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Clinician Perspectives on Gender Bias in Diagnosis of Borderline Personality Disorder

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Walden University
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Abstract

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Dissertation Submitted in Partial Fulfillment

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Forensic Psychology

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Abstract

Healthcare systems across the globe strive to provide equal treatment for all patients irrespective of their status; nevertheless, disparities occur. Gender-based prejudices are present in many cultures and often affect clinicians' diagnostic and treatment practices. Borderline personality disorder (BPD) patients represent a category that is more prone to gender biases. With a focus on Canada, this study was designed to contribute to currently limited evidence on BPD gender biases by addressing the knowledge gaps in clinical gender-based studies. The study was an exploration of forensic psychologists' and psychiatrists' methodology leading to making a diagnosis of BPD and the factors that the practitioners consider in their examination. Social constructivism served as the conceptual framework. A case study research strategy was adopted with participants from Western Canada who specialized in treating mental-related disorders such as posttraumatic stress disorder, psychiatric conditions, personality disorders, and mood disorder. In the study, semi structured interviews were employed for data collection. Purposive sampling was used to recruit 10 participants. Findings indicated implicit gender bias existed in the diagnosis of BPD among practitioners in Western Canada. This study may contribute to social change by promoting a clinician-client relationship free of bias that could compromise the diagnosis and therapeutic outcomes for the patient.

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Chapter 1: Introduction to the Study

Introduction

According to researchers, bias exists and thrives within mental health settings, primarily among professionals who treat borderline personality disorder (BPD; Lawn & McMahon, 2015; Merced, 2015). Research shows that gender differences are potentially relevant with BPD patients because the variations guide mental health practitioners when assessing and treating the condition (Merced, 2015). However, exactly what influences the perceptions of and attitudes toward people with BPD is debatable (Bernstein et al., 2016).

In 1938, A. Stern sought a criterion for diagnosing a set of individuals he called the borderline group. From that point, BPD began receiving much attention. However, it first appeared as a formal psychiatric diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; American Psychiatric Association [APA], 1980). Researchers have previously supported the idea that medical professionals have continued their focus on the etiology of symptoms associated with BPD. While they have explored the efficiency of available treatments, they have not emphasized the effectiveness of the assessment process (Merced, 2015).

Background

For many years, gender-based preferences have impacted clients undergoing psychological treatment, especially women (Merced, 2015). Healthcare systems in developed countries strive to provide equal treatment for all patients irrespective of their gender or sex; nevertheless, disparities occur (Joint Commission, 2016). Even though

some of these biases are intentional, others are nondeliberate. Implicit bias describes an attitude that subconsciously influences a person's understanding, decisions, or actions. Such biases usually occur involuntarily, without purposeful control or awareness of the individual (Joint Commission, 2016). All members of society, including physicians and clinicians, are susceptible to this form of prejudice, which can influence a clinician's behavior toward a client (Chapman, Kaatz, & Carnes, 2013).

Not all categories of implicit bias have an impact on the relationship between practitioners and their clients or clinical outcomes (Chapman et al., 2013). However, some biases have the potential of perpetuating health care disparities and the stereotyping of clients and can have drastic effects on the outcome of patient care. Merced (2015) revealed that discriminations based on race, weight, gender, socioeconomic status, or other demographics increased the likelihood of nonadherence to medical advice among patients and client-physician mistrust. BPD patients who experienced stereotyping were more prone to depression, high blood pressure, and low self-esteem (Merced, 2015). Despite the negative impacts associated with stereotyping, it continues to occur in health care settings.

A common form of stereotyping is sex-role labeling. Gender-based prejudices are present in many cultures and usually affect clinicians' diagnostic and treatment practices. For example, researchers have suggested that practitioners set different standards for males and females experiencing mental problems (Etaugh, 2017). The result of these inconsistencies is that the evaluation of many cases occurs in a biased manner. Even though health care discrimination cuts across all sexes, evidence in the literature suggests

the female gender is the most affected category (Healthline, 2017). In comparison to males, females are most often diagnosed with BPD. Currently, the issue of gender discrimination and its effects on women remains a global concern (Verona, Sprague, & Javdani, 2012). Practitioners may be discriminating when they diagnose women predominantly with BPD (Verona et al., 2012).

Patients with BPD represent a category that is more prone to gender bias. A vast majority of this group display suicidal behavior and are likely to commit suicide (Lieber, 2017. Inmates and forensic clients have a higher likelihood of developing BPD symptoms than do the rest of the population (Ndjaba, 2013; Skodol & Bender, 2003). According to Correctional Service Canada, in 2012, 16% of prisoners from the Ontario, Atlantic, and Pacific regions of Canada had BPD (Correctional Service Canada, 2013). In addition to imprisonment, other risk factors include comorbid mood disorders, anxiety, and prolonged unemployment.

BPD patients have healthcare-related problems that are unique to the category. First, diagnosing the condition can be difficult due to its similarities to other mental health conditions such as bipolar disorder (Biskin & Paris, 2012). Additionally, according to Liebman and Burnette (2013), patients with BPD are more likely to experience adverse countertransference reactions. The researchers scrutinized countertransference by noting the age and gender of the patients, along with analyzing clinicians' clinical experience, training, expertise, and age. Participants anonymously completed an online survey responding to questions about persons with BPD symptoms based on real case information (Liebman & Burnette, 2013). One outcome of the study pointed to higher

accuracy in the diagnosis of female patients compared to their male counterparts. The practitioners' reactions were also different based on the clients and the level of clinician experience. The researchers also established there was a tendency for professionals to view adolescents as less trustworthy, less ill, and more dangerous. Further, clients who received treatment from professionals with advanced levels of medical experience had positive reactions (Liebman & Burnette, 2013).

Canadian health care patients, like others around the globe, continue to suffer discrimination resulting from a variety of socioeconomic factors such as employment status, education, income levels, nationality, and race. For instance, a report by the Health Council of Canada related frequent cases of stereotyping among Aboriginal Canadians, making them experience health care inequalities. This discrimination hinders the population from accessing quality care (Barnes & Snyder, 2012). The report further illustrated that the Aboriginal population feels unsafe due to racism and partiality in the country's health care system. However, this color-coded care is not the only form of discrimination in Canada.

Problem Statement

Clinical diagnosis based on the client's gender is a frequent occurrence, and the sex of the patient is a common determinant in the examination of BPD (Liebman & Burnette, 2013). Significant behavioral and biological differences exist between males and females. For instance, scientists have discovered substantial dissimilarities in the structure, chemistry, activity, and processing in the brains of men and women (Jantz, 2014). These researchers believe the variations determine the extent to which persons of

each gender respond to different situations (Jantz, 2014). The differences affect the epidemiology, pathophysiology, and manifestation of some diseases. Therefore, scholars have argued for gender-specific health care and the consideration of sex as a risk factor (Regitz-Zagrosek, 2012).

Sexual stereotyping has always been present in society, and it adversely affects women. For instance, data from the U.S. Bureau of Labor Statistics revealed that, until the 1970s, men dominated the field of psychology (Lippa et al., 2014). Although this study was not about clinical diagnosis, it reflected the inclination of society toward women (Lippa et al., 2014). Gender differences in diagnosis are not exclusive to clinical settings; they also occur in the field of forensic assessment. In addition to diagnoses, there are vital methodological differences in research between the sexes, and women have been disadvantaged (Dyer, 2016). For instance, Dyer (2016) reported that women often received diagnoses based upon their emotional state rather than their symptomology. Practitioners in the field of forensic psychology also suffer from gender bias in diagnosing clients (Sygel et al., 2017). Despite the success of previous forensic psychologists, more work is needed to ensure clients' gender or sexual orientation does not adversely affect the results of their psychological evaluation (Sygel et al., 2017).

Purpose of the Study

This study explored psychologists' methodology in making a diagnosis of BPD. In the study I evaluated the factors considered by practitioners in their examinations, as well as scrutinized psychologists' experiences treating patients with BPD and these subsequent impacts on clinical outcomes. The present investigation was needed to

explore gaps in clinical gender-based studies, as it also involved examining the value of the clinician's skills and training in the assessment of patients with BPD. Many remote communities in Canada cannot attract qualified forensic professionals. This shortage often leads to less skilled or inexperienced candidates filling complex positions. Mental illness is responsible for the collapse of many families in northern Canadian territories such as Yukon, Nunavut, and Labrador. Suicide, addiction to prescription drugs, sexual abuse, and depression are some of the psychological conditions affecting these populations. Aboriginals in these regions are often overrepresented in prisons and jails, creating a need for many forensic psychologists to assist in their treatment (Bowen, 2016).

Research Questions

The research questions focus on a few critical issues that helped in further exploring the broader issue of gender bias associated with diagnosing BPD and how gender bias might affect the process of diagnosing BPD.

RQ1: What are the processes used by psychologists/psychiatrists when diagnosing clients for possible BPD?

SQ1a: What information/observations might prompt the clinician to consider BPD?

SQ1b: What information/observations would move the clinician to rule it out?

SQ1c: What information/observations would lead the clinician towards a provisional or final diagnosis of BPD?

RQ2: How does the gender of the client factor into the process of diagnosing BPD?

SQ2a: How does the gender of the client factor into the process of diagnosing BPD?

SQ2b: Why does the gender of the client factor into the process of diagnosing BPD?

RQ3: How do the psychologist/psychiatrist's clinical experiences with clients influence their processes in diagnosing BPD?

Conceptual Framework

A conceptual framework is a tool for organizing ideas and making abstract distinctions in research. A useful theoretical model will make it easier for the researcher to understand, apply, and remember what was captured (Berman & Smyth, 2015). Several types of conceptual frameworks exist, including formal, practical, descriptive, and working hypotheses. Researchers often apply other aspects to solve research questions once the conceptual framework or paradigm has been determined.

These aspects include positivism, constructivism, and postmodernism, among others. Each is relevant to the selected research method and provides ways to gain knowledge of the research technique. As highlighted above, more women are diagnosed with BPD than are men (Clearview Women's Center, 2017). Nevertheless, the actual prevalence of BPD by gender in the general population is still unknown, and there exist controversies regarding current statistics (Clearview Women's Center, 2017; Meyers, 2013) These controversies are discussed further in Chapter 2.

The conceptual framework for this study was social constructivism. The model is a synthesis of multiple cognitive and behavioral theories that emphasize a collaborative approach to learning and state that social interactions are essential for the construction of knowledge (Amineh & Asl, 2015; Johansen, Tavakoli, Bjelland, & Lumley, 2017; McKinley, 2015). Underlying the social constructivist framework is the assumption that humans are social, and that knowledge and additional information are created through interpersonal interactions (Amineh & Asl, 2015; McKinley, 2015). The model postulates that learning environments provide multiple representations of reality. Social constructivism has many applications in the management of societal issues. In the domain of clinical settings, it can be useful in explaining the definition-making and social forces that determine the categorization of personality disorders (Dyer, 2016). I applied this framework to analyze the existing criteria for diagnosing patients with BPD.

