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# **The Relationship Between Borderline Personality Disorder And Sex, Gender and Sexuality.**

## Intersecting Biological, Psychological And Sociocultural Constructs And Open Questions.

Relatore:
*Prof. Martin Dodman*

Laureanda:
*Arianna Salvini*
20 D03 265

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# Introduction

Borderline personality disorder (BPD) and sex, gender and sexuality are multidimensional biological, psychological, and sociocultural constructs. My aim in writing this thesis is to investigate how the relationship between them has been dealt with in the literature on research and clinical practice.

BPD is a complex mental health condition characterized by unstable relationships, self-image, and emotions, along with impulsivity and intense fear of abandonment. Chapter 1 of this thesis looks at the multifaceted nature of BPD, exploring its prevalence, diagnostic criteria, and potential causes. Research has shown that individuals with BPD often face significant challenges in interpersonal relationships and emotional regulation, leading to impaired functioning in various aspects of life. The chapter also examines the historical context and evolution of the diagnosis, highlighting debates and controversies surrounding its conceptualization and classification within the broader spectrum of personality disorders. Understanding BPD is crucial for effective diagnosis, treatment, and support for individuals living with this condition.

Chapter 2 focuses on the intersecting and often confused constructs of sex, gender, and sexuality, emphasizing the complexities and nuances within each dimension. Sex refers to biological characteristics such as chromosomes, hormones, and primary and secondary sexual characteristics, while gender encompasses the social, cultural, and psychological aspects of identity-related to presumed characteristics based on biological sex. Sexuality, on the other hand, pertains to one's sexual orientation, attractions, and behaviours. This chapter examines how these dimensions intersect and influence individuals' experiences, identities, and access to resources and opportunities. Additionally, it explores the impact of societal norms, stereotypes, and discrimination on individuals' sense of self and well-being. By

critically analysing the interplay between sex, gender, and sexuality, the chapter aims to look at ways in which a more inclusive and comprehensive understanding of human diversity can be promoted.

Chapter 3 focuses principally on biases and limitations in research related to BPD, sex, gender, and sexuality, highlighting the way in which recent literature emphasizes the importance of addressing these biases to both advance knowledge and promote equality. Biases and limitations may arise at various stages of the research process, including study design, participant recruitment, data collection and analysis, and interpretation of results. This chapter discusses common biases such as setting bias, and researcher bias, and their potential impact on the validity and generalizability of research findings. Moreover, it looks at what recent literature proposes for future directions for research aimed at mitigating biases and fostering more inclusive and equitable scientific inquiry. This includes promoting diversity in research samples, incorporating intersectional approaches, and critically examining underlying assumptions and cultural contexts. By addressing biases and embracing diverse perspectives, researchers believe that future research can contribute to more accurate, meaningful, and socially relevant knowledge in the fields of mental health, gender studies, and sexuality research.

In conclusion, this thesis aims to provide an overview of current research and practice in the field BPD, look at biases and limitations in how it has been connected to sex, gender, and sexuality, and consider how researchers envisage developments in this field that can contribute to a deeper understanding of human diversity and promote more inclusive and equitable approaches in research and clinical practice.

# Chapter One: Borderline personality disorder. A heterogenous diagnosis.

Borderline Personality Disorder (BPD) is a complex, challenging, and often misunderstood mental health disorder, that affects a significant number of individuals worldwide. The percentage of BPD in community settings is an estimated 1%, whereas in clinical settings it ranges from 12% in the outpatient psychiatric population to 22% among inpatients. (Ellison, Rosenstein, Morgan & Zimmerman, 2018). Individuals with BPD generally often struggle with intense and unstable emotions, difficulties in maintaining stable and healthy relationships, and impulsive behaviour (American Psychiatric Association, 2013). BPD is a serious condition because these symptoms can cause significant distress and disruption in various areas of functioning in the lives of those affected by the disorder, including their friends and family members.

This chapter will provide an overview of BPD, including its diagnostic criteria, epidemiology, aetiology, and treatment options. It will begin by describing the history and evolution of the diagnostic criteria for BPD, including the controversies and debates surrounding its classification and diagnosis. Next, it will explore the underlying causes of BPD, including genetic, environmental, and neurobiological factors that contribute to the development of the disorder, referring to a biopsychosocial model that aims to better understand what BPD really is. It will examine the complex interplay between these factors and the challenges they pose for the diagnosis and treatment of BPD.

