Distinguishing and Addressing Gender Minority Stress and Borderline Personality Symptoms

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Abstract: As transgender and gender-diverse people are gaining increased visibility in clinical settings, clinicians are requesting better guidance on providing affirming care to improve the mental health and well-being of these patients. In particular, more direction is needed on whether, when, and how to diagnose and treat borderline personality disorder among gender minorities, partially in response to beliefs among some mental health clinicians that a gender minority identity may be a manifestation of identity diffusion. In this Perspectives article, we argue that gender minority identity, even when fluid, is rarely a sign of identity diffusion. By taking a careful history of a patient's gender identity development, the clinician can clarify and gain more conviction regarding the presence of a patient's gender minority identity. Moreover, multiple stigma-related stressors experienced by gender minorities may produce symptoms and behaviors that can mimic or be consistent with certain diagnostic criteria for borderline personality disorder. We therefore conclude with recommendations for adopting a gender-affirming framework to treat borderline personality symptoms when present among gender minority patients, with implications for future research and practice.

Keywords: borderline personality disorder, gender dysphoria, gender identity, gender minority, transgender

Visibility is increasing in clinical settings for people who present with a transgender or gender-diverse identity, and who seek mental health treatment or referral for medical and surgical interventions to affirm their gender identity. At times, clinicians hesitate to deliver or offer referrals for gender-affirming care, wondering whether a patient's stated gender minority identity is caused by unstable self-image within the context of borderline personality disorder (BPD). These concerns highlight the paucity of research on diagnosing and treating BPD among gender minorities, as well as the lack of guidelines for psychiatrists and other mental health clinicians who seek to make informed and compassionate recommendations for their patients.

Although more research is needed to determine the best course of care for gender minorities with and without BPD, gender minority patients require evidence-informed support today. As clinical educators specializing in the care of people with diverse gender identities, we have written this Perspectives article as a response to the dearth of guidance on BPD among gender minorities. We do not claim to have answers to all questions regarding the mental health care of gender minorities since we, too, are limited by the existing evidence. We do, however, seek to further educate clinicians on the ways in which multiple stigma-related stressors experienced by gender minorities in daily life can produce symptoms and behaviors that resemble borderline psychopathology. Such symptoms are likely to diminish if clinicians acknowledge the sources of these gender minority stressors and help patients address the sources directly. Gender minority patients who meet diagnostic criteria for BPD stand to benefit from the same evidence-based treatments as all patients with BPD; these treatment protocols, however, likely require cultural tailoring for gender minorities and possible augmentation or integration with evidence-based interventions developed specifically for gender minority populations. Finally, we offer guidance for clinicians on supporting gender minority patients with a BPD diagnosis or borderline personality symptoms who are seeking access to gender-affirming health care.

DEFINITIONS

We begin by defining terms relevant to gender minorities and BPD in order to facilitate a greater understanding of the historical context, research findings, and treatment recommendations that follow.

Gender identity is a person's inner sense of being a girl/woman, a boy/man, a combination of girl/woman and boy/man, something else, or having no gender at all. Distinct from gender identity, *sex assigned at birth* is based on an infant's biology (usually female or male). Although everyone has a gender identity, it does not necessarily align with the expectations that are traditionally associated with the sex assigned at

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birth. Additionally, not everyone has a gender identity that fits neatly within the binary paradigm of either girl/woman or boy/man. Gender minorities therefore constitute a broad diversity of people who experience an incongruence between their gender identity and what is traditionally expected based on their sex assigned at birth. Identity terms vary and evolve over time. Currently, the most common umbrella term for gender minority identities is *transgender*. A *transgender man* typically refers to someone assigned female sex at birth who identifies as a man; a *transgender woman* is someone assigned male sex at birth who identifies as a woman. *Non-binary* and *genderqueer* are terms used by some people who identify as a combination of girl/woman and boy/man, as something else, or as having no gender. A *gender fluid* person is someone who does not have a fixed gender identity and whose gender identity may inherently fluctuate over time. Finally, many use the term *cisgender* to describe the gender majority—that is, people whose gender identity is congruent with what is traditionally expected based on their sex assigned at birth.