In this study I employed a qualitative approach rather than a quantitative one. The quantitative technique was not useful for this study because it does not provide in-depth inquiry into individual clinicians' experiences. Additionally, quantitative research usually involves measuring or quantifying something. It encompasses gathering numerical data of much larger sample sizes, which can be transformed into generalizable statistics (O'Dwyer & Bernauer, 2013). The variables for the present study relate to the behavior of practitioners and could not be quantitatively defined or measured.

Qualitative methods allow the researcher to explore and explain the topic and answer the research questions (Creswell, 2013). A qualitative approach uncovered clinicians' attitudes toward patients with BPD to provide a better understanding of the

reasons, motivations, and opinions of health care practitioners during diagnosis. According to Creswell (2013), qualitative methods provide insight into the problem or help develop hypotheses or ideas for potential quantitative research. In this study I explored clinicians' thoughts and opinions and uncovered trends by studying the problem in depth. I used interviews to collect data that helped reveal those patterns. Creswell (2013) emphasized that observations and interviews are core techniques for collecting qualitative research data. However, the researcher must be flexible and respond appropriately to data changes. Accordingly, the qualitative approach was useful in understanding and exploring the research problem.

The phenomenological methodology was appropriate for the current study because it allowed for an in-depth exploration of the situation under investigation. I collected data using interviews that that emphasized the exploration of meanings (O'Dwyer & Bernauer, 2013). The interviews provided sufficient information for analyzing the phenomenon.

Definition of Terms

Borderline personality disorder (BPD): A personality disorder characterized by highly impulsive behaviors, extreme or inappropriate emotional reactions, intense mood swings, and a history of unsteady relationships.

Forensic client: A person who is not guilty on the grounds of mental illness and/or unfit for a judicial trial who has been transferred to a psychiatric facility from prison or is serving a limiting term after a special hearing (Aiyegbusi & Kelly 2012).

Gender bias: The unequal treatment and expectations of a person because of attitudes based on the sex of an individual or a group of people (Dyer, 2016).

Personality disorder: A pattern of behavior or feelings that cause many problems in an individual's life but appear appropriate to the person experiencing them (Lieber, 2017).

Sex-role stereotyping: A situation in which a clinician misjudges a client based on gender (Fingerhut, Abdou, Wheaton, Jackson, 2016).

Assumptions

The study used participants who had indicated in interviews that they witnessed or had been involved in some form of gender bias in their practice. The participants were anonymously interviewed, and I assumed that the participants would be honest in the interviews due to the anonymity of the research. I assumed the participants had interest in taking part in the research and did not have any hidden motives, such as benefiting from the results of the study directly or any monetary gain from their participation.

Study Scope and Delimitations

In this study I intended to examine gender biases from the perspectives of clinicians and experts. Therefore, patients were not included in the sample. The study was limited to practitioners in the field of personality disorders and forensic research.

Limitations

The use of the phenomenological approach places restrictions on the participants. A small group of participants may not provide a good understanding of gender bias. The questionnaires were designed to assess the respondent's perception of gender-based

biases in the diagnosis of BPD; however, participants may not provide sufficient evidence of the extent of prejudice in these settings. Further, the accuracy of the research outcome may be influenced by respondent biases.

Significance of the Research

In this study I explored psychologists' methodology that leads to making a diagnosis of BPD. Gender bias is a problem because it has unintended negative consequences for clients (Merced, 2015). Patients who are misdiagnosed can experience a worsening of their symptoms and psychological issues. Furthermore, misdiagnosed forensic patients may experience a delay in recovery and, in some cases, be denied early parole due to insufficient progress in recovery.

This research adds to the efforts to identify misdiagnosis situations by examining the possibility of gender discrimination in diagnosis and treatment. Merced (2015) discussed the disadvantages of gender-based diagnosis, noting that it leads to a lower rate of therapeutic effectiveness and a loss of status in the field of forensic psychology for the patient. In the present study, I explored ways of improving clinician's efficiency in the assessment of BPD.

Walden University emphasizes that knowledge should be used to enact positive social change (Weinstein, 2010). The outcomes of the present study may help clinicians become aware of their individual biases and the impacts of such prejudices on the diagnosis of mental illness. The research also contributes to the literature by identifying factors that lead to gender bias. Further, it supports the exploration of possible ways of

detecting and minimizing gender-based preferences during the diagnosis/assessment of BPD.

Structure

In this research I examined the perspectives of clinicians regarding BPD and clients and ways in which these views influence their procedures for making diagnoses. Chapter 2 provides a summary of the relevant literature and its implications on the research scope and direction. Following in Chapter 3 is a discussion of the research methods. Chapter 4 presents the main findings, and finally, Chapter 5 includes a discussion of the implications of the research outcomes.

Chapter 2: Literature Review

Introduction

The extent of gender-based prejudices in health care has been the subject of many studies. Existing literature reveals biases in research methods, clinical diagnoses, and delivery of care when dealing with BPD patients. There seem to be gaps in the authenticity of gender bias-related studies and causes of these discriminations. Most researchers propose implementing education programs to make clinicians aware of the need to understand the experiences of clients with BPD.

Search Description

The search for relevant literature involved using appropriate inquiry terms, such as *gender bias, stereotyping in a clinical setting, personality disorder, BPD,* and other applicable search criteria according to the objectives of the study. I authenticated the validity of data sources by comparing them with other sources on similar subjects and selected appropriate documents from these results.

Conceptual Framework

A conceptual framework is a tool for organizing ideas and making abstract distinctions in research (Berman & Smyth, 2015). A useful theoretical model makes it easier for the reader to understand, apply, and remember what was captured in a study (Berman & Smyth, 2015). Several types of conceptual frameworks exist, including formal, practical, descriptive, and working hypotheses.

Research methods often incorporate other aspects to solve research questions once the conceptual framework or paradigm has been determined. These include positivism, constructivism, and postmodernism, among others. Each is relevant to the selected research method and provides ways to gain knowledge of the technique. As highlighted previously, there are more women diagnosed with BPD than men (Clearview Women's Center, 2017). Nevertheless, the actual prevalence of BPD by gender in the general population is still unknown, and, as discussed further in Chapter 2, controversies in current statistics exist (Meyers, 2013; Clearview Women's Center, 2017). According to Limandri (2018), there is no specific drug to treat BPD; however, most medications used in combination with psychotherapy can make a difference for the patient.

This study incorporated the social constructivist conceptual framework. The model is a synthesis of multiple cognitive and behavioral theories that highlight the collaborative approach to learning and posits that social interactions are essential for the construction of knowledge (Amineh & Asl, 2015; Lumley Johansen, Bjelland, & Tavakoli, 2015; McKinley, 2015). It puts forth that humans are social, and that knowledge and additional information are created through interpersonal interactions (McKinley, 2015). Social constructivists focus on learning that occurs because of individuals interacting with others in their social group (Amineh & Asl, 2015; Joint Commission, 2016). The model postulates that learning environments provide multiple representations of reality.

Social constructivism has many applications in the management of societal issues. In the domain of clinical settings, it can be useful in explaining the definition-making and

social forces that determine the categorization of personality disorders (Dyer, 2016). I applied this framework to analyze the existing criteria for diagnosing patients with BPD.

Theoretical Framework

Labeling Theory

This study drew on the labeling theoretical perspective to gain deeper insights into gender bias and the marginalization influence of BPD diagnosis. As Walthall (2013) asserted, labeling theory suggests that deviant behavior is a product of social constructions and, as such, not rooted in a specific act. Not only does the theory empathize with the person labeled as "deviant," but it also focuses on those individuals who make such judgments, how they come to such conclusions, and the content within which the judgment is made. Drawing on a study by Henry and Cohen (1983), who sought to investigate the relationship between this theory and the increased number of BPD diagnoses in women, Walthall (2013) argued that stigmatization is not the consequence primarily of personality traits but of interactions and relationships. A stranger within a group of people acts in a way that is incongruent with societal norms and is thus perceived by the group as either being bad, weak, or dangerous. The stranger is thus reduced in the minds of the group from a whole and normal being to a discounted, tainted individual. These attributes, according to Walthall (2013), amount to stigma, particularly when coupled with an extensive discrediting effect. Walthall further described three stigmatization types, namely physical deformity, tribal stigma, and deviation in personal attributes. While deviation in personal attributes such as unemployment and addiction is perceived to result from a mental disorder, tribal stigma

includes religion, nationality, or race. Toward this direction, Walthall (2013) confirmed deviation in personal attributes as the type of stigmatization, which defines a personality disorder both linguistically and through description in the *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. (DSM-5; APA, 2013).

Review of Research Concepts

Gender Discrimination in Health Care

Gender-based prejudice in health care is unique. Unlike in other sectors where one gender has specific advantages over the other, discrimination in health settings can go either way. Both males and females face unfair expectations and stereotypes. Such biases can occur in training facilities, among workmates, toward patients, or between workers and their clients. One aspect of this discrimination is in medical diagnosis. For example, women are more likely to receive a psychosomatic diagnosis for physical illness than men are, even if they display similar symptoms. Additionally, owing to women's physiological differences, some physicians do not take females with unexplained ailments seriously (Healthline, 2017). Millner et al., 2019 reported that bias in the health care system often leads to a worsening of symptoms for the patients that can sometimes include suicide. As patients have difficulties accessing treatment from practitioners in the healthcare system, they can sometime resort to unwanted behaviors and self-harm to lessen the psychological pain that they experience (Millner, 2019).

Gender-based biases are particularly evident in forensic practice due to the uniqueness of the field. Clinicians must maneuver through complex procedures as they seek appropriate information while maintaining a positive attitude. They must also be

sensitive to possible biases that may jeopardize their efforts to provide comprehensive care to their clients. Individuals who experience gender bias have a higher likelihood of developing BPD compared to the rest of the population (Al-Dajani, Gralnick & Bagby, 2018). According to Allen, DeYoung, Bagby, Pollock, and Quilty, 2019, patients are also at risk of becoming alcohol dependent, developing anxiety, becoming prone to panic attacks, and experiencing other major depressive disorders due to gender bias and missed diagnosis. The worsening of symptoms can be causally related to biases in the health care systems and lead to further emotional trauma for the patient (Allen et al., 2019). According to Howner et al., 2020, forensic patients are often treated differently due to the severity of their diagnoses and the impending behaviors that follow if the patient isn't properly treated. Violent behaviors, substance abuse, sexual promiscuity, and worsening of symptoms are experienced by BPD patients if there are difficulties with their treatment. Howner et al.'s 2020 study revealed that women are often the victim of bias in the system and are often the ones who suffer the most in forensic psychiatry.

