Chapter #6

POSITIVE AND NEGATIVE ASPECTS OF THE BORDERLINE PERSONALITY LABEL FOR TRANSGENDER YOUTH

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ABSTRACT
Transgender youth experience societal stigma, rejection, and other psycho-social stressors associated with the crisis of their gender identity. Due to these struggles, the youth can present with suicidality, mood swings, fear of abandonment, and identity disturbances – main features that are similar to borderline personality disorder (BPD) and its traits. We interviewed four transgender youths who were labelled as potentially borderline or were diagnosed with the disorder. The data was analyzed using a thematic qualitative research method resulting in several important themes. One theme across participants was anger at the mislabeling which slowed the investigation into their transgender concerns and affirmation journey. Another emergent theme was the BPD label can be helpful at times to externalize the symptoms for these youth. All participants acknowledged that the symptoms that match with BPD subsided with gender-affirming treatment and social transition. Findings can inform clinicians about the potential symptom overlap and raise awareness about both the extreme harm and some good that the label of BPD carries for transgender youth.

Keywords: borderline personality disorder, transgender experiences, misdiagnoses, mislabeling.

1. INTRODUCTION

A small body of recent research indicates that there is a higher prevalence of borderline personality disorder among trans, gender diverse and sexual-preference minorities (Goldhammer, Crall, & Keuroghlian, 2019; Rodriguez-Seijas, Morgan, & Zimmerman, 2020). Extant literature suggests that types of mental illness and stress, like post-traumatic stress disorder, can also present as BPD when referencing the symptomology found in the DSM-5 (Mizock, Harrison, & Russinova, 2014). It follows that the high prevalence of BPD traits among trans populations is concerning. Indeed, trans youth experience psychosocial stressors and minority stress that can inspire strong reactions, sensitivity, fear of abandonment, and identity confusion, among other BPD traits from the DSM-5 (Puckett, Cleary, Rossman, Mustanski, & Newcomb, 2018). Given that trans youth are often flagged from hospital visits, we wanted to learn about youth's experiences with clinicians regarding the presentation of BPD.

The clinical assessment and treatment of gender-variant children and youth can prove complex, due to their developmental stage, and is further complicated by minority pressures (Meyer, 2003). Many trans youth are struggling with mood swings, suicidality, and

irritability when trying to cope with internalized transphobia, social stigma, marginalization, and feeling that their experienced gender does not match their expressed gender (Bockting et al., 2020). Due to the complexity, the nuances of the lived experience of trans youth should be explored to appreciate how they feel about their BPD-like traits or diagnosis. To our knowledge, there no studies to date that qualitatively address the clinical needs, perspectives, and experiences of gender variant-youth with an active or contested diagnosis or the suspected traits of BPD. To offer effective clinical services for the population, it is critical to appreciate insider perspectives and lived experience of the group. The present qualitative inquiry provides insight into trans youth's thoughts about BPD or BPD-like symptoms.

2. PARTICIPANTS AND METHODS

We hypothesized that trans youth would reject their label or diagnosis of BPD. In lieu of IRB-approval, a third-party licensed psychologist reviewed the research project and methods for ethical and legal compliance, and approved the proposed study. Four participants who identified as trans or gender variant were recruited from a community-based, private mental health clinic in the Lower Mainland of British Columbia, Canada. Each participant had either a diagnosis of borderline personality disorder currently, in the past, or were suspected of the disorder, and they were aware of these labels. Information about their relationship to BPD was accessed through medical records sent to the clinic. These records were primarily received from hospitals that treated the participants for suicidal behaviors. Informed consent was obtained from each participant and their legal guardian (if relevant) to take part in the study.

Table 1.
Participant Demographics.

Participant	**Age**	**Gender Identity**	**Diagnosis**
Participant 1	21	Transgender Female	Former Borderline Personality Disorder (contested)
Participant 2	17	Transgender Male	Borderline Personality Disorder
Participant 3	20	Transgender Male	Autism Spectrum Disorder, Borderline Personality Disorder (contested)
Participant 4	16	Transgender Male	Suspected Borderline Personality Disorder

This study was conducted in December, 2021 through March, 2022, using a qualitative semi-structured individual interview format. The prompt for the interview was, *how have things changed for you as a result of your gender affirmation journey?* The interviewer also asked about how they felt about their BPD label. All interviews were one hour in length, audio recorded (stored locally on the researcher's hard drive), transcribed, and analyzed by each of the authors for emergent themes using qualitative thematic analysis (Braun & Clarke, 2006). Ten subthemes emerged from the analysis (see results figure 1) with five broad themes that capture the participants words and the meaning of their experiences. The headings are included in the table below along with the participants' words to contextualize and give voice to the findings.