By gaining a deeper understanding of this complex disorder, we can better support individuals with BPD and their families and others in close interpersonal

relationships. The overall objective is to raise awareness regarding BPD by providing evidence-based information.

## 1.1 Classification systems.

The term "borderline" was originally used in the early 20th century by psychiatrist Adolf Sterne who observed patients with symptoms that did not fit neatly into established diagnostic categories. These patients were described as "in the middle" between neurosis and psychosis, or between other diagnostic categories (Al-Alem & Omar, 2008). In the 1960s, the same term was used more specifically to describe a group of patients who were diagnosed with a range of psychiatric conditions but had similar clinical presentations and treatment needs. This group was seen as having a distinct personality organization that was characterized by emotional instability, impulsivity, and difficulties in interpersonal relationships.

The concept of "borderline personality disorder" (BPD) as a distinct clinical entity emerged in the 1930s and 1940s when psychiatrists began to describe patients who had chronic difficulties in interpersonal relationships, emotional regulation, and sense of self (Gunderson, 2009). These patients were seen as having a core disturbance in their identity or self-structure, leading to instability in their relationships, affects, and behaviours. At the time, this description fell into the diagnostic category of "schizophrenia" (Knight, 1953).

The term BPD was first introduced in the DSM-III (Diagnostic and Statistical Manual of Mental Disorders, Third Edition) in 1980. Prior to this, the condition was referred to as "a pseudo neurotic form of schizophrenia" and was considered a variant of schizophrenia, where at surface level-everything was calm, covering a state of psychosis (Hoch & Polatin, 1949). Subsequently, Robert Knight introduced a term that

remained for a long time to describe borderline patients: "These subsets of patients had no sense of self, and so in times of stress succumbed to borderline states of madness" (Knight, 1970; Redmayne, 2020).

However, this view was gradually challenged, and in the DSM-III BPD was recognized as a distinct personality disorder with its diagnostic criteria (APA, 1980), thanks to the work of psychoanalysts Otto Kenberg and Heinz Kohut. Their studies identified and demonstrated a distinct personality behaviour that was classified as "borderline personality organization", introducing the primitive self-defence mechanism of splitting (Kernberg, 1987).

The introduction of the term BPD in the DSM-III was a significant milestone in the recognition and understanding of this disorder. It helped to establish BPD as a distinct clinical entity with specific diagnostic criteria, which in turn facilitated research and treatment efforts. (Since then, the diagnostic criteria for BPD have been refined in subsequent editions of the DSM, including the DSM-IV-TR in 2000 and the DSM-5 in 2013, reflecting ongoing developments in the understanding and treatment of this complex disorder).

BPD is indeed a disorder that is often overlooked, misunderstood, and misdiagnosed, due to its overlapping symptoms with other psychiatric conditions, such as bipolar disorder or major depressive disorder. The highest rates of comorbidity regard substance abuse (64%), eating disorders (53%), mood disorders (80 to 96%), anxiety disorders (88%), attention deficit hyperactivity disorder (ADHD) (10 to 30%), bipolar disorder (15%) and somatoform disorders (10%) (Chapman, Jamil & Fleisher, 2023). Precisely for this reason an accurate diagnosis is crucial for the individual's well-being and their effective treatment: "Therefore, it is important to address relevant sociocultural issues, such as those related to gender, to improve the accuracy of the diagnosis and the effectiveness of treatment interventions" (Glover, 2021, p. 2).

There are different classification systems used as the basis of evaluation of BPD, each with its own set of diagnostic criteria and approach to assessing and treating the disorder. One of the most known and used classification systems worldwide is the *Diagnostic and Statistical Manual of Mental Disorders,* published by the American Psychiatric Association. Since the introduction of DSM-III, the diagnostic criteria for BPD have undergone several revisions. The DSM-IV-TR (APA, 2000) was the most widely used version until the release of DSM-5 in 2013, and it can provide a useful key to understanding and interpretation.

The nine symptoms used as criteria for BPD in DSM-IV-TR are:

1. Frantic effort to avoid real or imagined abandonment.

2. Unstable and intense interpersonal relationships are characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., substance abuse or binge eating).