The Prevalence of Borderline Personality Disorder in Males and Females

Controversies exist regarding the frequency of BPD occurrence across different genders. Some researchers have suggested the condition is more prevalent in women than it is in men. They also purported that some symptoms are more evident in one gender than in the other. A higher overall symptomatology in females with BPD than in their male counterparts has been identified (Allen et al., 2019). For example, women demonstrated frequent relationship disruptions, depression, anxiety, or hostility. The males had higher rates of narcissistic and antisocial personality disorders. Proponents of

this view identified several factors that contribute to the supposed higher prevalence rates in women. For instance, some psychiatrists have associated hormonal or genetic factors, severe premenstrual tension, sexual abuse, separation or abandonment, or rejection with frequent occurrences of BPD (Clearview Women's Center, 2017; Silberschmidt et al., 2015).

However, other researchers have disputed these views and established an equal distribution of BPD patients among males and females (Meyers, 2013). Scholars have attributed the differences in research outcomes to clinician prejudices and sampling errors. Practitioners with gender leanings may provide biased reports regarding their clients. Even though several studies have established gender-based preconceptions among clinicians, this view is also a point of debate.

Regarding sampling, most prevalence studies occur in psychiatric settings. The findings from such environments may not reflect the actual picture. Additionally, most of the samples do not have equal proportions of males and females. For instance, Silberschmidt et al.'s (2014) sample was only 27% male. Whether the observed differences were accurate reflections of BPD prevalence or the result of sampling biases is yet to be established. Dyer (2016) asserted that until researchers develop efficient mechanisms for eliminating sampling biases, discrepancies will continue to occur in studies regarding gender biases among patients with BPD.

Nevertheless, the studies themselves are indications of gender biases. None of them justify the inclusion of fewer males than females in the samples. In addition to sampling- and clinician-related factors, cultural bearings and the influence of parenting

may also contribute to the disparities in the findings. Dyer (2016) identified another problem regarding existing studies. Even though researchers have been able to establish differences in prevalence rates of BPD across different genders, none of them have determined the extent to which they authenticate gender imbalances. Additionally, they have not been able to demonstrate whether these biases affect clinical outcomes. These gaps affect the quality of care patients with BPD receive. Shapiro, Wachtel, Bailey, and Espiritu (2018) conducted a study looking at socioeconomic status and bias in the healthcare system. According to Shapiro et al., patients with lower socioeconomic status experience bias in the system, whereas those with higher socioeconomic status experience less bias or none. Shapiro et al. revealed that women made up a larger percentage of patients with lower socioeconomic status and thus experienced implicit bias while seeking treatment for a variety of health concerns. The study further revealed that physicians who displayed biases based on socioeconomic status of the patient were less likely to refer that patient for further treatment such as counseling. The authors of the study suggested further studies should explore the relationship between biases in the health care system by physicians and the impact on vulnerable populations such as women and other groups with lower socioeconomic status (Shapiro et al., 2018).

Nonetheless, there have been concurrences in investigations examining the prevalence of BPD across different clinical settings. Researchers have suggested that psychiatric inpatients have the highest likelihood of developing BPD traits, while the lowest incidence rates occur among patients in urban primary care centers (Skodol,

2017). However, these investigations have not traced the root of these variations. There exists a need for a comprehensive evaluation of the causes of these differences.

Discriminatory Practices and Stereotyping of Borderline Personality Disorder Patients

Health professionals tend to develop stronger attitudes and less empathy toward patients diagnosed with BPD than they do toward individuals with other psychiatric conditions (Veysey, 2014). Veysey (2014) demonstrated that patients with histories of self-harm are particularly vulnerable to discriminatory practices from caregivers. Clinicians tend to ascribe negative labels such as attention seekers, poor historian, liars, or manipulators to clients with BPD. In a study on Australian hospitals, Lawn and McMahon (2015) confirmed these findings. They reported that patients with BPD, both in private and public health care centers, continued to encounter significant discrimination as they attempted to seek medical services.

It is worth noting that, like Lawn and McMahon (2015), Veysey (2014) attested to the discriminatory trends across genders. In using samples that were 88% female, Veysey (2014) acknowledged this limitation could have affected the accuracy of their findings. This observation confirms the argument that sampling biases affect the precision of BPD investigations. The discriminatory experiences contribute to negative self-esteem and a prolonged history of self-harm. Several factors, including the conduct of patients with BPD, low optimism for change, and limited resources to care for these individuals, contributed to this apathy. Lawn and McMahon (2015) identified inadequate community support as a leading contributor to BPD stereotyping.

Langer (2015) examined the legal, criminological, psychological, ideological, and narrative representations of BPD within the clinical and scholarly literature in the contexts of mental disorder, gender, and liability and identified worrying trends in the Canadian health care and legal systems. Langer established that medical professionals are culpable of revictimization and exploitation of therapeutic patients. He also identified an overrepresentation of the female forensic population in the diagnoses of BPD. It is worth noting this study validated BPD as a forensic category.

Knaak, Szeto, Fitch, Modgill, and Patten (2015) proposed that educational and improved use of social contact elements among clinicians who focus on BPD can help minimize these prejudices by improving caregivers' attitudes. However, Knaak et al., (2015) demonstrated that such an intervention was more effective in patients experiencing general mental problems than it was with BPD individuals. Their observation supports Lawn and McMahon's (2015) assertion that there exists a limited understating of the experiences of patients with BPD who seek medical care and treatment.

Gender Stigma within Borderline Personality Disorder Diagnosis

A growing body of literature confirms that preference both exists and blossoms within mental health environments among therapists charged with the responsibility of care for people who meet BPD criteria/standards, as stipulated in the *DSM-5* (APA, 2013) as well as the *DSM-IV-TR* (APA, 2000; Busch et al., 2016; Heightman, 2014; Ntshingila et al.,, 2016; Veysey, 2014; Walthall, 2013). Veysey argued the psychiatric diagnosis of BPD attracted significant stigma. Individuals diagnosed with this disorder

may be described as attention-seeking, manipulative, difficult, or even untreatable. (Quenneville et al., 2019) further explained that forensic patient diagnosed with BPD faces severe stigmatization due to their mental illness. In their study 244 participants were interviewed, 136 had attention deficit hyperactive disorder, 69 had bipolar disorder (BD) and 39 had BPD. Quenneville et al., (2019) study revealed that faced twice as much stigma as the other closest group, even though they made up a smaller sample of participant group. The participants showed biases and has stigma towards BPD patients which further compromise their ongoing treatment (Quenneville et al., 2019). Toward this direction, Walthall (2013) and Veysey (2014) pinpointed gender bias as one of the stigmas ascribed to a BPD diagnosis. Not only has the issue of gender bias concerning *DSM-5* (APA, 2013) personality disorder criteria been debated, but it has also been laden with controversies (Heightman, 2014; Walthall, 2013). This begs the question of whether the role of a client's gender in guiding the clinician's BPD diagnosis process.

Walthall (2013) identified a female-to-male ratio of 7:1 in patients diagnosed with BPD. He cited the *DSM-IV-TR* (APA, 2000), which stated that women form 75% of people diagnosed with BPD. This inconsistency, according to Walthall, informs theories posited by researchers probing why primarily women are diagnosed with BPD. This includes, but is not limited to, the following diagnostic criteria: women tend to display outwardly social characteristics, gender bias, and gender-linked risk factors. There is also a higher probability of sexual abuse against women, particularly in childhood (Walthall, 2013). There are many gender-related risks factors, including childhood temperament, genes, automatic nervous system arousal, environmental toxins, and perinatal factors in

childhood. Furthermore, Walthall cited Skodol and Bender (2005), who presented other biological factors and etiology that varied between females and males in the growth of BPD diagnostic attributes and features. This further demonstrates the absence of a clear etiology of BPD.

To this end, I have postulated that gender differences in individuals diagnosed with BPD play an influential role in guiding clinicians in both assessment and treatment (Busch et al., 2016). To date, various clinical features of BPD have been studied for gender differences (Banzhaf, et al., 2012; Busch et al., 2016). Although a substantially higher proportion of women than men are diagnosed with BPD, Edmondson, Brennan, and House (2016) argued that gender bias may not be present in BPD concerning specific self-harm behavior types, including self-cutting and psychological distress levels at clinical presentation, among others.

In another important study to this effort, Banzhaf et al. (2012) sought to examine gender similarities and differences on Axis I comorbidity and Axis II comorbidity, as well as in diagnostic criteria for clients with BPD. The researchers revealed considerable gender differences in BPD relating to personality characters, Axis I comorbidity, and Axis II comorbidity, as well as treatment utilization. Regarding personality traits, women with BPD are less likely to demonstrate higher novelty-seeking levels or explosive temperaments (Banzhaf et al., 2012). Regarding Axis I, while men with BPD are more likely to demonstrate disorders associated with substance use, women are more likely to exhibit mood swings, binge eating, posttraumatic stress disorder, and anxiety (Banzhaf et al., 2012; Edvinsson et al., 2013).

About Axis II, women with BPD are less likely to demonstrate antisocial personality disorder as compared to men (Anderson et al., 2018; Banzhaf et al., 2012). As to utilization of treatment, whereas men with BPD are more likely to record treatment accounts associated with substance abuse (Banzhaf et al., 2012), women with BPD are more likely to reveal posttreatment accounts coupled with psychotherapy and pharmacotherapy (Baltacioglu, et al., 2017; Gianoli et al., 2012; Ripoll, 2013). Consistent with the social constructivist conceptual framework and labeling theory, it would be necessary to examine how and why the client's gender factors into the clinician's process of diagnosing BPD.

Clinician Training

Veysey (2014) observed that the absence of specialized training and a well-connected knowledge base is a critical issue in clinician attitudes toward clients with BPD. This begs the contemporary question regarding what specific training influences a clinician's process of diagnosing BPD. Veysey presented numerous studies, which tended to echo the claim that specific BPD training plays an influential role in improving the attitudes and confidence of clinicians in working with clients with BPD. For example, Veysey (2014) cited Miller and Davenport (1996), who found that self-instruction is important in improving clinicians' care of and attitudes toward clients with BPD. Here, clinicians' attitudes affect their confidence, enthusiasm, optimism, and willingness to work with clients diagnosed with BPD.

Besides, Veysey (2014) drew on Krawitz and Jackson's (2008) study, which disclosed that cotaught training supports the conclusions that adding a consumer-

presenter or clinician-presenter to BPD training is of significant value. Consumer-presenters personify training styles coupled with a history of having attained diagnostic criteria for BPD for which they received mental health treatment. Clinician-presenters reflect psychiatrist trainers with specialization in and the offer of clinical services within the area of BPD. In another important study to this effort, Vollmer, Spada, Caspar, and Burri (2013) sought to examine how training received at the educational institution of their choice and the consequent practical experience influence expertise in clinical psychology. The researchers found that university training and successive professional training and practice had a positive effect on expertise development. Based on their findings, the researchers argued that, as opposed to neophytes, experts share some common features because they have gained a well-connected and wide knowledge base (Vollmer et al., 2013). Knowledge of concepts, procedures, and facts, according to these researchers, are key factors in differentiating novices and experts.