3. RESULTS

3.1. Testing True Positive for BPD can be Beneficial for the Youth

When the youth welcomed the diagnosis, it helped externalize their symptoms. Two of the participants welcomed the diagnosis because it felt like they and others validated them, and they were more receptive to treatment as a result. The participants that felt they truly related to the BPD diagnosis developed more self-understanding of the struggles that they experienced. Participant 2 discussed that, *"In the past (before the BPD diagnosis), I felt like a bad person and I didn't have the best personal relationship skills. But now I tell myself that [it] was the best that I could, so I can forgive myself. I can't say that what I did was right. But I can say I forgive what I did. And I just understand a lot of things [now]."* He went on to state, *"I reject the stigma, and things are improving for people with personality disorders."*

Those that accepted the BPD diagnosis found DBT helpful in conjunction with their gender affirmation journey (not in its absence). For those that have an accurate positive BPD diagnosis, they will be more accepting of the BPD treatment. Participant 4 said, *"I wasn't upset about it [the BPD diagnosis]…I actually felt like happy …because I finally felt like it made sense like, why I was feeling the way I was … for me…it was like finally it just seemed like everything just sort of made sense."* Participant 2 discussed how he does not feel stigmatized by the BPD label, and it is part of his identity now. He shared, *"I reject the stigma, and things are improving for people with personality disorders."* The participant further found social connections and formed friendship through BPD support groups and DBT-skills groups.

3.2. Testing False Positive for BPD can be Harmful for the Youth

When the youth rejected the diagnosis, they found it invalidating and stigmatizing. The practice of being assigned a diagnosis that does not fit with one's experience can be an invalidating, negative experience. Youth are less likely to work collaboratively with staff or other clinicians in the hospital given their negative experiences. Participant 1 stated, *"it felt like [the psychologist] was really trying to get me a diagnosis so that she could push me off onto someone else. Rather than actually addressing the reasons …like why I wanted to commit suicide and work out why I was feeling this way, and why I was feeling bad, and why unless something changed in my life I wasn't going to stop trying to do this."*

Participant 1 stated, *"psychologists and doctors were convinced that I just had a borderline-personality-disorder thing"* and they neglected her gender dysphoria as a result. Participant 3 stated, that he felt "*manipulated to believe that he was borderline"* and like his trans identity or *"what I was going through wasn't real."* The comments suggest that as

a result their gender dysphoria- their distress- was not treated or addressed, and instead the focus shifted to BPD. Ultimately, the distraction of BPD delayed access to the treatment that they needed.

Creates doubt in caregivers and parents about trans identity. Two of the participants in our sample noted that, at the time they received the BPD label (during early adolescence) it created doubt for the caregivers to provide affirmative support for the youth's gender identity. Participant 1 stated that "*the rest of the world can give you … hollow validation of who you are [referring to the BPD label and viewing her as cis gender] when the person that you see and experience and live as is not strictly speaking accurate. After my suicide attempt and hospital visit…they [parents] were very against the idea of me medically transitioning."* This resistance on the part of her parents during early adolescence when she came out to them contributed to much suffering for the participant.

3.3. Clinician Lack of Understanding of Trans Experience Affects Judgement and Timely Intervention

Minority stress of trans youth can overlap with other mental health issues – training is required to be helpful and discerning. Many trans youth can present with multiple issues, such as Autism Spectrum Disorder, trauma and post-traumatic stress disorder, and learning difficulties. Participant 3 explained that, *"it is a double-edged sword, especially in my clinical context because I'm autistic and I have a female phenotype…there's also past experience of trauma in both my childhood and adolescence. And considering the fact that I'm trans, it gives room for a lot of misinterpretation."* Professionals can be unappreciative of the complexity of their symptoms. The untrained clinician may overlook relevant details when a transgender youth presents in their office, clinic, or hospital. There are multiple factors at work and BPD may not accurately explain the situation despite their being some diagnostic overlap.

Participant 3's hospital psychologist diagnosed him with BPD rather quickly. He stated, *"considering the fact that I was diagnosed within two sessions of seeing the psychiatrist and then immediately…discharged by him…I should have noticed that was a red flag."* Participant 3 went on to state, *"I'm so exhausted and tired of having to deal with this, and I'm tired of having to advocate [for] myself and be an advocate for myself every single time."* When clinicians have a lack of training and experience in working with transgender youth, sometimes with good intentions, they may have a biased clinical approach with the potential of damaging future relationships the youth have with clinicians.

Delays in helpful treatment and intervention can lead to increased self-harm and suicidality. Participant 3's gender affirming treatment was delayed due to his unwelcomed BPD diagnosis until he was an adult. He stated, *"It was heartbreaking because, here I am struggling, and I'm still struggling now, because I've had a lot of problematic symptoms that weren't addressed properly, that weren't even understood correctly. And I have had to deal with this over the years."* Three youth in our sample expressed suicidal ideation at some point due to their symptoms of gender dysphoria being invalidated by professionals that focused on BPD rather than gender dysphoria. In fact, one participant expressed multiple attempts due to this.