5. Recurrent suicidal behaviours, gestures, threats, or self-mutilating behaviour.

6. Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation, or severe dissociative symptoms.

Generally, BPD is characterized by a pervasive pattern of instability in interpersonal relationships, self-image, affect regulation, and marked impulsivity. Individuals with BPD may experience intense and unstable relationships with others, shifting between idealizing and devaluing significant others (Gazzillo & Lingiardi, 2014).

To be diagnosed with BPD, an individual needed to meet at least five of these criteria, with symptoms occurring across multiple contexts and beginning by early adulthood (APA, 2000). The DSM-IV-TR also provided additional information about BPD, including its prevalence rates, associated features, and cultural, sex and gender considerations. Additionally, the manual included a section on different diagnoses to help clinicians distinguish between BPD and other mental health disorders. It is important to highlight that the DSM-IV-TR criteria are not definitive, nor do they give a sufficiently exhaustive description of the disorder, but rather serve as a tool to help mental health professionals to identify and diagnose those conditions.

In the DSM-5 (APA, 2013) the criteria remain nearly the same, with symptoms occurring across multiple contexts and beginning by early adulthood. Additional information about BPD remains unaffected and still includes associated features and disorders, prevalence rates, and cultural and gender considerations. Although some aspects are present in both the DSM-IV-TR (APA; 2000) and DSM-5, there have indeed been developments and it would be important to dwell on them for a better understanding of the disorder. These key differences include:

1. Number of Criteria. In the DSM-IV-TR, there were nine diagnostic criteria for BPD, whereas, in the DSM-5, there are only eight. Criterion 9 of DSM-IV-TR ("Transient, stress-related paranoid ideation or severe dissociative symptoms") was removed from the DSM-5.

2. Impulsivity Criterion. In the DSM-IV-TR, criterion 4 ("Impulsivity in at least two areas that are potentially self-damaging") was expanded to "Impulsivity in at least two areas that are potentially self-damaging and include one or more of the following: spending, sex, substance abuse, reckless driving, binge eating".

3. Identity Disturbance Criterion. Criterion 3 in the DSM-IV-TR ("Identity disturbance: markedly and persistently unstable self-image or sense of self") was revised to "Identity disturbance: markedly and persistently unstable self-image or sense of self, with efforts to compensate for the instability by excessive self-dramatization, and superficial, impressionistic speech".

4. Affective Instability Criterion. Criterion 6 in the DSM-IV-TR, "Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days), was changed to:

> Affective instability due to marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days) and including at least two of the following: (1) marked reactivity of mood in response to environmental cues, (2) intense and unstable interpersonal relationship, (3) chronic feelings of emptiness.

5. Severity Rating. The DSM-5 introduced a new system for rating the severity of BPD based on the number of diagnostic criteria met, with mild (5-6 criteria), moderate (7-8 criteria), or severe (9 criteria) ratings.

Overall, the changes in DSM-5 criteria for BPD reflect an increased emphasis on impulsivity and a greater recognition of the role of identity disturbance in the disorder (APA, 2013). These changes may help to improve the accuracy of BPD diagnosis and promote more effective treatment approaches.

Another globally recognized system for classifying medical diagnoses is the International Classification of Disease (ICD, 2019). Borderline Personality Disorder is included under the category of "Personality disorders characterized by emotional dysregulation". The ICD criteria for BPD share some similarities to the DSM-5, which are based on the Borderline PDM diagnostic criteria, but with some differences (Bach et al., 2022).

1. Disturbance in self-image: the individual experiences a pervasive and persistent disturbance in their self-image or sense of self.

2. Emotional instability: the individual experiences marked and persistent instability in their emotional state, including intense and often unpredictable emotional responses.

3. Interpersonal dysfunction: the individual experiences marked and persistent difficulties in maintaining close relationships, often including a fear of rejection or abandonment.

4. Impulsivity: the individual exhibits risk-taking behaviour that is potentially harmful, such as reckless driving, substance abuse, or binge eating.

5. Negative self-concept: the individual experiences pervasive feelings of worthlessness or inadequacy.

6. Inappropriate anger: the individual experiences intense and appropriate anger, including difficulty controlling their anger or expressing it appropriately.

7. Dissociation: the individual may experience dissociative symptoms, such as feeling detached from their thought or feelings, or experiencing transient episodes of depersonalization or derealization.