Gender expression refers to the ways in which a person communicates femininity, masculinity, androgyny, or other aspects of gender, often through mannerisms, gait, speech, or style of dress. Gender nonconformity does not necessarily indicate a gender minority identity; many cisgender people have a nonconforming gender expression. *Sexual orientation* is conceptually separate from gender identity and gender expression. Whereas gender identity refers to the inner experience of gender, and gender expression refers to the outer representation of gender, sexual orientation refers to a person's physical, emotional, and romantic attachments in relation to gender. Everybody has both a sexual orientation and a gender identity; and all people, regardless of gender identity, can have a sexual orientation that is straight, gay, bisexual, lesbian, queer, or something else.

Gender dysphoria, a diagnosis introduced in the latest, fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), requires significant distress or functional impairment caused by differences between one's experienced or expressed gender identity and society's expectations based on sex assigned at birth. The diagnostic criteria include significant distress that persists for at least six months.[1] Importantly, not all gender minority people experience gender dysphoria, and having a gender minority identity is not a mental illness. In this article, we refer to gender dysphoria only when referencing someone who meets the DSM-5 diagnostic criteria.

Borderline personality disorder is a psychiatric condition characterized by impairment in self-identity, self-direction, and interpersonal relationships. Symptoms include intense anger and hostility, high levels of rejection sensitivity, impulsivity, and emotional instability that often involves depressive thoughts, anxiety, and feelings of shame and emptiness.[1,2] People with BPD often engage in risk-taking behaviors, recurrent self-harm, and suicidal behavior.[1–3] A core feature of BPD is "unstable self-image,"[1] which patients may manifest by providing incoherent or contradictory descriptions of themselves[4] or by experiencing "dissociative states under stress."[1] To be diagnosed with BPD, full DSM-5 criteria must be met. The term *borderline* derives from the psychoanalytic conceptual framework for *borderline personality organization* (i.e., the level of functioning between psychotic and neurotic).[5] In this article, we use *BPD* when referring to the DSM-5 definition and *borderline personality symptoms* when discussing patients who do not meet full DSM-5 criteria.

HISTORICAL CONTEXT

The study of BPD among gender minorities is best understood within its historical context. Although records throughout time are peppered with instances of people living as a gender not expected based on sex assigned at birth, it was not until the mid-twentieth century that the American medical community began to pay attention to gender diversity.[6,7] With a few notable exceptions, psychiatrists and other medical experts regarded "transsexuals" (in the vernacular of the time) as mentally ill, delusional, or sexually deviant.[6,7] In 1980, DSM–III added a diagnosis for transsexualism, categorizing it under psychosexual disorders and describing transsexual individuals as generally having "moderate to severe coexisting personality disturbance."[8] Moreover, DSM-III added uncertainty of gender identity as an example of identity disturbance among people with BPD. Accordingly, much of the literature in the 1980s discussed gender minority identity as a possible subtype of BPD or other personality disorders.[9,10] Although DSM-IV-R no longer included gender identity references under a BPD diagnosis, it did use the terminology of gender identity disorder and disturbance as diagnostic guidance for gender minorities, thereby lending ongoing credence to the notion that gender diversity was inherently pathological.[11] It was not until 2013, with the publication of DSM-5, that gender identity disorder was replaced with gender dysphoria in order to avoid the implication that the identity itself is disordered. In addition, the label *gender dysphoria* was chosen to emphasize the need to treat dysphoria through gender affirmation rather than to treat psychopathology. Despite this positive shift in the psychiatric field toward affirmation of gender minorities, many people believe that any inclusion of a gender identity–related diagnosis within the DSM predisposes clinicians to view gender minorities as mentally ill.[6,7]

BPD PREVALENCE AMONG GENDER MINORITIES

The psychiatric literature reports a wide variability in the prevalence of BPD and other personality disorders among gender minorities.[12] Our search of the literature found that the reported prevalence of BPD among transgender subjects ranged from 1% to 33%, with all but one study reporting 7% prevalence or less (note that these studies used wide-ranging terminology to describe gender minorities; we use the term *transgender* for all studies to avoid confusion and to standardize the language without distorting the findings of the studies).[13–17] Two other studies reported a prevalence of 8% and 23% of Axis II Cluster B personality disorders among transgender participants.[18,19] Studies that measured all personality disorders reported a range

of 2% to 81%.[15,20,21] These highly inconsistent findings are not surprising, given the methodological differences across studies. For example, studies used different eligibility criteria (e.g., clients diagnosed with gender identity disorder seeking surgery at gender identity clinics; outpatient clients in various stages of gender affirmation; general population) and measures to assess gender minority identity and psychiatric morbidity. DSM diagnostic definitions for gender minorities have also fluctuated over the years. Additionally, the studies were conducted in diverse countries (e.g., Iran, Italy, Serbia, Sweden, United States) with different cultural norms regarding gender minority identities. Finally, contradictory findings may have arisen from selection bias and limitations in the study designs: all studies were cross-sectional, and many had sample sizes of less than 100 participants.