Participant 1's treatment was delayed due to the BPD diagnosis since it was determined that her coping behavior symptoms should be addressed first. During this period, she was hospitalized three times for suicide attempts. She described how she felt at the time; *"I would rather just call it quits now cut my losses and get out…I'm not sure if I want to live with this suffering and then the lifelong suffering because of this [remaining in a body and gender that did not match her experience]."* Clinicians can be overly focused

on BPD or they fail to understand the gender dysphoria symptoms and these are both invalidating experiences. Further, professionals may neglect to understand that some of the BPD-like symptoms stem from gender distress and minority stress. Ultimately this can delay appropriate intervention.

3.4. Youth Feel Best when they are Treated Like the Expert in their Own Experience

Including youth in their assessment and asking them about whether a BPD label fit their experience is helpful. From the research, participants who were a false positive (who met BPD criteria yet did not feel it was a BPD-related issue), had expressed more distress due to the ensuing confusion. Participant 1 described how belittling it felt to be treated that they were not part of their diagnosis and psychological evaluation, "*I saw a doctor ..[at a local hospital] who I would describe as antagonistic …[and] she had a very set idea of what was up and anything that I said that conflicted with what she believed was really taken as further evidence that she was right and that I was wrong. It was that approach in medicine where it's 'I am the doctor and I know things and you are the patient and therefore stupid and don't know anything. So please listen, while I tell you what is wrong with you*.'"

Damage to the youth's faith in medical and mental health services when not listened to. The youth feel less positive about the experience and less trusting of hospital staff as a result of feeling mislabelled. They felt the narrative of their experiences is not fully understood with simply a BPD diagnosis. Further, participant 3 felt invalidated and like they did not matter when they were assigned a BPD diagnosis and were deemed unable to make decisions about their gender due to this. The youth expressed feeling not heard and undermined. He stated that clinicians would imply that, "*maybe you don't have the mental capacity to make decisions for yourself,"* rather than asking him about his experience.

3.5. Regardless of BPD Diagnoses, Gender Affirmation Treatment Improved BPD Traits and Symptoms

Treatments that affirm gender identity, such as medical intervention, alleviated BPD-like presentations in each of the participants. In being able to address their gender distress and help them be more gender congruent by accessing treatment for their affirmed gender reduced various BPD-like symptoms. Participant 1 stated, *"all of the external validation in the world is not going to help the trans kid who is dysphoric at the end of the day when they're alone at night."* The participant stated that socially transitioning was like *"a band aid over like a large wound across your chest. It doesn't do much and you need stitches and a band aid might make you feel a little better because someone's trying something but …it's not an adequate support really. There are some people that really need to medically transition because their dysphoria is rather severe."*

Youth that either rejected or accepted the BPD diagnosis felt gender affirmation treatment was a significant instrument of positive change for them. Medically transitioning, in Participant 1's case, was critical to alleviating her gender dysphoria: *"Most of the [BPD] traits that I was described with, they immediately stopped when I finally started the…HRT [hormone] treatment, a little too late [delayed due to suspected BPD], and also eventually getting my top surgery."*

Participant 4 appreciated the BPD label, and he also shared that, *"when I was dysphoric, it would be like the only thing on my mind like I would like…I could do things, but it would always ruin the things that could make me happy potentially. But it would always come back to that, even when I tried to ignore it, and it would just ruin everything pretty much. I can never feel good, because there is always the biggest problem of not feeling comfortable in my own body."*

Figure 1.
Organization of Themes.

Testing true positive for BPD can be beneficial for the youth	**Testing false positive for BPD can be harmful for the youth**	**Clinician lack of understanding of trans experience affects judgement and timely intervention**	**Youth feel best when they are treated like the expert in their own experience**	**Regardless of BPD or not, gender affirmation treatment improved BPD traits and symptoms**
When the youth welcomed the diagnosis, it helped externalize their symptoms.	When the youth rejected the diagnosis, they found it invalidating and stigmatizing.	Minority stress of trans youth can overlap with other mental health issues – training is required to be helpful and discerning.	Including youth in their assessment, and asking them about whether a BPD label fit their experience, was helpful.	Treatments that affirm gender identity, such as medical intervention and social transitions, alleviate BPD-like presentations in each of the participants
Those that accepted the BPD diagnosis found DBT helpful in conjunction with their gender affirmation journey (not in its absence)	Creates doubt in caregivers and parents about trans identity	Delays in helpful treatment and intervention can lead to increased self-harm and suicidality	Damages the youth's faith in medical and mental health services when not listened to.	Youth that either rejected or accepted the BPD diagnosis felt gender affirmation treatment was a significant instrument of positive change for them.