To receive a diagnosis of BPD in the ICD-11, an individual must exhibit at least three of these seven criteria. The severity of the diagnosis is determined by the number of criteria met mild (3-4 criteria), moderate (5-6 criteria), and severe (7 or more criteria) (Bach, Kramer, Doering, et al., 2022).

## 1.2 A biopsychosocial model.

The origins of BPD are not fully understood, but a biopsychosocial model has been developed because it is believed to result from a complex interaction between biological, psychological, and social factors (Garland & Miller, 2020). It follows that BPD is not caused solely by genetic or environmental factors but by a combination of many intersecting variables.

Biological factors may play a role in BPD, including genetic predisposition, brain structure and function, and neurotransmitter imbalances. Studies have found that individuals with BPD have abnormalities in brain regions associated with emotional regulation, impulse control, and interpersonal behaviour. Some research suggests that BPD may have a hereditary component with an "estimated heritability of approximately 40%. Moreover, there is evidence for both gene-environment interactions and correlations." (Amad, Ramoz, Thomas, Jardri & Gorwood, 2014, s.1), with a higher risk of the disorder among individuals with a family history of BPD. Some twin studies show more than 50% heritability, which supports the idea of genetic predisposition (Chapman, Jamil & Fleisher, 2023).

This evidence suggests that BPD runs in families, indicating that genetic factors may contribute to the development of the disorder. Up until now genetic causes "were largely ignored until the first significant twin study estimated its heritability at 69% about 17 years ago" (Gotlieb, 2021, para.2). Studies have shown that individuals with a first-degree relative (such as a parent or sibling) with BPD are more likely to develop the disorder themselves compared to those without such a family history (Braga et al., 2015). A study published in the American Journal of Psychiatry in 2005 used family and twin studies to investigate the heritability of BPD. The results showed that it was more common among first-degree relatives of individuals with the disorder and that genetic factors accounted for approximately 60% of the variance in BPD symptoms (Distel et al., 2008). More recently, a meta-analysis of twin studies published in the National Library of Medicine in 2014 (Amad et al., 2014), found that the heritability of BPD was estimated to be around 40%, indicating that genetic factors play a significant role in the development of the disorder.

These studies suggest that genetic factors alone are not sufficient to cause BPD and that environmental factors play an important role in the development of the disorder (Carpenter et al., 2013). Gene-environment interactions provide a framework for understanding how genetic and environmental factors may interact to increase the risk for BPD and highlight the importance of early intervention and prevention efforts, that address both genetic and environmental risk factors (Distel et al., 2011). Gene-environment interaction refers to the idea that genetic factors and environmental factors interact to influence the development of a particular trait or disorder.

A study published in 2004 (Tsuang et al., 2004) investigated the role of gene-environment interactions in the development of BPD. The study found that individuals with a genetic predisposition to BPD were more likely to develop the disorder if they experienced childhood maltreatment. Another example of gene-environment interaction in BPD comes from a study published in the journal

Psychological Medicine in 2014 (Cicchetti et al., 2014). Specifically, individuals with a particular variant of the oxytocin receptor gene (OXTR) were shown to have accentuated BPD symptoms if they experienced childhood trauma, emotional neglect, or abuse during childhood.

In terms of biology, researchers have identified differences in brain structure and function in individuals with BPD. An example is set by some alterations found in the amygdala, a brain region involved in emotional processing, and the prefrontal cortex, which is involved in decision-making and impulse control (Lis et al., 2007). These changes could contribute to the emotional dysregulation and impulsive behaviour that are characteristic of BPD. Individuals with BPD may also have abnormalities in their levels of certain neurotransmitters, such as serotonin and dopamine, which are involved in mood regulation and reward processing. These neurotransmitter imbalances seem to contribute to the emotional instability and impulsivity seen in BPD. A study conducted in 2014 (Iofrida, Palumbo & Pellegrini, 2014) examined the association between specific genes and BPD. The study found that certain variants of the serotonin transporter gene (SLC6A4) and the dopamine D4 receptor gene (DRD4) were more common in individuals with BPD compared to healthy controls, suggesting that these genes may be involved in the development of the disorder.