Studies on the prevalence of BPD and other personality disorders in the general population have reported similar or lower percentages compared to studies on gender minority populations. The World Health Organization's mental health survey of 13 countries estimated a 6.1% prevalence of personality disorders and a 2.7% prevalence for Cluster B disorders.[22] The National Comorbidity Study Replication (2001–03) reported a past-year prevalence of 1.4% for BPD and 9.1% for all personality disorders in the general U.S. population.[23] In a meta-analysis of 43 studies reporting BPD prevalence among college students from six countries (the majority from the United States), the authors reported a prevalence range of 0.5% to 32.1%, with a pooled lifetime prevalence of 9.7%.[24]

In sum, due to variability in findings, small sample sizes, diversity of settings, the lack of longitudinal data, and other limitations in the current literature, it is difficult to know the prevalence of BPD among gender minority populations. Importantly, we agree with the authors of the studies that concluded that psychiatric morbidities among gender minorities do not indicate that a gender minority identity is disordered or is an outcome of a psychiatric illness. Rather, psychiatric disorders among gender minorities may develop, among other possibilities, in response to the challenges of living as a stigmatized minority in a discriminatory environment.[12,13,17–20] In the next section, we describe pathways by which stigma, bias, and discrimination may negatively influence the mental health of gender minorities.

THE ROLE OF GENDER MINORITY STRESS

It is difficult to overstate the amount of societal discrimination faced by gender minorities on a daily basis across multiple settings. The 2015 U.S. National Transgender Survey of 27,715 transgender and non-binary respondents serves as collective testimony on this stigma. One in 10 respondents reported violent victimization from a family member; most reported some form of mistreatment at school, including 54% reporting verbal harassment; and 30% of respondents who were employed reported being fired, being denied a promotion, or experiencing some other form of harm based on gender identity. Finally, 33% of respondents reported being harassed, being denied treatment, or having another negative experience related to their gender minority status when seeing a health care provider in the past year.[25] Consistent with a similar national survey from 2011, these findings painfully substantiate a common experience among gender minorities of chronic and pervasive societal oppression in many facets of life.[26] According to minority stress theory, multiple acts of discrimination, trauma, and abuse enacted on the individual, interpersonal, and structural levels may lead to internalized stigma, expectations of rejection, and identity concealment among sexual and gender minorities, thereby producing chronic stress that may result in mental and physical health disparities.[27–29] Among the most common disparities linked to such stress among gender minorities are depression, anxiety, substance use disorders, suicidal ideation and attempts, and sexual risk behaviors.[29–31]

Borderline Personality Symptoms as Response to Minority Stress

Members of gender minorities who experience chronic, stigma-related stress may develop symptoms that resemble those of BPD; these individuals may or may not meet full diagnostic criteria for BPD. Gender minority stress–related symptoms may explain why some studies report a higher prevalence of borderline personality symptoms among gender minorities and why clinicians sometimes mistakenly believe a gender minority patient is exhibiting identity diffusion rather than a gender minority identity. In addition, since BPD is thought to develop partially in response to an invalidating early childhood environment,[32–34] and childhood maltreatment is common among gender minority children,[25] clinicians may think that gender minority identity and BPD have a common etiology. Although punishing a child continually for gender-nonconforming behaviors may lead to disrupted attachments later in life,[21,35] childhood maltreatment is only one of several forms of stigma and abuse experienced by gender minorities; pervasive societal stigma toward one's identity continues into adulthood for most gender minorities.[25]

