psychiatrists, mental-health counselors, and clinical social workers were more inclined to diagnose BPD than clinical and counseling psychologists. However, the reasons for this appeared to differ across groups. Whereas psychologists underdiagnosed BPD in the transgender condition, psychiatrists, mental-health counselors, and clinical social workers seemed more inclined to underdiagnose BPD in the cisgender conditions relative to their agreement that the patient in the described vignette met diagnostic threshold. These results bear important implications for future research to understand the overlap between SGM minority stress processes, their deleterious effects, and the conceptualization and diagnosis of BPD among SGM—and particularly transgender and gender-diverse—populations. These results also directly highlight the need for increased training in BPD and other more severe forms of psychopathology, bias among individuals within the mental-health-service-provision profession, and the importance of ensuring diagnostic criteria are met in adjudicating any psychiatric-disorder diagnosis.

## Appendix

### *Clinical Vignette*

Key:

Blue = cisgender-gay vignette

Pink = transgender vignette

Jesse is a 23-year-old, straight (heterosexual) [gay (homosexual)], cisgender (he/him) [transgender (they/them)] non-Hispanic White man [person] with a college degree who works full-time as a team supervisor in a local grocery store. He shares [they share] an apartment with a friend whom he has [they have] known since high school. At the beginning of the intake interview, Jesse appeared anxious and apprehensive. He [they] gave very short replies to the interviewer's questions initially and fidgeted in his [their] seat. As the interview progressed, however, he [they] relaxed and spoke more freely. Jesse has never been in therapy before and said that he was [they were] raised to believe that people should handle their own problems. But he [they] decided to seek treatment because he feels [they feel] depressed and confused about many recent changes in his life: "I feel like I don't know who I am anymore. I don't like the person I'm becoming. It's hard to cope right now." Jesse reported seeking therapy now due to distress and interpersonal difficulties following the ending of his [their] last romantic relationship.

Jesse said that he [they] had a very sheltered childhood in a small, rural town in Ohio. His [their] parents were devout Christians, and Jesse always felt like he [they] had to hide aspects of his [their] life from them. He [They] reported that his [their] parents would reprimand him [them] for being an "emotional" child and crying when he was [they were] upset. Jesse went on very few dates in high school; he [they] said that he [they] stayed busy with studying, extracurricular activities at school, and youth group activities at his [their] church. He [They] never had a "real" romantic relationship until he was [they were] in college. "I was wound pretty tight in high school," he [they] said, "and when I got to college, everything broke loose." Jesse also reported feeling like he [they] never quite fit in with any peer groups in college and high school: "I tried being a lot of things . . . goth, band geek, theater kid . . . but nothing quite fit." During college, Jesse had two tumultuous relationships with women [men / men]. Jesse said that the first relationship began hastily, following a drunken sexual encounter ("we hooked up") that was coordinated via a dating app. Jesse said that it was the first time he [they] had ever been in love ("I just loved her [him / him] so strongly"), and he was [they were] devastated when the relationship ended 2 months later. He [They] said that he [they] "went crazy" and had a series of brief sexual encounters ("one-night stands") to "take his [their] mind off it." Jesse's next relationship began approximately 4 months later and lasted for 1 month. Jesse said that he [they] felt "infatuated." He has [They have] felt lonely since the breakup 1 month ago and keeps [keep] trying to think of ways to salvage the relationship. "I feel embarrassed that I couldn't make it work. Everyone else is in happy relationships. Mine just seem to go crazy."

Jesse reported the following experiences since the breakup. He [They] said that he feels [they feel] very depressed and has [have] had a few "bad nights" when he [they] hoped that he [they] would not wake up the next morning. Jesse reported trying to end his [their] life once in the past. When he was [they were] 15 years old, he [they] "downed a bunch of pills," after which he [they] fell asleep. He [They] never told anyone about this experience before today. He [They] reported having thoughts about taking sleeping pills twice in the past week. He [They] denied any desire or intent to end his [their] life at the time of the intake. Jesse reported drinking heavily at parties on weekends in the past month ("I get blackout drunk"). He [They] described that drinking helped reduce anxiety about interacting with women [men / men] and made sex easier ("I can get out of my head and loosen up"). Jesse also reported being irritable within the past "month or two." His [Their] roommate plans to move out when their lease ends, and Jesse is worried it is because the roommate doesn't like him [them] anymore. Jesse reported that he [they] lost his [their] temper and yelled at a customer who was being rude and demanding at work. He [They] reported being very anxious about being fired since the event happened 3 weeks ago. When the interviewer asked Jesse if he [they] had talked to anyone about his [their] difficulties, he [they] looked pained and shook his [their] head. He [They] said that he [they] wanted to call his [their] parents but did not want to spoil their image of him [them] as their "strait-laced, Sunday School-attending son [child]." He [They] said that his [their] mother would be "crushed" and his [their] father would be "pissed" if they knew about his [their] lifestyle: "They would not approve of the new Jesse." Jesse reported having three close friends currently. Jesse reported "feeling embarrassed" to talk about his [their] current difficulties: "I feel like I shouldn't be this upset about a breakup and they'd think it's weird."

**Transparency**

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**Skylar Hawthorne:** Methodology; Project administration; Writing – original draft; Writing – review & editing

*Declaration of Conflicting Interests*

The author(s) declared that there were no conflicts of interest with respect to the authorship or the publication of this article.

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This article has received the badge for Preregistration. More information about the Open Practices badges can be found at http://www.psychologicalscience.org/publications/badges.

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## Supplemental Material

Additional supporting information can be found at http://journals.sagepub.com/doi/suppl/10.1177/21677026241267954

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