A case report published in the Journal of Psychiatric Practice in 2019 described the successful treatment of an individual with BPD using a medication called lamotrigine. The medication, which is typically used to treat seizures and bipolar disorder, was found to reduce the severity of BPD symptoms, suggesting that the disorder may have a biological basis that can be targeted with medication (Naguy & Al-Enezi, 2019).

Other studies have focused on the following characteristics of BDP:

- Brain structure and function. Research using magnetic resonance imaging (MRI or fMRI) to investigate brain structure in individuals with BPD compared to healthy controls, found that they had 13% reduced volume in regions of the brain involved in emotional regulation, including the amygdala and anterior cingulate cortex (Ruocco et al., 2013). In the following years, another study found that individuals with BPD had altered activity in regions of the brain involved in emotion processing and self-referential processing, suggesting that these brain abnormalities may contribute to the symptoms of BPD (O'Neill et al., 2015; Schultze et al., 2016). Moreover, it appeared that individuals with BPD had reduced grey matter volume (Hazlett et al., 2005) in regions of the brain involved in emotional regulation and impulse control (Aguilar-Ortiz, 2018).

- Neurotransmitter systems. Many researchers have investigated alterations in neurotransmitter systems in individuals with BPD compared to healthy controls. A study found that individuals with BPD had altered levels of several neurotransmitters, including serotonin and dopamine, which are involved in mood regulation and reward processing (Friedel, 2004). Another study found that individuals with BPD had increased levels of glutamate, an excitatory neurotransmitter, in regions of the brain involved in emotional regulation (Hoerst et al., 2010).

- Stress response system. A study published in 2011 investigated alterations in the stress response system in individuals with BPD compared to healthy controls (Simeon et al., 2011). The study found that individuals with BPD had a blunted cortisol response to stress, suggesting that the stress response system may be dysregulated in BPD.

The exact percentages of genetic and biological factors in the development of BPD are difficult to determine, as the disorder is complex and likely influenced by a

range of genetic and environmental factors. Biology can help understand the underlying mechanisms that contribute to developing and expressing this complex mental health condition. By studying the biological and genetic factors that may contribute to BPD, researchers can gain insight into the brain structures, circuits, and chemical messengers that play a role in the disorder. Moreover, understanding the biological underpinnings of BPD can help clinicians and researchers develop more effective treatments and interventions that target specific aspects of the disorder. Researchers may be able to identify individuals who are at increased risk of developing the disorder. This could lead to earlier identification and intervention, which may result in better outcomes for individuals with BPD.

Psychological factors may also contribute to the development of BPD, which has been strongly associated with a history of childhood trauma, such as physical (Sansone et al., 2002), emotional (Harned et al., 2008), or sexual abuse (Johnson et al., 1999). Individuals with BPD may also have difficulty regulating emotions, experiencing intense and rapidly shifting moods, and engaging in impulsive behaviours. They may have a pervasive sense of emptiness and feel disconnected from themselves and others (APA, 2013).

Childhood trauma, such as emotional, physical, or sexual abuse, has been linked to the development of BPD as being one of the strongest predictors of its symptoms (Trull et al., 2011). Trauma in childhood can lead to emotional dysregulation, difficulties in attachment, and problems with self-identity, which are all hallmark features of BPD. A study published in the *Journal of Personality Disorders* found that individuals with BPD reported significantly more childhood trauma than individuals without it. Specifically, the study found that emotional abuse and neglect were strongly associated with BPD, as well as physical and sexual abuse. The severity of abuse can positively correlate with the severity of BPD symptoms (Zanarini et al., 1997).

Research suggests that as many as 60-70% of individuals with BPD have a history of childhood trauma. It can disrupt normal emotional development and can make it difficult for individuals to regulate their emotions in healthy ways. This can lead to intense and rapidly shifting emotions that are difficult to manage, which is a characteristic feature of BPD. People who have experienced trauma in childhood may have difficulties in trusting others, forming, and maintaining relationships, may struggle with intimacy, and may have a distorted sense of self. Addressing trauma in treatment is often an important aspect of recovery for individuals with BPD, and trauma-focused therapies such as dialectical behaviour therapy (DBT) and eye movement desensitization and reprocessing (EMDR) can help address the effects of childhood trauma. It is important to note, however, that not all individuals with BPD have experienced childhood trauma, and not all individuals who have experienced childhood trauma develop BPD.