In addition to attachment challenges, borderline personality symptoms may include suicide attempts and nonsuicidal self-injury (NSSI), behaviors that were once (although no longer) considered to occur only in people with BPD.[36–38] As many as 41% of gender minorities may have attempted suicide in their lifetimes,[25] and up to 53% report NSSI in their lifetimes.[37] Suicidal behaviors and NSSI among people with BPD may primarily be associated with impulsivity, low distress tolerance, and co-occurring major depressive and substance use disorders.[39] By contrast, many instances of suicidal ideation and NSSI among gender minorities are thought to largely be responses to societal discrimination.[40]

Rejection sensitivity is another BPD characteristic that may be found among gender minorities. In a 2016 qualitative study that interviewed 30 people about their experiences as gender minorities, all participants reported that they expected rejection in social interactions, and 17 mentioned feeling anger and frustration in reaction to expectations of rejection.[41]

Over time, these types of experiences may adversely affect emotion regulation, coping skills, interpersonal functioning, and cognitive processes, all of which are categories of impairment similar to those described in standard diagnostic criteria for BPD.[42] Nonetheless, although gender minority stigma may produce rejection sensitivity and other symptoms that resemble BPD, these symptoms could be interpreted as reasonable—or even adaptive—responses to pervasive societal stigma, rather than as an underlying personality disorder.[43,44]

Impulsivity is a BPD diagnostic criterion that may be interpreted as present among gender minority subpopulations who have high-risk sexual behaviors—although one that clinicians ought to attribute with caution, and only after considering the context of gender-related stigma and discrimination.[45] For example, a study of 300 U.S. transgender adults reported a significant association between engaging in sexual-risk behaviors or expecting rejection and experiencing gender-related discrimination.[29] In an analysis of qualitative interviews with transgender women of color from the San Francisco Bay area, participants distinguished engaging in high-risk sexual activity from impulsive behavior per se, explaining that this sexual activity often occurred in the context of survival sex work after they had been rejected by their families of origin and discriminated against in the workplace. Some respondents also reported that having multiple male partners was one of the only ways to affirm their gender identity as a woman.[46] Although clinical evaluators may perceive these behaviors as impulsive, they can also be perceived as reasonable and well-planned survival or developmental behaviors within an economically and socially marginalized community. By contrast, historical theories regarding BPD have attributed impulsive sexual behaviors to maladaptive responses resulting from disordered attachments or other personality vulnerabilities that predispose a person to intolerable feelings of loneliness or emptiness.[47,48]

Finally, gender minorities have experienced a long history of rejection when attempting to pursue physical and mental health care.[49] Gender minority patients may therefore mistrust clinicians at first and demonstrate pronounced affective responses to perceived slights. Clinicians may, in turn, be inclined to interpret these responses as possible borderline personality symptoms, without necessarily understanding the underlying contextual factors. In fact, these affective responses may not occur in clinical settings that patients experience as gender affirming and less threatening. It is therefore especially important that the diagnosis of BPD in gender minority patients be conferred only after a thorough clinical evaluation and a careful review of diagnostic criteria.

In sum, although the clinical presentations of BPD in gender minorities and cisgender people are similar, the factors driving borderline personality symptoms in gender minorities may uniquely stem from gender minority stressors. Therefore, in order to improve borderline personality symptoms in gender minorities, the therapeutic approach will need to generally address minority stressors and should occur within an affirming health care environment.

GENDER MINORITY IDENTIFICATION AMONG PATIENTS WITH BPD

Clinicians new to gender-affirming care who are treating patients with BPD will often inquire whether a patient's gender dysphoria or gender minority identity is a manifestation of unstable self-identity or identity diffusion. For example, clinicians have wondered if patients with BPD began identifying as transgender in response to engaging with gender minority people in treatment settings. If such a patient asks for gender-affirming medical or surgical care, clinicians may worry that the patient's underlying motivation is to gain attention or to disrupt preexisting treatment goals, rather than to affirm the patient's true gender identity. These concerns can generally be allayed by taking a careful history of gender identity development to assess if the patient's disclosed gender identity has been persistent over time.[50] For instance, the DSM-5 diagnosis of gender dysphoria includes a persistence requirement of at least six months.[1] The World Professional Association for Transgender Health Standards of Care, version 7, provides recommendations for evaluating patients for persistence.[50]

Although gender identity for many gender minorities may be stable, some people go through periods of questioning. Rather than being a sign of identity diffusion that fulfills one criterion of BPD, however, questioning one's identity is typically the opposite: a process of clarifying and gaining comfort with one's true gender identity despite societal pressures to the contrary. In such cases, the patient may benefit from experimenting with different gender-identity labels and expressions. Clinicians can support patients in their journey of self-discovery by using a gender-exploration therapeutic approach that does not favor one particular gender identity over another. Patients can be supported in pursuing reversible social forms of gender affirmation, such as changes in name, pronouns, and style of dress.[7,51] Such changes can enable identity exploration and clarification in a flexible manner and may help reduce the patient's resistance to engaging in evidence-based BPD treatment.