Faced with a challenging situation, forensic treatment experts can recall more relevant items, including identification of pertinent information, while disregarding irrelevant ones (Vollmer et al., 2013). Unlike novices, experts could perform domain-specific problems and tasks both at a faster rate and with higher accuracy levels. Like medicine, Vollmer et al. asserted that psychotherapy is coupled with complex problems and its professional training and status. As such, a well-connected and broad knowledge base assists clinician in generating accurate hypotheses at a faster rate. Consistent with such, Schuppert et al. (2012) conducted a study aimed at examining the value of emotion regulation training (ERT) in dealing with adolescents identified as having BPD

symptoms. The adverse consequences and prevalence of BPD symptoms, particularly in the long-term, have led to the development and evaluation of various treatment protocols. However, the available interventions are intensive and, as such, require clinicians to obtain extensive training (Schuppert et al., 2012). To this end, through this study, I seek to expound this line of thought by assessing how and why specific training influences clinicians' processes of diagnosing BPD.

Clinician Experience with Forensic Clients

Mikesell, Bromley, Young, Vona, and Zima (2016) argued the quality of mental health care primarily depends on the clinician-client communication. Not only does clinician-client communication help in completing clinical tasks, but it also improves health outcomes. As such, any violation of this relationship may affect client treatment. Accordingly, Veysey (2014) argued that clinicians' negative attitudes toward clients diagnosed with BPD may affect their treatment. The researcher professed BPD attracts stigma for many reasons. Stereotypes, according to Veysey (2014), can influence the type of information clinicians pay attention to. According to Zeifman, Boritz, Barnhart, Labrish, & McMain (2020), the training of the clinician can influence the quality of care received by patients and especially forensic patients. In this regard, more vivid, recent, and negative exposure has become more accessible. In this way, the researcher noted that a single incident can represent quickly the classifications of "difficult" and "borderline" (Veysey, 2014).

Also, Veysey (2014) asserted that, as a patient experiences traumatic episode, they become self-sustaining and lasting for the patient. The patient may dread receiving a

BPD diagnosis prior to entering a treatment facility (Veysey, 2014). This plays a critical role in setting the stage for both confrontations and negative relationships. Bodner et al. (2015) expounded on this line of thought, pointing out that negative attitudes toward individuals with BPD may influence the patients' treatment. Generally, clients with BPD pose significant challenges to the mental health system. Veysey (2014), Bodner et al. (2015), and Mancke, Bertsch, and Herpertz (2015)agreed that not only do these clients negatively engage with staff, but they also have a negative reputation coupled with unconscious violence and hostility, suicide threats, self-harm, staff antagonism, and high degrees of treatment dropout (Bodner et al., 2015).

As such, patients with BPD are more often seen as annoying, manipulative, difficult, and "bad" rather than "ill" (Bodner et al., 2015). This brings into context the role of clinicians' attitudes and experience with forensic clients in shaping the process of diagnosing BPD. Consequently, such negative relationships may be used to confirm gender stigma and negative stereotypes. In the past, there were no effective mechanisms to treat BPD symptomatology (Veysey, 2014). This, together with low change optimism, has significantly contributed to the negativity about BPD diagnoses. Veysey continued to expand on this line of thought by discussing how behavior and symptoms linked to BPD may cause strong emotional reactions from clinicians. Here, the researcher cited the *DSM-5* (APA, 2013), which pointed out conflict and unstable, intense relations as part of the BPD diagnostic criteria.

Based on such, the researcher posited the challenges clinicians face in interacting with patients with BPD catalyze stigma around diagnosis. Moreover, clinicians might

also perceive patients with BPD as being more culpable considering their actions and high emotional distress levels compared to other mental health diagnoses. It is worth noting personality disorders are categorized differently from mental disorders such as schizophrenia and depression. Placing personality disorders on different axes—Axis I and Axis II—based on clinical knowledge and etiology was meant to avoid inclusion with diagnoses such as depression that are more transient and resultantly classified as Axis I. However, Veysey (2014) commented the consequence of such has been ironically ill-fated, forming an "Axis II ghetto" in which these diagnoses are not only isolated but also ignored. Thankfully the DSM-5 has upgraded its categories and "Axis" no longer exists. BPD is listed simply as a personality disorder. This upgraded thinking has brought more awareness to the disorder and the plight of those struggling with its symptoms (APA, 2013)

In other words, clinicians might consider these patients as having more control over their symptoms as compared to other patients with other diagnoses. More recently, Loader (2017) echoed this claim, arguing that, since BPD clients are difficult to operate with, they are often described as unworthy of care owing to their challenging and antisocial behaviors. Accordingly, Bodner et al. (2015) argued the attitudes of clinicians toward both hospitalization and treatment of individuals diagnosed with BPD may influence the way they handle such patients. Negative attitudes may also increase vicious communication cycles and trigger a revolving hospitalization door as well as high rates of treatment dropout (Bodner et al., 2015). The current study will expand on this line of

thought by examining how clinical experience with forensic clients influences the process of diagnosing BPD.

Summary and Conclusions

This study will use the social constructivist conceptual framework for exploring the situation of BPD and forensic clients in Canada. The review of relevant literature has revealed the existence of gender biases in clinical research and diagnoses, especially regarding BPD and forensic clients. Such discriminations are evident in the Canadian legal and health care systems. The literature review allowed for the identification of the different gaps present in the current literature. There exist discrepancies regarding the findings of studies on gender biases. Some researchers revealed the existence of biases, while others refuted such claims. However, none of the inquiries have established the sources of these differences. Most researchers have used samples with uneven gender representation. The literature review also revealed the need for an educational program to improve the use of social contact elements that emphasize BPD to minimize prejudices.

Chapter 3: Methodology

Introduction

As noted, the current study was aimed at describing the process clinicians use when diagnosing forensic clients with BPD, as well as identifying the factors that affect patient outcomes. I developed three primary research questions to attain this aim. The following is a description of the research methods, including the design, setting, study participants, data collection, and analysis. I used a qualitative design for this study.

Research Design

Consistent with the social constructivist conceptual framework, I adopted a qualitative research design. I based the choice of this research design on the nature of research questions and objectives posited in the study (Maxwell, 2012). As Saunders, Lewis, and Thornhill (2016) asserted, to gather nonnumerical information, a qualitative research approach is justified. In other words, a qualitative research approach entails obtaining respondents' opinions and perceptions by asking structured questions so they can disclose statistics and other data. After the data and statistics are analyzed, meaningful insights and conclusions can be drawn.

Saunders, Lewis, Thornhill, and Wilson (2009) noted qualitative research scholars make it possible to arrive at detailed information without the respondent withholding any valuable data. This enables researchers to draw valuable inferences and conclusions emerging from themes in the collected data. The present study design followed the grounded theory approach, which helped to generate useful interpretations by constant

comparisons. Because grounded theory studies usually begin with the gathering of background data and guiding questions, the investigation merited different research questions. Additionally, I performed an extensive literature review to establish research objectives and questions.

Research Strategy

Saunders et al. (2016) offered that research strategy includes the direction researchers take in their sample size determination process. Research strategy encompasses the plan of action the researcher seeks to use to achieve the study's aims and objectives (Creswell, 2013). Toward this direction, Sekaran and Bougie (2016) identified surveys, case studies, and ethnographics as the key research strategies. As Saunders et al. (2016) asserted, a case study is the most popular theoretical perspective linked to qualitative research. Consistent with such and in consideration of the limited resources and time constraints, this research followed a case study research strategy. The study utilized participants who were licensed psychiatrists and licensed forensic and clinical psychologists in a western Canadian province. The participants specialized in treating individuals with mood-related disorders such as BPD.

Target Population

Saunders et al. (2009) described the target study population as the whole group of objects or individuals for which a researcher is interested in generalizing conclusions. In the same spirit, Sekaran and Bougie (2016) defined the target population as a group of individuals a researcher selects to study. As an attempt to respond to the research questions in this study, the target study population included clinical psychologists,

forensic professionals, and psychiatrists currently working as independent contractors in a western Canadian province.

Sampling Procedure

I adopted a purposive sampling procedure for this research. Etikan, Musa, and Alkassim (2016) described the sampling procedure as a process or approach of selecting a subgroup of individuals from the target study population. Sekaran and Bougie (2016) supported this, commenting that it is the process of choosing several people for a study. This is done in such a manner that the selected individuals typify the larger group of a population from which they were chosen. As such, purposive sampling allowed quick access to the target population with given attributes. By using a purposive sampling procedure to identify managers and regular employees currently working as clinical psychologists, forensic professionals, and psychiatrists in a western province, I saved time, money, and effort.

Sample Size

A sample size, as described Sekaran and Bougie (2016), is a representative subset of the target study population from which data is obtained. After such data is assessed, the information can be generalized to the whole target population, but not with qualitative research in most cases. To this end, considering time and resource constraints as well as the nature of this study, I used a purposive sampling procedure to select 10 study participants from the directories. Selected participants comprised both male and female practitioners.

Data Collection Methods

I used an ethnographic data collection method, semistructured interviews, in this study. According to Saunders et al. (2009), semistructured interviews include both open and closed questions covering identified research topics. Phenomenological studies often apply semistructured interviews to obtain data regarding the research problem (Creswell, 2013; see Appendix 1 for a sample interview questionnaire). Therefore, the research process involved interviewing the participants. Data collection occurred up to a saturation point among individuals who were qualified to diagnose and treat BPD in adults according to APA and Canadian Psychological Association (CPA) criteria. After obtaining the informed consent of sampled respondents, I conducted, recorded, and transcribed these interviews. Saunders et al. (2009) observed that semistructured interviews are performed with a transparent framework, which permits conversational and focused cooperative communication. Besides, a considerable number of questions in a semistructured interview are created and designed during the interview. As such, both the researcher and interviewees are flexible enough to gain much deeper details when needed.

Data Analysis

An investigative researcher aims to model and transform the gathered information into conclusions and propositions that assist in effective decision-making for treatment plans. In this regard, analytic thinking techniques used by researchers help in their data interpretation or to derive the intended meaning. Analysis requires critical thinking and proper selection of an analytic strategy. Critical reflections are essential dimensions

throughout a qualitative investigation; they provide a researcher with a conceptual mechanism for engaging in effective techniques for drawing information from a data set (Kirk & Pitches, 2013). Reflections also assist in the performance of a systematic self-examination.

Qualitative methods allow the researcher to offer a more powerful or nuanced description of the experience (Creswell, 2013). One of the conventional qualitative methodologies used in research is phenomenology, which draws upon the experiences of the respondents or the researcher to examine a phenomenon (Wilson, 2015). The goal of a researcher when using this approach is to assign meanings to situations and relate them to other facets of life. The phenomenological study was an appropriate choice for the study of gender bias. In the present research, phenomenology was used in conjunction with grounded theory to explore and give insight into the assessment and treatment of patients with BPD as they relate to gender. Interviewees' experiences provided abundant data concerning the occurrences of this phenomenon in clinical institutions. Such material will aid in the development of an in-depth appreciation of gender-based prejudices.