Generally, people with BPD suffer from maladaptive patterns of thinking that are most known as cognitive distortions (Barnow et al., 2010). We can find black-and-white thinking, more negative self-beliefs, higher levels of cognitive distortions than individuals without the disorder, overgeneralization, or personalization (Giesen-Bloo et al., 2006). These cognitive distortions can contribute to, and are associated with, higher levels of emotional dysregulation and impulsivity (Levy et al., 2018). As a result of research (Sinnaeve et al, 2018), it has been shown that cognitive distortion can operate as a mediator between childhood trauma and BPD symptoms and their development or maintenance. This will lead to more difficulties associated with interpersonal relationships than any individual with other personality disorders (Fossati et al., 2005).

Emotional dysregulation is a central feature of BPD and can lead to difficulties in managing emotions, impulsivity, and unstable relationships. It appeared to stem from a combination of biological vulnerability and invalidating environmental factors

(Linehan, 1993). The impulsivity factor is key to evaluating and predicting suicidal behaviours (Yen et al., 2021). A study from 2015 (Kuo et al., 2015) found that emotional dysregulation mediated the relationship between invalidating environments and both BPD symptoms and suicide risk in adolescents (Soloff et al., 2015).

Additionally, it appeared that individuals with BPD who engaged in impulsive and self-destructive behaviours had greater levels of emotional dysregulation than individuals with BPD who did not engage in these behaviours. The effects of emotional dysregulation are experiencing intense and rapidly shifting emotions that are difficult to manage and this dysregulation is associated with more severe BPD symptoms and greater levels of functional impairment (Gratz et al., 2006).

Social factors may also play a role in the development of BPD. Individuals with BPD often report unstable relationships, including difficulties with attachment and interpersonal relationships, such as problems with trust, fear of abandonment, and rejection (Bohus et al., 2000). They may also experience social isolation and have difficulties with employment and education. Invalidating environments, such as those where emotions are dismissed or punished, can lead to the development of BPD. An example of an invalidating environment is one in which an individual's emotional experiences are dismissed, ignored, or invalidated by others, such as parents, caregivers, or peers. It can take many forms, including denying or minimizing an individual's feelings, telling them how they "should" feel, or punishing them for expressing their emotions, especially during childhood (Smolewska, 2012). Invalidation can lead to feelings of self-doubt, low self-esteem, and an inability to regulate emotions (Gratz et al., 2002).

Therefore, individuals may learn to distrust their own emotional experiences and may develop difficulties regulating their emotions in healthy ways, being more vulnerable to negative emotional cues (Beauchaine et al., 2009). Addressing

invalidation in therapy, such as through validation-focused therapy, may be an important aspect of BPD treatment.

People with BPD may experience social isolation and rejection due to their difficulties in interpersonal relationships. Social isolation can exacerbate symptoms of BPD, leading the individuals to be the centre of discrimination and marginalization (Bodner et al., 2011), heightening the suicide risk percentage, mostly in adolescents (Kuo et al., 2015). It also can serve as a predictor of suicide attempts among individuals with BPD (Muehlenkamp et al., 2004).

Social isolation and loneliness are common problems among individuals with BPD, reportedly associated with greater levels of depression and anxiety (Nenov-Matt et al., 2020). This may contribute to the development and maintenance of the disorder. A study by Sharp et al. (2015) found that social isolation was associated with more severe BPD symptoms and greater levels of distress in a sample of individuals with BPD and another study by Huh et al. (2017), highlighted the importance of tracking and considering the interplay of social isolation, loneliness, and emotion dysregulation.

These studies suggest that social isolation and loneliness may be important factors to consider in the assessment and treatment of BPD and that addressing these problems in therapy may improve outcomes. Interventions such as group therapy, social skills training, and mindfulness-based approaches may help address social isolation and loneliness in individuals with BPD, whereas a lack of social support is associated with poorer outcomes in these types of therapy programs (Beeney, Hallquist, Clifton, Lazarus & Pilkonis, 2018).

A study published in the *Journal of Abnormal Psychology* found that individuals with BPD reported more negative family experiences than individuals without it. Specifically, the study found that BPD was associated with high levels of family

conflict and low levels of family cohesion, supporting the importance of the role of the family (Cohen et al., 2008).