Questions regarding persistence of gender minority identity can arise when assessing patients who identify as gender fluid. Gender identity fluctuations, however, are not the same as unstable identity as conceptualized in BPD; many gender minority people endorse and live most comfortably and adaptively with consistent gender fluidity over time. Gender identity, depending on context, can vary throughout a person's life along a continuum, without causing distress to the individual, and without indicating any disturbance in gender identity.[52]

GENDER-AFFIRMING TREATMENTS FOR PATIENTS WITH BPD

Best practice for initiating gender-affirming hormone therapy and surgeries with adult patients who have a documented, persistent gender minority identity is to follow an informed consent model. In accordance with this model, gender-affirming medical intervention is indicated as long as the patient has the capacity to

make a fully informed decision and to consent for treatment.[53,54] If a patient has been diagnosed with BPD, we recommend treating BPD in parallel with, rather than prior to, the patient's desired gender-affirming interventions, as long as BPD does not impair the patient's capacity to give informed consent or to safely engage in the clinical necessities of the treatment. Clinicians can determine the patient's capacity for medical decision making and informed consent according to the same standards used for all potentially life-saving medical and surgical interventions. Inhibiting access to gender affirmation has historically led to a justifiable mistrust of psychiatry among gender minorities.[6] Moreover, studies have demonstrated that prioritizing either treatment of psychiatric disorders or gender affirmation alone, at the exclusion of the other, can result in worse outcomes.[55] Although clinicians may fear that some patients will subsequently revert to cisgender identification and regret medical or surgical interventions, the evidence shows that patients who are appropriately determined to have a gender minority identity virtually never regret undergoing gender affirmation.[56–59] Mental health clinicians' overall role in the gender-affirmation process is therefore to facilitate gender identity exploration, discovery, and affirmation, while also supporting the patient's psychosocial adjustment.[7,50,55]

BPD TREATMENT MODALITIES

Currently, the treatment modalities with the strongest evidence for reduction in borderline personality symptoms are based on four theories of core deficits that lead to a BPD phenotype: transference-focused psychotherapy hypothesizes excessive aggression as the core deficit in BPD; dialectical behavioral therapy regards emotional dysregulation as the primary mechanism; mentalization-based therapy addresses failure to accurately discern one's own internal states and those of others; finally, good psychiatric management focuses on interpersonal hypersensitivity as the core deficit.[42] It is important for clinicians to carefully consider the underlying etiology of symptoms when selecting or integrating therapeutic paradigms. In some cases, BPD treatment modalities may be helpful for alleviating gender minority stress symptoms, such as rejection sensitivity, even if the patient does not meet diagnostic criteria for BPD.

To achieve optimal outcomes for gender minority patients, clinicians may need to tailor standard BPD treatments to directly address minority stress, to accommodate the unique experiences of living as a gender minority person, and to bolster individual and community resilience factors. Although there is not yet a large body of evidence to support clinicians in cultural adaptation of treatments for gender minorities,[60] clinical researchers have convincingly argued that the underlying principles of dialectical behavioral therapy align with gender minority stress theory.[61,62] These authors have published case examples and practical guidance for tailoring dialectical behavioral therapy for gender minority people, with the goal of addressing minority stress while improving emotional regulation, mindfulness, and interpersonal effectiveness.[61,62] For example, under the dialectal behavioral target of "wise mind," a transgender client can be encouraged to "attend to true sense of self in larger context of gender-binary environment."[62]

Evidence-based, integrative health interventions for gender minority people are also now emerging. As an example, the LifeSkills intervention integrates certain treatment themes often emphasized in BPD-focused interventions, such as boundary setting and communication skills, with solidarity-building activities among transgender participants. A randomized, controlled trial of LifeSkills led to significant reduction in high-risk sexual behavior among young transgender women.[63,64] When making referrals for surgeries, housing, and other needs, clinicians ought to identify and partner with gender-inclusive services that will not exacerbate minority stress for their patients. Gender minority patients may also benefit from additional case-management and legal resources to help navigate barriers to insurance coverage or to change name and gender on identity documents.[20]