An essential strength of the phenomenological approach is that it allows a researcher to experience the phenomenon under investigation. Such involvement permits the investigator to connect the experiences of the participants and the situation. The process of phenomenological analysis occurs in distinct stages. According to Moustakas (1994), it begins with a transcendental reduction. In this phase, the investigator sets aside any preconceptions concerning a phenomenon and considers it with an open mind while exploring possible dimensions. Imaginative variation is another step described in

analyzing data. It involves constructing the flow of the experience, imagination, and insight to carefully examine the relationship relevant to the experience. When the phenomenon is observed, it is integral to explore space and time about the experience, thus forming a textual, structural description. The researcher repeats this process for each participant until data saturation is attained. Examining all aspects of the phenomenon will lead to the formulation of a composite depiction of the group experience (Creswell, 2013).

In the study I used a computer-based data analysis program such as NVivo (2012) (see Creswell, 2013). This software was useful in organizing data through the concept or themes from existing empirical or theoretical literature. These tools are designed for deep levels of analysis on large or small data volumes.

Validity and Reliability

Validity refers to the extent to which research scholars employ valid techniques to investigate the original purpose of the study (Drost, 2011). Both the internal and external validity of this research was achieved through constant revision and evaluation of the applied approach, the assumptions, and the conclusions throughout the study process. It is worth noting that the nonmaleficence principle guided the research throughout this process. Also, reliability refers to the ability of an entire study analysis or environmental analysis to be duplicated by either the same researcher or other independent scholars (Drost, 2011). The information on the transcripts were revised to eliminate any mistakes that otherwise would have affected the reliability of the outcome.

Issues of Trustworthiness

Trustworthiness is an essential concept of qualitative research. I endeavored to ask the same questions of all respondents and allowed participants to review the collected data and my interpretations to ensure credibility.

Ethical Considerations

Ethical considerations play an instrumental role in research, both quantitative and qualitative (Mollet, 2011). Informed consent, or voluntary participation and confidentiality, is the most common ethical issue experienced while conducting research (Mollet, 2011). As such, I obtained written informed consent from all 10 study participants. I e-mailed a written introduction letter to potential participating forensic professionals and psychiatrists. When I received confirmation of participation from the respondents, I e-mailed them a copy of the consent form and questionnaire. Using initials or pseudonyms in transcripts ensured confidentiality. Where possible, I also altered other identifying details of the participants and place of study.

Conclusion

The study used a qualitative grounded theory approach, adopting a case study research strategy with the participants from a western Canadian province. This study will use the phenomenological approach to analyze the data. I used NVivo (QSR International NVivo version 12) software to organize the data and find themes. I shared a summary of the research findings with the respondents. Through triangulation of the data source and member checking, I was able to assure the trustworthiness of the data.

Chapter 4: Main Findings

Introduction

The primary goal of most global healthcare facilities is to provide quality patient care services based on equity. In this study I analyzed data relating to gender bias through the perspectives of clinic practitioners toward BPD patients (Travis et al., 2004). The overall purpose of this study was to understand the processes that practitioners use to diagnose and treat BPD patients. By investigating these processes, I hoped to improve diagnosis and treatment of BPD patients by increasing awareness of implicit gender bias by therapists.

In this investigation, I answered the following research questions:

RQ1: What are the processes used by psychologists/psychiatrists when diagnosing clients for possible BPD?

SQ1a: What information/observations might prompt the clinician to consider BPD?

SQ1b: What information/observations would move the clinician to rule it out?

SQ1c: What information/observations would lead the clinician towards a provisional or final diagnosis of BPD?

RQ2; How does the gender of the client factor into the process of diagnosing BPD?

SQ2a: How does the gender of the client factor into the process of diagnosing BPD?

SQ2b: Why does the gender of the client factor into the process of diagnosing BPD?

RQ3: How do the psychologist/psychiatrist's clinical experiences with clients influence their processes in diagnosing BPD?

Setting/Condition of Interview

In Chapter 3 on methodology, I explained the use of semistructured interviews as part of data collection. According to Saunders et al. (2009), semistructured interviews performed within a transparent framework often permits cooperative conversation and honest dialogue between participants and researcher. During this current study, the Coronavirus (COVID-19) pandemic suddenly occurred in North America. This pandemic disrupted everyday life in North America and globally. All nonessential businesses were closed. This included schools, counseling centers, universities, and retail stores. Hospitals, banks, and stores that sold essential supplies were allowed to remain open. Thousands died and many more became sick with the virus. Social distancing was implemented by government agencies. This included sheltering in place or people remaining at home. Masks were required to be worn in public places, and individuals were required to remain six feet apart from each other in all public spaces. Due to this event, many of my participants were not able to go to work, and others were also not able to participate in the study due to added responsibilities that arose in the ever-changing pandemic. This greatly limited the number of participants who were able to engage in the study. Additionally, some availability was limited during the interview process.

Furthermore, the pandemic affected me in several ways. First, as the researcher, I had to devote more time to the study because it was more difficult to establish contact with participants. I had to make numerous phone calls and send several e-mails to contact participants. Secondly, I had to reschedule previously arranged interview appointments. Thirdly, because I had to change the mode of communication from face-to-face interviews (via Skype) to phone interviews, this limited my ability to visually observe the nonverbal language of the participants (such as body language, facial expressions, and emotional reactions to the interview questions). Fourthly, it took longer to complete dissertation-related work in general.

Data Collection

This study was designed to have 10-12 participants. However, only 10 participants engaged in this study. Some participants who previously agreed to participate in the study were unavailable due to the pandemic.

As previously stated, I had planned to interviewed participants using skype video conferencing and phone interviews. However, due to technical difficulties with Skype and availability of the respondents, I was unable to use that medium to interview respondents. Thus, all respondents were interviewed by phone.

I originally sent e-mail invitations to 12 forensic psychologists/psychiatrists who provide forensic services and treated mood disorders. I used two licensing board lists to generate a list of possible participants. From that list, I selected practitioners who treated women and had a specialty in forensic mental health and mood disorders. Practitioners who responded by e-mail and stated their interest were included in this study.

Demographics of Participants

All participants were doctorate level forensic psychologists or psychiatrists in a western Canadian province. They were all board certified and certified in their field of expertise. Six women and four men participated in the research study. All the participants had clinical experiencing ranging from 5 years to 35 years.

Participant # 160114_0013 was a board-certified psychiatrist in a western Canadian province. He had 25 years of experience as a psychiatrist and had worked in Canada, United States, Pakistan, and England. His specialization was personality and mood disorders in forensic patients. He also served as an expert witness for the government in competency hearing trials.

Participants # 160106_0005 was a board-certified psychiatrist serving in a hospital setting in a western Canadian province. She was the director of the mood disorder clinic at the facility in which she worked. She had 20 years of experience in the field. She also had specialization in trauma informed therapy in a forensic setting.

Participants # 160107_0007 was a doctorate level psychologist working in a Western Canadian province. She had 20 years of experience as a psychologist and specialized training in PTSD, servicing first responders.

Participant # 160111_0012 was a board-certified psychiatrist practicing in Washington State and a Western Canadian province. She practiced in a hospital setting, where she headed the residency board for new trainees. Her specialization was BPD and forensic profiling. She had 18 years' experience as a psychiatrist.

Participant # 160105_0004 was a registered psychologist in a Western Canadian province. He had 10 years of experience practicing in a forensic setting. He was chief clinician at a local prison. He was trained in forensics and had 2 years of experience as an expert in forensic assessment.

Participant # 160107_0008 was a psychologist who practiced in a Western Canadian province. He specialized in mood disorders in a forensic setting. He worked at a local hospital in a Western Canadian province. He had 5 years of experience working as a psychologist.

Participant # 160110_0010 was a registered psychologist practicing in a Western Canadian province. He specialized in treating mood disorders in women and serving the Lesbian, Gay, Bisexual, Transsexual, and Questioning (LGBTQ) community. He had 35 years of experience practicing as a psychologist in private practice.

Participant # 160111_0011 was a board-certified psychiatrist, providing service in a prison forensic setting. She had 18 years of experience and specialized in treating mood disorders.

Participant # 160121_0015 was a board-certified psychiatrist with 12 years of experiencing practicing in a hospital setting. She worked as a general practitioner, providing specialized service for BPD and PTSD clients and patients with historical trauma.

Participant # 1601122_0013 was a board-certified psychiatrist who provided services in a forensic setting. She had expertise in providing court competency hearings.

She also conducted personality disorder trainings. She had been practicing for 25 years in the United States and a Western Canadian province.

Data Analysis

I used NVivo computer software to analyze the data for themes. NVivo text frequency search yielded interesting trends among female responders. Often the words manic, moody, full of emotions were used to describe female BPD patients. When describing male patients, words such as aggressive and emotionless were used by the respondents.

Evidence of Trustworthiness

As mentioned in Chapter 3, trustworthiness is an important factor of qualitative research. Creswell (2013) mentioned that trustworthiness validates the accuracy of the findings of the research. I asked the same research questions of each participant. Participants could review the transcription to ensure the accuracy of the information obtained. The main reasons were to ensure the accuracy of the transcription and to increase the trust level with the participants (Creswell, 2013). As the researcher, I wanted to be certain that the information shared during the interviews was accurately reflected in the transcription. I also wanted to make sure the stories that the participants relayed were portrayed correctly. I did not enlist the participants as coresearchers in this research study , but I took the time to explain to the participants my role as the researcher to develop rapport with them. According to Creswell (2013), by doing this, the researcher clarifies their biases (p. 251). I also utilized my colleagues (dissertation committee) to review the findings. According to Creswell (2013) this is referred to as an external audit.

Results from NVivo

From the NVivo-based findings, a more substantial assortment of the practitioners in the Canadian healthcare system revealed concurrence regarding the use of DSM-5 technique in diagnosing BPD. The NVivo software's text search query results are shown as a word tree in Figure1 reflecting the DSM-5 diagnosis approach. Despite the general understanding that the use of such benchmarked diagnostic approaches could help alleviate performance issues, its increased use in diagnosing BPD among other cognitive and mental disorders raises a wide range of unanswered questions, especially regarding the effectiveness of the selected diagnosis procedure in the context of BPD. As revealed in the final report of the NVivo analysis , premeditated judgements and assumptions could be prolific contributors to misdiagnosed cases of BPD.

However, an essential element of the findings, which is worth mentioning, is the specific information that practitioners use to dictate whether the mental and cognitive-based symptoms are implications for the prevalence of borderline personality symptoms. To differentiate from other mental disorders such as post-traumatic stress disorder (PTSD), bipolar, and depression, more than 80% of the respondents asserted that suicidal ideation, extreme emotional swings, impulsivity, unstable relationships and fear of abandonment are vital key indicators for the prevalence of BPD (Woodward et al., 2009). As such, the findings of the study show an association of women to the incapacity to regulate their emotions, especially when subjected to compromising phenomenon socially. However, Macksey-Amiti & Donenbery (2020) pointed out that the patient’s inability to control their emotions should not be the sole predictor of BPD. When

emotional regulation is used as an identifier, along with other symptoms it can become a good predictor of BPD (Macksey-Amiti & Donenbery, 2020).