4. DISCUSSION

The voices of trans youth were prioritized in this study to allow for their experiences to dominate the findings and inform the implications of the research. The initial broad themes that false positives of BPD were harmful and true positive of BPD were helpful is an important finding, and was counter to our initial hypothesis. We expected that trans youth would uniformly reject the BPD label as a misdiagnosis of their gender stress symptoms. Two of the participants did not appreciate the BPD label and felt it was not an accurate representation of what they were experiencing. The other two participants felt it was validating because it provided context to describe their intense feelings. These very different perspectives highlight the need to carefully understand the trans youth's experience, involve them in their assessment, and ask them about how a BPD diagnosis resonates with them.

In line with the second broad theme, the youth each experienced clinicians who lacked awareness in trans issues. The biased treatment was harmful, and led to different issues, such as undermining their experience. Youth indicated that clinicians who lacked in cultural competency influenced how parents felt about their coming out. Perhaps this can also affect the attachment between the youth and their parents because the parents might adopt the position of the hospital opposed to siding with what the youth was explaining to parents. The importance of feeling believed by family is in line with ample research that indicates that supportive families foster healthy outcomes for the trans child (Simons, Schrager, Clark, Belzer, & Olson , 2013).

Since a BPD diagnosis can impact the provision of trans support services (Ashley, 2019), it is critical that clinicians be competent in trans issues. The youth were overwhelmed with relief when trans-competent clinicians expressed understanding of the kinds of struggles that they experienced and supported them. They also reported positive mental health improvements as a result of affirming care.

The third broad theme related to including the youth in their care and maintaining a person-centered approach. The participants made it clear that when they felt heard and included in their evaluations, or treated like the expert in their own experiences, they felt empowered, validated, and like the support was more appropriate. The treatment also appeared to help them have a positive working relationship with the clinician once the trust is developed. Thus, the youth are more likely to discuss other mental health challenges that they have once initial trust about their trans experience is established. The opposite was true when clinicians were less understanding of the transgender experience and their unconscious biases undermined the youth's presentation. Encounters like this can create long lasting distrust among transgender youth and other clinicians which may delay the youth in accessing timely interventions from the specialist.

Each of the participants found gender affirmation treatment to be the most helpful in alleviating their BPD or BPD-like symptoms. Thus, clinicians should not delay gender dysphoria intervention to first treat the BPD or BPD-like symptoms with trans youth. Having a detailed assessment that includes bio, psycho, social, and cultural dimensions (American Psychological Association, 2015) will help to understand the complexity and the added stressors that gender and sexual minorities experience, and will help the clinician understand the dynamics involved in the youth's experience before making *any* diagnosis.

4.1. Limitations

The study is limited in that there is a small sample size – even for qualitative standards (N=4) – and thus the experiences shared by the participants may not reflect the general population. Along similar lines, the youth were patients of one clinic, Diversity and Emotional Wellness Centre, and were selected to participate for having met the criteria of both BPD and trans identity. Further, youth that patronize the clinic have means to seek private psychological services, and while the centre does offer sliding scale rates to limit barriers, the participants are of a socio-economic level where they can afford these fees; again, limiting the generalizability. More research with larger sample sizes and perhaps those that include mixed methods or quantitative methods would enrich and add more meaning to these initial findings.

5. CONCLUSION

Trans youth indicated that they want to be included in their psychological evaluations. The participants felt strongly about whether BPD fit them as a label or not, and BPD diagnosis could be helpful if the youth felt that their symptoms matched that label. The BPD diagnosis was harmful if the youth felt that the label did not match their experience and instead their symptoms were mostly associated with their minority stressors and being gender dysphoric. Importantly, provision of gender affirming treatments supported all four of the youth in feeling more comfortable in their bodies, and led to a reduction of BPD or BPD-like symptoms. It is critical that these findings reach clinicians- particularly those working in hospitals that receive suicidal youth.

Further studies should expand these interviews, and perhaps include quantitative data to help substantiate and further provide evidence for these results and conclusions. Clinicians require training in distinguishing between BPD and transgender distress symptoms, and to learn about the complexity of transgender youth experiences and their significant minority stress. Clinicians must examine their biases based on gender binary systems and heterosexism when providing treatment for transgender youth. A thorough assessment should include a bio, psycho, social, and cultural perspective as well as incorporating different sources of information, such as family members or the perspective of other clinicians more experienced with the population. Most importantly, when youth are misdiagnosed with BPD, it can delay the gender dysphoria treatment, and can potentially damage the relationship between the youth, family, and their clinicians.

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