REDUCING STRUCTURAL STIGMA

Structural forms of stigma, such as institutional policies and practices or systemic societal marginalization, may be contextual factors that undermine the efficacy of mental health interventions for minority populations.[65] When gender minority patients access mental health care, they are interacting not only with their physicians or counselors but also with the front desk staff, billing staff, and overall practice environment. For example, a transgender patient receiving otherwise excellent treatment may still report high levels of rejection sensitivity and emotional dysregulation in a residential program if the facility lacks an inclusive and affirming overall environment for gender-diverse people. Examples of ways to create gender-affirming practice environments include training all clinicians and support staff to consistently use the self-determined names and pronouns of all patients, having policies to prevent discrimination based on gender identity and expression, and offering all-gender restroom facilities.[66] Clinicians working with gender minority patients with borderline personality symptoms should, in light of the highly interpersonal nature of both gender affirmation and BPD treatment, be especially attuned to potential barriers to treatment efficacy within the organizational culture (Figure 1).

ALTERNATIVE TREATMENT MODELS

Given the complexities of BPD in gender minorities, it is worthwhile for clinicians to remain open to alternative treatment models. Skinta and colleagues[67] recommend functional analytic psychotherapy for helping sexual and gender minority patients address negative responses to minority stress, such as rejection sensitivity, that act as barriers to the formation and maintenance of interpersonal relationships. Additionally, Pachankis and colleagues[68] developed a transdiagnostic treatment approach emphasizing minority stress as the proximal etiological cause of an interrelated "syndemic" (i.e., synergistic epidemic) of mental health concerns for sexual minority men—an approach that can potentially be adapted for gender minorities.