As the participants clarify on the issue of emotional control and suicidal ideation among women, NVivo's analytical findings not only show a sense of gender bias in healthcare facilities when it comes to taking up responsibilities of patient care. Generally, women are over-represented with BPD diagnosis due to the ways they are socialized in most cultures and the accepted norms of socially expressing your feeling in most cultures for women. Figure 4.2 below further makes it more precise and comprehensive how the concept of socializing women reflects the tendencies for BPD diagnosis, particularly in the Canadian and western cultural context. This leads to logical reasoning that task allocation, male chauvinism, and limited, compromised liberty together add meaning to the rampant cases of females that are diagnosed with a BPD compared to men. However, it is also notable and arguable that gender bias plays a role in not only pardoning men when it comes to diagnosing with BPD, but also explains the increased chances of associating men with an extreme emotional response such as anger with conduct disorder or antisocial personality disorder and not BPD (Veague & Hooley, 2014). Although, not many practitioners relate with this concept, the few who did helped the NVivo analysis in distinguishing why most women register BPD diagnoses compared to Canadian population, considering the purposively selected respondents for the study.

Besides diagnosis using the DSM-5 methodology, the findings reveal that more than 67% of the participants show a pre-meditated notion of gender bias when it comes to the resultant behaviors that relate to BPD symptoms; such that most of the respondents

reveal a correlation between gender and the capacity to contain the undesirable behavioral symptoms of the disorder. Precisely, male patients tend to contain the disorder better than their female counterparts, because men manage and express emotions differently and therefore, they can be underrepresented with BPD diagnosis. Men are conditioned through social constructivism, often learning through social interaction and from societal norms (Mackesy-Amiti & Donenberg, 2020). The findings from the interviews further explained the theoretical framework used for this study. The theoretical framework aligned with the findings of the study. Clinicians learns through social interaction and those interactions manifest itself in their profession and personal lives. The finding shows that the biases may not be intentional, but rather unintentional because of social interaction and training they received.

To elaborate on this claim, the word tree compiled for Figure 4.2 below indicates the way women are centered in the biased treatment criterion. Also, it is arguable that BDP symptoms can be rampantly prevented in women as compared to men. Healthcare practitioners that were interviewed (the study's participants) show that there is a relationship between the clinicians' understanding of BPD and the manifestation of gender bias during diagnosis and treatment.

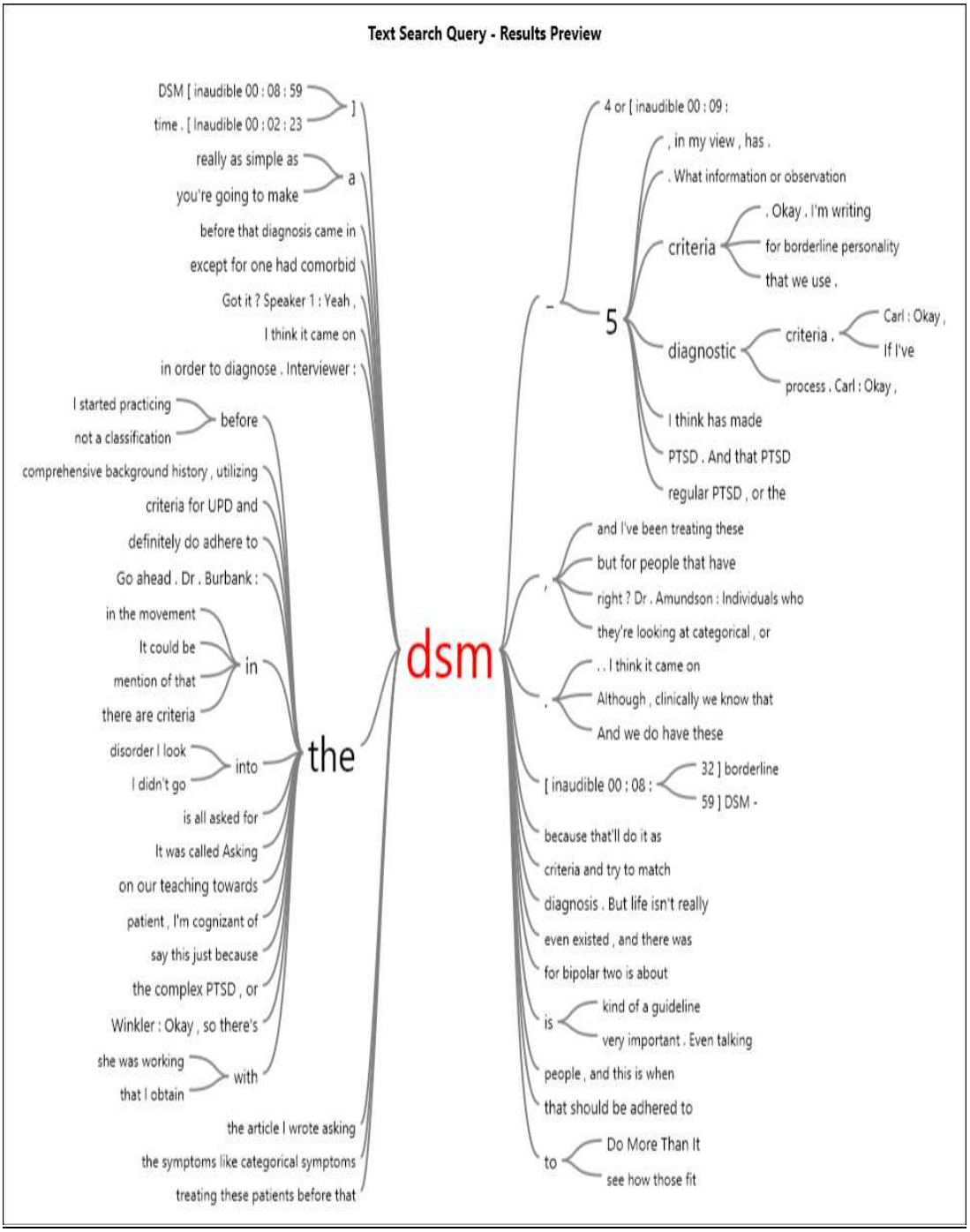

Figure 1. Word tree from NVivo text search query findings.

Similarly, other than the correlation between gender and behavioral symptoms of BPD, most respondent practitioners reveal that perceptions and pre-meditated assumptions play a core role in defining the prejudiced in-patient care among the Canadian female BPD victims. For example, trauma appears along the chain of causality owing to its impact on the mental and cognitive systems. As shown in Figure 3, trauma is one of the words that NVivo analysis finds to appear frequently among the reasons behind a lack of equilibrium in the practitioners' approach. The inclined bias is dependent on gender because trauma plays a more significant role in displaying the BPD symptoms in Canadian female patients more than their male counterparts. Trauma informed therapy is a treatment approached used by most forensic and clinical facilities in Alberta and throughout Canada (Casey, Bentley & McDonald, 2020). Most trauma informed groups are 80% women in their make-up and 5 percent men, the remainder do not identify as either sex (Casey et al., 2020). These findings lead to an argument that the mental and cognitive disorder jeopardizes the patients' capacities in managing their emotions. Practitioners' perceptions lead to a definition of the techniques that could be preferably applied in the diagnosis and treatment stages as well as the readiness to deal with the negative side of the disorder symptoms during the patient care period. In this case, biases spring from plenty of pre-judgmental perspectives, which was learning through norms, social interaction and social constructivism (Sygel et al., 2015).

For instance, psychologist and psychiatrists tend to prefer dealing with males then females, owing to the perceived incapacity of female's forensic patients to regulate their emotions and feelings when undergoing treatment for BPD. Also, the sense of bias

extrapolates to diagnosis and treatment procedures whereby it is easy for other mental patients to be wrongfully diagnosed with BPD on account of their inability to control their emotions or when they get to point of manifesting suicidal ideations. This assertion implies potentially high chances of misdiagnosis based on gender bias. On the one hand, female Canadian patients stand more chances of being wrongly diagnosed with BPD using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Likewise, men also stand chances of misdiagnosis with other disorders like conduct disorder or antisocial personality disorder, amid depicting symptoms of BPD just because of a gender-based bias.

Looking at the NVivo software analysis of the textual data sets from the interview results, it is arguable regarding the accuracy and rigor of the findings. As shown in Figure 3, the word cloud portrait depicts *borderline personality disorder* as the three outstanding words that appear in almost all the responses. While, the study is centered on the disorders' diagnosis and associated perspectives that invite gender bias during diagnosis, treatment, and therapeutics, the phrase appears in almost every section of the empirical study and the interview alike. In this context, it is assurance for the rigor and validity of the findings extracted from the NVivo software.

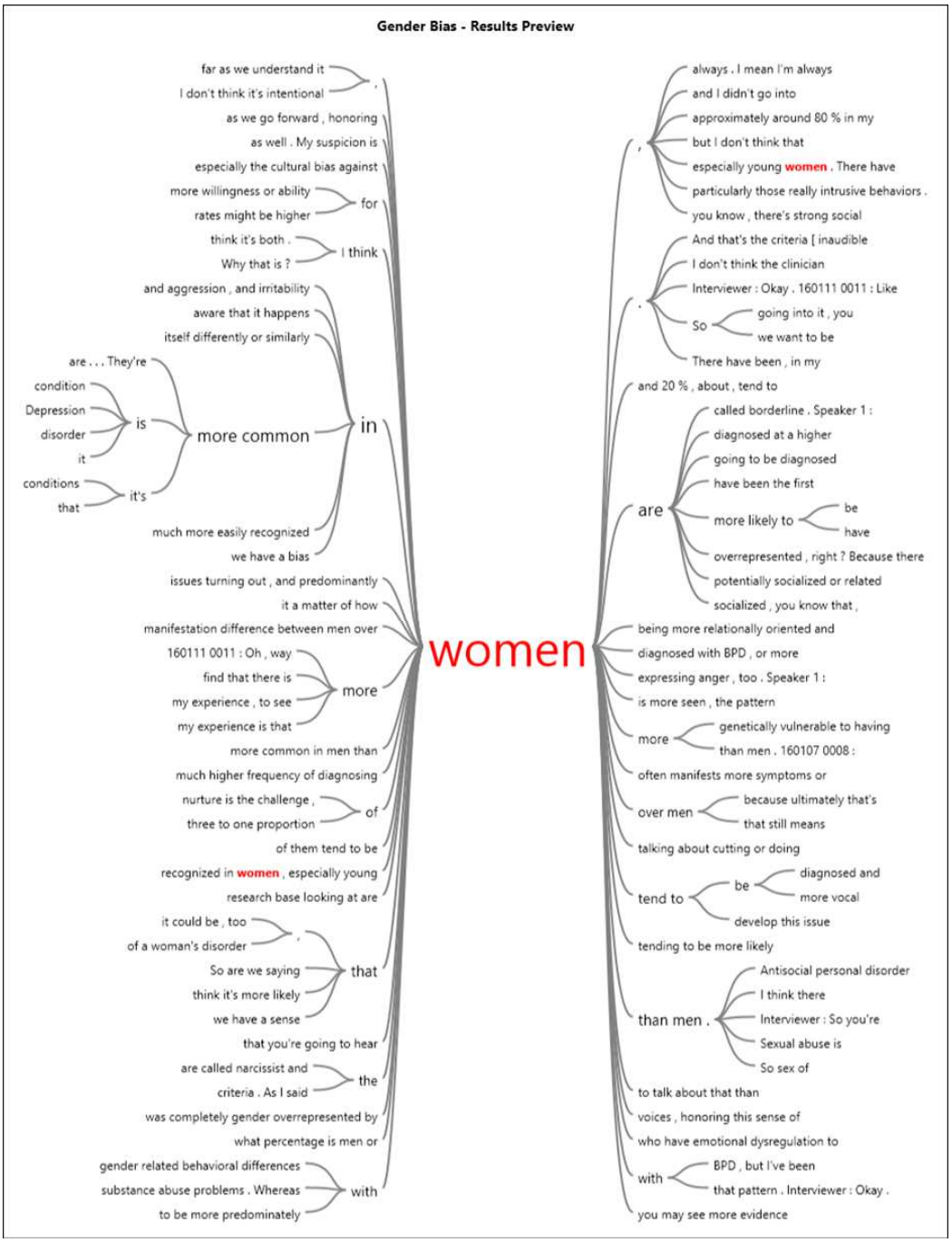

Figure 2. Word tree for the NVivo text search query findings.