One prominent theory is the biosocial theory, proposed by Linehan (1993), which posits that the development of BPD is a result of a biological vulnerability to emotional dysregulation combined with an invalidating environment. These aspects can act as both triggers and predictors in the future development of BPD in adolescents (Sharp et al., 2016).

Finally, another key aspect to take into consideration whilst talking about BPD is attachment style. Attachment styles refer to the way individuals form and maintain emotional bonds with others, and this can shape an individual's ability to form and maintain healthy relationships throughout their lifetime. The concept of attachment style was first introduced by psychologist John Bowlby, who developed the attachment theory in the 1950s and 1960s and defined it as a "lasting psychological connectedness between human beings" (Bowlby, 1969, p. 194). Bowlby's work focused on the importance of early childhood relationships in shaping an individual's attachment style and the impact this could have on their emotional and social development throughout their life.

Since Bowlby's initial work, many other researchers and psychologists have contributed to the understanding of attachment style. Mary Ainsworth (1970) developed the Strange Situation experiment to assess infants' attachment to their caregivers (Ainsworth et al., 1978), finding a solid ground for her previous studies, which led to the conclusion that "attachment is not coincident with attachment behaviour" and, "attachment behaviour is heightened in situations perceived as threatening" (Ainsworth & Bell, 1970, p. 64).

The attachment styles were divided into four categories: secure, adults with secure attachment are effective in communicating their feelings and thoughts and tend

to be strong-goal oriented; avoidant, to feel in control individuals tend to be very independent and not rely on others; anxious, individuals fear abandonment and can easily be jealous of the significant other in the relationship because of their low self-esteem, leading them to become a clingy person; and disorganized, implies a lack of coherence in one's social behaviour incorporating both anxious and avoidant styles (Lingiardi & Gazzillo, 2014).

There are several theories and studies that have examined the relationship between attachment style and BPD, in each of which the most frequent pattern emerged as insecure attachment style (Levy et al., 2005), disorganized attachment style (Scott et al., 2013), anxiety and avoidant attachment paired with functional impairment (Scala et al., 2018) and romantic attachment (Smith & South, 2020). A study from 2022 (Erkoreka et al., 2022) found that attachment anxiety mediated the relationship between childhood maltreatment and BPD symptoms.

The mentalization-based theory (MBT), proposed by Fonagy and Bateman (Fonagy & Bateman, 2008), suggests that individuals with BPD have difficulties with mentalizing, or the ability to understand their own and others' mental states. This difficulty with mentalizing may result from an insecure attachment style, particularly a disorganized attachment style, which is characterized by a lack of coherent strategies for coping with stress and regulating emotions. These are important factors to consider in the assessment and treatment of BPD.

Overall, the biopsychosocial model of BPD recognizes that the disorder is the result of a complex interplay between biological, psychological, and social factors. This model highlights the need for a holistic approach to the diagnosis and treatment of BPD, addressing not only the individual's symptoms but also their social and environmental context (Paris, 2020).

## 1.3 Assessment and Treatment.

Despite the challenges associated with BPD, effective treatments are available. A range of psychotherapeutic approaches, such as Dialectical Behaviour Therapy (DBT), Cognitive Behavioural Therapy (CBT), and psychodynamic therapy, seems to be effective in reducing symptoms and improving the quality of life for individuals with BPD.

Studies have shown, in particular the McLean Study of Adult Development, that is possible for a patient, who is carefully following a tailored process to obtain "a good vocational adjustment and overall recovery" (Zanarini, Frankenburg, Reich & Fitzmaurice, 2010, sec. Discussion).

1. Transference-based psychotherapy (TFP). TFP is centred on the way the patient experiences the relationship with the clinician, to foster a differentiation between representations of self and others and greater integration of representations. Individuals with BPD have difficulty with object constancy, which means they struggle to maintain a stable sense of self and others over time (Cohen & Sherwood, 1989). This can lead to intense and unstable relationships, fear of abandonment, and difficulty regulating emotions. The therapist seeks to address this by focusing on the transference, or the individual's feelings and reactions towards the therapist.

The therapy is typically conducted on a twice-weekly basis and is highly structured (Doering, et al., 2010). The aim is to help individuals understand and change maladaptive patterns of thinking, feeling, and behaviour that contribute to their emotional dysregulation and interpersonal difficulties (Levy, Draijer, Kivity, et al., 2019).