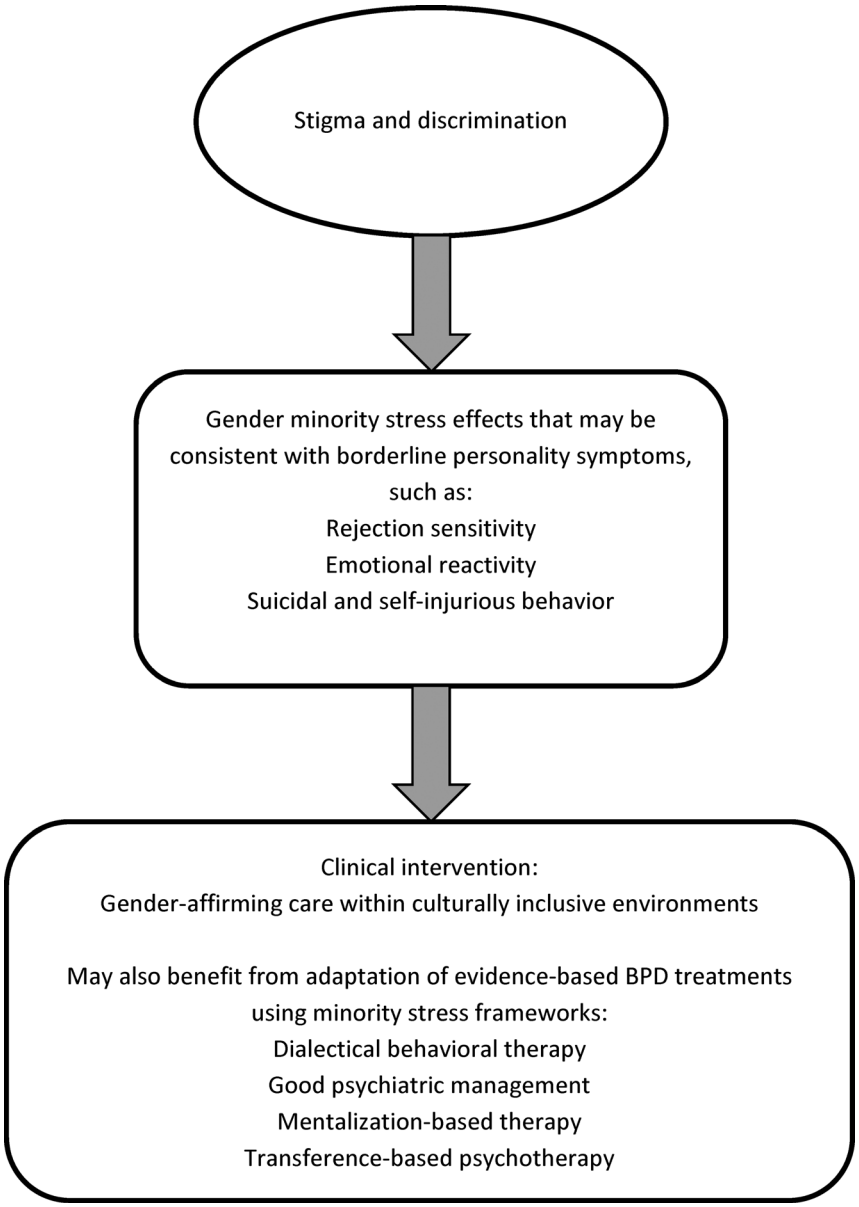

Figure 1. A framework for understanding and addressing gender minority stress effects that may be consistent with borderline personality symptoms.

Treatment goals in this model are to normalize the adverse impact of minority stress; facilitate emotion awareness, regulation, and acceptance; reduce avoidance; empower assertive communication; restructure minority stress cognitions; validate minority individuals' unique strengths; build supportive relationships; and affirm healthy, rewarding expression of stigmatized identities. In a randomized, controlled trial, the investigators tested a cognitive-behavioral therapy intervention focused on reducing minority stress processes among young gay and bisexual men, and found that, compared to a waitlist condition, treatment significantly reduced depressive symptoms, at-risk alcohol use, sexual compulsivity, and recent condomless sexual intercourse with casual partners, while also improving condom use self-efficacy.[69]

IMPLICATIONS FOR FUTURE RESEARCH AND PRACTICE

To our knowledge, no currently available interventions are designed for the treatment of personality disorders in gender minority patients. The research to date has focused on the prevalence of these disorders among gender minorities and on mental health status before and after gender-affirming medical interventions.[12] To address gaps in the knowledge base that impede advances in care, future studies ought to focus on tailoring evidence-based BPD treatment modalities for gender minority populations, using minority stress and gender affirmation frameworks.[68–70] In particular, gender minorities may benefit from the adaptation of interventions that show positive outcomes related to attachment, emotion

regulation, and coping skills (e.g., mentalization-based treatment and dialectical behavioral therapy). It will also be important to study any direct or indirect effects of minority stress factors on clinical outcomes. We recommend that researchers collect more longitudinal data on specific psychiatric outcomes of patients with preexisting psychiatric disorders who have accessed gender-affirming medical or surgical treatments. Such data will help better inform customization of gender-affirming care for gender minorities with BPD and other mental illness. Additionally, future large, general-population intervention studies on BPD should consider collecting demographic data on the gender identity of all participants (oversampling may be necessary) in order to assess treatment outcomes specific to gender minority people. Research studies provide evidence-based guidelines for measuring gender identity.[71]

Finally, in order to meet the mental health needs of gender minority communities, all clinicians should receive, during medical education, psychiatry residency, and other mental health clinical training programs, specific training on best practices caring for gender minorities. They should also be encouraged to access continuing education programs, such as those from the National LGBT Health Education Center (www.lgbthealtheducation.org) and World Professional Society of Transgender Health (www.wpath.org).

CONCLUSION

Increasingly, clinicians are requesting recommendations on the provision of affirming mental health care for transgender and gender-diverse people whom they perceive as presenting with symptoms of BPD. In our view, it is critical for clinicians to recognize that a gender minority identity is rarely a sign of identity diffusion and that borderline personality symptoms among gender minorities may occur in response to chronic invalidation and experiences of stigma and discrimination. To treat borderline personality symptoms among gender minority patients, we recommend clinicians use evidence-based treatments, such as dialectical behavioral therapy, in a manner that is culturally affirming for gender-diverse people.[61,62] Mental health treatments can be delivered in tandem with gender-affirming medical care, such as hormone therapy, for patients who have decision-making capacity to provide informed consent. By offering skilled and compassionate care, psychiatrists and other mental health professionals can help address the adverse effects of societal stigma and can improve the overall health and well-being of gender minority people.

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