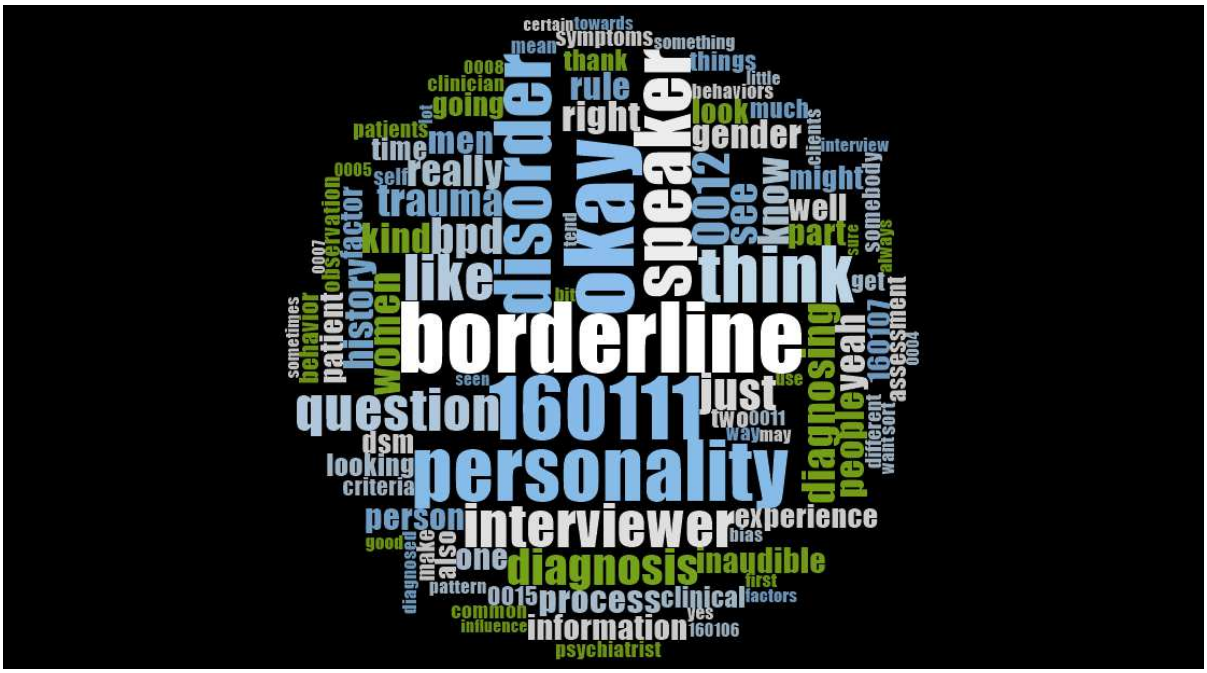

Figure 3. Word cloud from the NVivo overall text frequency search.

Summary of the Findings

I carried out this research project to answer a few questions about the practitioners who diagnosis and treat BPD. I wanted to understand what observation or information prompt the clinician to consider BPD. How does the gender of the patient factor into the diagnosis they receive? And how does the experience of the clinician factor into the process of diagnosing BPD. Those answer were clearly revealed in the NVivo analysis of the data. In summary, the NVivo software analysis shows correlated findings from the respondents' understanding of gender bias and healthcare practitioners' perceptions when diagnosing and treating BPD among Canadian patients. The findings lead to an empirical conclusion that there is an inevitable correlation between what forensic practitioners know about BPD and the unfolding of gender bias in the course of diagnosis. Further,

females are more prone to receiving a diagnosis of BPD, when compared to men because of how they are socialized and express their emotions across the Canadian cultural dimensions. The high tendency to manifest uncontrollable emotions also sparks a sense of fright and avoidance among practitioners. Notably, the DSM-5 technique stands out as the benchmarked primary diagnosis approach for almost all mental disorders. However, the data also illustrated that practitioners with experience in treating mood disorders and experience with a forensic population base, are better equipped to avoid the unintentionally use of bias in their diagnosis. This criterion also promotes the increasing building of stereotypes regarding the potentiality of BPD's prevalence. In the upcoming chapter 5 of the research, I will discuss what the study means and what the implications on the healthcare system in Canada are. I will also evaluate and discuss what is positive social change and additional limitations faced in the study due to COVID-19 and social distancing.

Chapter 5: Discussion

Findings and Analysis of Data: Referral Process

As part of the analysis of the data, I recorded all the interviews and had them transcribed. I read all the transcripts and examined the data for themes. The data was analyzed and coded in nodes based on the research questions mentioned in Chapter 2.

The purpose of the study was to explore psychologists' methodology that led to making a diagnosis of BPD. In the study I explored the factors considered by mental health practitioners in the examination of patient leading to a BPD diagnosis. I also scrutinized the experience of clinicians and how it impacted their decisions when making a BPD diagnosis. The findings indicated that bias does exist in the diagnosis and treatment of women with BPD and those biases can have negative consequences for the women being treated. The findings showed that 80 % of the practitioners unintentionally stereotyped their female patients based on the mood being displayed. This was especially true for patients with PTSD related issues, those who were frequently incarcerated, and those who had additional mood disorder related illnesses. Although the practitioners were aware that bias does exist in the diagnosis and treatment of BPD patients, they often were not aware of their own biases and sometimes unable to identify them before they had an impact on their patients.

Interpretation of the Findings

Empirically based research findings illustrated that gender biases exist in the health care system Creswell, 2013). However, most of the researchers were unaware how

it was impacting female forensic patients. The theoretical framework used in this research study was social constructivism. Social constructivism is built on the premise that we learn though social interaction, which aids in our construction of knowledge (Sygel et al., 2015). Most participants in the research project spoke highly of their mentors in the field. A large percentage of those mentoring the practitioners or respondents were men. Participants acknowledged that their training and experience were directly related to their mentoring and credited their mentors in the field and their educational institutions. Participants were also able to acknowledge that it is possible they are unintentionally carrying on the biases of their mentors without intent to do so. BDP condition can be dangerous if not diagnosed and treated in a reasonable timeline (Silberschmidt et al., 2015). It can lead to a worsening of symptoms for a patient and the development of unstable relationships, self-harming behaviors, the feeling of emptiness, mood swings, and impulsive/self-destructive behaviors (Casey et al., 2020). The findings of the research study suggested that bias does exist in the treatment of BPD patients and some of those biases can be traced back to the experiences of the practitioners and who their mentors or field supervisors were. Experienced clinicians are better able to understand their innate biases and introduce measures to lessen their impact on their care for the patients. Casey et al. (2020) illustrated that implicit bias is prevalent in everyone, including clinicians. Understanding the impact of each practitioner's implicit bias should be the goal of every practitioner.

The interviews conducted in this study aided in understanding the state of BDP from a medical personnel's perspective. The respondents answered all the questions asked

regarding the current state of the BDP illness conditions. There were various factors that were common in their explanations. For instance, the existence of bias in healthcare, particularly in the diagnosis of BPD, can be attributed to various factors. First, there exists various forms of bias in society. While discrimination in healthcare is discouraged, the subconscious attitudes, motivations, and opinions of the physicians regarding various individual groups may permeate into their practice leading to stereotyping and perpetuation of healthcare disparities (Joint Commission, 2016).

The difficulties associated with the diagnosis of BPD can also contribute to bias in the handling of this population. There exist several differences, biological and behavioral, between men and women, a factor that can affect diagnosis of BPD among the two populations (Liebman & Burnette, 2013). This claim is supported by scientific studies that have shown the existence of various structural and chemical differences between the brains of men and women (Jantz, 2014). These differences affect the pathophysiology, epidemiology, and manifestation of various diseases. As such, differences in the accuracy of diagnosis also arise (Regitz-Zagrosek, 2012). Finally, the methodological differences in research between men and women can also be blamed for gender-based bias in the diagnosis of BPD, though more research into the topic is needed (Sygel et al., 2017). Similarly, the biological and structural differences have also been blamed for the higher incidence of BPD in women as compared to men (Clearview Women's Center, 2017). However, the prevalence of implicit bias exhibited by practitioners or biases in any format does not improve the patient's health or their therapeutic relationship with the practitioners.

Limitations of the Study

In Chapter 1 of the study, I mentioned the use of the phenomenological approach, which places restrictions on the participants. According to O'Dwyer & Bernauer (2013) phenomenology is good for a study with a small participant sample. It allows for an in-depth exploration of the situation under investigation. The interview of the participants did provide enough information to analyze the phenomenon. Some issues arose around trustworthiness when conducting the study. Due to the global pandemic and the limiting effect of COVID-19, the semistructured interview was replaced with skype and phone interview. This was done to limit the spread of the virus which was ravaging the world at this time. Phone and skype interview do not allow the researcher to investigate the emotion on the participant's face or get a feel for their mood when answering a question. The availability of resources also shrinks during a pandemic, and participants may become unavailable. An already small sample size in this study became smaller due to COVID-19 fears. It took time, effort, and alternative tactics to keep the small sample size together. Once the Institutional Review Board issued the directive to use alternative mean to complete the interview with the participants (Walden Institutional Review Board approval no. 03-04-20-0083001), it became easier to arrange with the participants to complete the data collection process. However, despite the alternative means to interview the participants, I found many of the participants deviated from the issue being discussed. Also, due to the open-endedness of the research question, the participants did seem to have some control over the content they were willing to share. I also found the process to be labor-intensive; recording, analyzing, and categorizing the data became a time-

consuming process. Another limitation I faced during the research was the inability to statistically represent the sample, which is one of the limitations of qualitative research. There is no way to analyze the data mathematically; the research and analysis of data is based more on judgement and opinion, rather than empirical results (Creswell, 2013).

Recommendations

One of the benefits of doing a research study is that new ideas develop, and this is a result of the new knowledge that is unearthed during the research undertaking. I would first recommend postponing a future research study to be conducted in a COVID-19 environment. The global COVID-19 pandemic and the social distancing requirements it creates greatly impacts the ability of the researcher to conduct face-to-face semistructured interviews. During face-to-face interviews, the researcher can observe the emotions on the respondents' faces, which can lead to further questions during the interview process.

I would also recommend that a future research study should look at the treatment of patients with bipolar disorder. The basis for this recommendation is the similarity in symptoms between BPD and bipolar diagnoses. Even though bipolar is a mood disorder, some of the symptomology in patients is strikingly like those for BPD patients. I would like to see a future study focus on a bigger sample size and look at two competing sample groups. Interviewing 12 male practitioners and 12 female practitioners may present different data that should be able to more fully explain a phenomenon. However, such a research study may have to be quantitative so that the researcher can look at the impact of competing variables and measure the relationship between dependent and independent variables.

I would also recommend the same research conducted in a different setting, different location, and/or between different cultural groups, for example, in a prison setting among prison practitioners or in a hospital setting, where treatment is the focus rather than a punishment. A future research study may also examine different cultural groups or ethnicities. A future researcher may look at European American/Canadian respondents as one group, African American/Canadian respondents as another independent group, and a third group of respondents. The goal of such a study would be to see if implicit bias is cross sectional, specific to a culture or ethnic group, or is innately imbedded in each group. Any future research using quantitative methods would allow for the measuring of variables and understanding the impact of each variable.

Implications of the Study

According to Creswell (2013), all research undertaken and completed should add new information to the phenomenon being investigated by the researcher. Walden University sets the standard high, expecting each research study to have positive social change for the community and the field. For this research study, the positive social change would be improvement in the relationship between practitioners and their patients, ensuring that the relationship is free of bias or anything that hinders the diagnosis and therapeutic effects for the patient. Walden University emphasizes that a research study should create and apply ideas. The research study should develop strategies to promote the dignity, worth, and development of individuals in their institutions, cultures, and communities (Gray & Rarick, 2018). I believe that this research study can have lasting impacts on the health care institution in Canada and the

communities in which the practitioners serve and reside. The findings of this research study further affirmed that bias does exist in the health care system in Canada. The study also inferred that bias in health care exists and often is manifested through cultural stereotypes and societal norms. This can lead to unintentional biases around the care and treatment of patients. Everyone is susceptible to implicit biases, including physicians (Casey et al., 2020). As the NVivo word finding for this research study revealed, many of the negative words used to describe patient behavior were used towards women. This means that it is possible that such implicit bias may contribute to the disparities in the health care system in Canada. Bias can shape the practitioner's behaviors, thus producing different treatment to different groups based on their race, gender, or ethnicity. This can be especially problematic in any community, especially in many of the Northern communities in Canada where aboriginals make up a large portion of the client population. Implicit biases can have devastating effect on those communities. Practitioners should guard against complacency and understand that it is not inconceivable that every practitioner has some form of implicit bias that can indirectly impact the quality of care they provide to the community they serve (Liang, Wolsiefer & Zestcott, 2019). I also believe it is important for all clinicians/ practitioners and healthcare workers to include bias-reduction strategies in their daily practice. Bias-reduction strategies can be achieved by intentionally taking the patient's perspective and focusing on the patient's individual information, apart from their social group (Chapman et al., 2013). In Western Canada, each province has a College of Physicians and Surgeons body that oversees the implementation of reducing implicit bias practices. Currently

practitioners only take one course during the initial licensing process. Once fully license in their field, any future course is not deemed mandatory. In rare cases where a physician is reprimanded for behavior detrimental to their practice, they may be directed to take a mandatory sensitivity training course to maintain their license. It is my belief that the governing body for each discipline should enact mandatory implicit bias training whenever possible to improve the patient experience.

Implication for Future Research

The finding for this research study found that some biases exist in the health care system; however, I went one step further by understanding the nature of the bias and one area where it originates from. In society norms men and women are seen differently, women are taught to be expressive, cry and to show their emotions (Casey, et al., 2020). On the other hand, men are taught the opposite; to show little emotion, maintain their emotional composure, be aggressive, and be mentally strong at all times; and where appropriate to protect the family and uphold the family finances (Barnes & Snyder, 2012). This research study found that those social norms and the emotional expectation of women are working against them when seeking treatment for BPD. Many of the participants acknowledged that women were easier to diagnosis due to their outward emotional toolset and their very well-developed ability to express their needs, even negatively at times. The finding of this research study found that through social constructivism many participants were doing the same treatment model they learned from their trainer, teachers and from the modality treatment model they were trained to follow in graduate school. During the interviews of the respondents, some referred to forensic

female patients as “borderline chick’ or “the emotional ones”. Bowen (2016) pointed out that simply holding negative views or implicit bias and beliefs about a group is enough to unintentionally harm the group or the treatment you provide to that group. Even though all practitioners are aware of bias against women in the healthcare system, they illustrated that they do not believe they were biased in their treatment of BPD patient. However, during the interview many consciously or unconsciously referred to BPD patient who are women as the “borderline chick” and the “emotional one/ lady”. The women participants in my research study acknowledge that their goals as Psychiatrists/Forensic Psychologists is to provide good patient care while earning a decent living. They acknowledge that reducing biasness in the system is a good thing but feel that women’s emotional state works to their advantage if the practitioner is skilled and has experiencing diagnosing BPD patients. Most practitioners agreed that if a patient is expressive, interacts with the clinician positively and expresses their symptoms to the clinician, this will provide an easier basis to diagnosis or treat the patient’s symptoms. The participants cited that because women are emotional being and have been trained to express their emotions from young, they are better able to express their feelings to the practitioner and more willing to do so. This research study was able to point out that some biases does not have to be intentional, it further implores practitioners to be aware of the implicit biases and try to ensure it does not dictate their decision making.

Maybe future research can guard against practitioners who uses words that implies implicit bias. Maybe pointing out to the practitioner that they are using such language and create dialogue around it, will help to clarify the practitioner’s perspective.

Maybe a future study should use a larger sample size to ensure that the finding could apply to large group. Another study can interview only female respondents for their perspective on BPD and how it impacts their clients. Having male only respondents can be another section of the study and cross-referencing the findings.

Representativeness in Sampling

Sampling errors have also been cited as one of the factors that lead to gender-based preconceptions among clinicians (Gray & Rarick, 2018; Travis et al., 2004). Also, since most of the existing studies have been carried out in psychiatric settings, and there is a possibility that sampling biases might have affected their credibility. Moreover, the issue of lack of enough representativeness in past studies was noted throughout the study. For instance, females formed 88% of the sample in one area of studies analyzed. As such, the findings from such studies cannot be considered sufficiently representative (Veysey, 2014). For the sake of future studies and to shed more light into the issue of gender-based bias in diagnosis of BPD, researchers should strive to make their samples more representative. The study also identified that enhancing the use of social contact elements among healthcare providers focusing on BPD can also help address prejudice and improve the attitudes of caregivers.

Training and Experience of Clinicians

This research study showed that the training and experience of the clinicians play a significant role in shaping their behavior and attitudes towards dealing with BPD patients. There is a need to incorporate more specialized aspects in their training to improve their diagnostic capabilities. The move will ultimately enhance the patient

outcomes by enhancing the quality of treatment they received. The experience of the clinicians should also be considered, for instance, where underserved or the most vulnerable populations are concerned. More experienced clinicians will help address the prejudice and or implicit bias that BPD patients face; a factor that will in turn improve patient outcomes. In Canada and the United States, qualification to become a psychiatrist or Psychologist are identical. However, the level of training each practitioner receives during their internship and specialize residency can be very different. According to the American Psychiatric Association (2013) practitioners who are training in large metropolitan cities, often are exposed to more senior clinicians, thus adding more skills to their skill set. Practitioners who operates in smaller cities, with smaller sample sizes, can take longer to acquire the knowledge and experience of their metropolitan counterparts (American Psychiatric Association, 2013). Casey (2020) mentioned that implicit bias can plague smaller community more than larger metropolitan areas. Particularly, some small communities in Northern Canada have one practitioner serving the entire community. These practitioners may have no one to consult with and are often overworked, leading to mistakes while treating patients (Biskin & Paris, 2012).

Other studies have also identified other interventions that can be employed to address gender-based bias in mental healthcare. As mentioned earlier in this study, some bias is part of different societies. Clinicians might subconsciously fall victim to the use of these bias in the course of their practice. Therefore, tackling of societal norms, values, practices, and behaviors should be explored in the quest to minimize gender-based discrimination in the provision of mental health services (Govender & Penn-Kekana,

2008). Gender-specific exposures, vulnerabilities to disability and disease should also be addressed. Health systems as well as health research should also be engendered (Govender & Penn-Kekana 2008).

Conclusion

The empirical research leads to a conclusion that BPD is common in females. Besides, as the DSM-5 techniques makes the primary and universally acceptable diagnostic procedure, the practitioners' perceptions that are reliant on their knowledge and understanding of the disorder along gender lines invites bias. As such, several interventions that can be successfully used to address gender-based bias in the diagnosis of BPD in Western Canada. First, the training and experience of clinicians should intentionally seek to address the issue. Second, health systems and research should be engendered to avoid unrepresentativeness. Third, practitioners should guard against implicit bias, and take steps to ensure it does not affect their diagnosis and treatment of BPD patients. Gender-specific exposures and vulnerabilities must also be addressed. Finally, societal bias should be tackled to prevent its permeation into healthcare.

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Appendix: Sample Questionnaire for Clinicians

Name of interviewer

Date

Dear Sir/Madam. My name is (Name). I am conducting research on ways of improving the clinical outcomes for BPD clients. I would appreciate your honest contribution to this study. Kindly note that this is not an exam. All your responses will be strictly confidential according to the national regulations on research. Thank you.

Personal Details

Name_____

Profession _____

Gender (Choose one)

☐ Male ☐ Female

Diagnosing for BPD

RQ1: Describe the process used by psychologist/psychiatrist when diagnosing clients for possible borderline personality disorder.

i. (a) What information/observations might prompt the clinician to consider BPD?

_____

ii. (b) What information/observations would move the clinician to rule it out?

_____

iii. (c) What information/observations would lead the clinician towards a provisional or final diagnosis of BPD?

RQ2: How does gender of the client factor into the process of diagnosing BPD?

i. (a) How does it factor into the process of diagnosing BPD?

ii. (b) Why does this factor into the process of diagnosing BPD?

RQ3: How do the psychologist/psychiatrist clinical experiences with clients influence their processes in diagnosing BPD?

Thank you once again for your participation. I am looking forward to meeting you again.