2. Schema-focused therapy. This is a therapy created by Dr. Jeffrey Young that focuses on identifying and changing patterns of thoughts and behaviours

called "schemas." Schemas are core beliefs or themes about oneself, others, and the world that are developed early in life and often continue to influence an individual's thoughts, feelings, and behaviours into adulthood. They can be either adaptive or maladaptive: adaptive schemas are healthy beliefs that allow individuals to function well in the world, while maladaptive schemas are unhealthy beliefs that lead to dysfunctional patterns of thoughts and behaviours. The ultimate aim of this therapy is to identify and change maladaptive schemas through a variety of techniques, including cognitive restructuring, experiential exercises, and behavioural techniques (Young, 1999). It is a long-term treatment that involves weekly sessions over several months or years where the therapist works with the individual to identify more adaptive ways of thinking and behaving that can help to replace the maladaptive schemas. It also focuses on emotional regulation and interpersonal skills, as individuals with BPD often struggle with these areas. The therapy may include techniques such as role-playing, imagery, and other experiential exercises to help the individual learn new skills and develop more adaptive patterns of behaviours (Young, Klosko & Weishaar, 2003).

3. Systems Training for Emotional Predictability and Problem-Solving (STEPPS). STEPPS is a group-based treatment approach designed for individuals who may not have access to or may not be ready for, individual psychotherapy. The program is structured and time-limited, typically lasting for 20 weeks, and combines psychoeducation with skills training. The idea behind this is that symptoms arise from an interplay of individual and environmental factors, including family and social networks, and these can either support or undermine emotional stability and problem-solving skills. It aims to help individuals develop skills and strategies to manage their emotions, improve interpersonal relationships, and solve problems effectively (Blum, Pfohl, St. John, Monahan, & Black, 2002).

It is led by a trained therapist who guides group members through a curriculum that includes a combination of cognitive-behavioural therapy (CBT), dialectical behaviours therapy (DBT), and social skills training. STEPPS consists of seven modules that cover understanding and managing emotions (Emotional Regulation), practising awareness of the present moment (Mindfulness), improving communication and relationships (Interpersonal Effectiveness), coping with intense emotions and crises (Distress Tolerance), identifying and solving problems effectively (Problem-Solving), improving relationship satisfaction (Relationship Effectiveness), self-esteem, building self-confidence and self-worth (Ekiz, Van Alphen, Ouwens, Van de Paar, & Videler, 2023). The STEPPS program is based on empirical research and is effective in reducing BPD symptoms, improving emotional regulation, and enhancing interpersonal relationships (Blum, St John, Pfohl, Stuart, McCormick, Allen, Arndt, & Black, 2008). Additionally, the group format provides social support and validation for individuals with BPD, which can be particularly beneficial for those who may feel isolated or misunderstood.

4. Mentalization-based psychotherapy (MBT). MBT is a method created by Peter Fonagy and it represents an intervention model that, in the most severe cases, is based on partial hospitalization and psychotherapy, both group and individual, focusing on extending and strengthening the patient's mentalization (Linehan & Wilks, 2015). It is not only suitable for adults but is also recommended for children and young people. To measure its effectiveness, some clinical trials have shown improvement in BPD patients even after years later the end of the treatment, specifically a better control of the impulses and relationship with others (Tavistock and Portman, s.d.) and this may be effective because the patient is constantly encouraged to reflect on their very angry impulse to understand the international process behind (Ruggiero, 2013).

5. Dialectical behavioural therapy (DBT). This treatment was born of personal experience since Masha Linehan herself was once a 17-year-old suicidal girl who was wrongly diagnosed as schizophrenic instead of borderline (Redmayne, 2020). It synthesizes the psychodynamic and cognitive-behavioural approaches. It has the main aim of correcting cognitive distortions, encouraging acceptance of emotional states, and reinforcing positive aspects of the patient. The therapist has the task of teaching certain skills to control emotionality and limit any maladaptive behaviours (e.g. through mindfulness techniques) (Daubney & Bateman, 2015). Probably due to it being based on her own experience, this therapy now can count as having one of the highest rates of recovery (Redmayne, 2020).

Patients need therapeutic relationships with well-defined boundaries and structures, facilitating the expression and communication of effects. "Creating a safe environment while firmly establishing boundaries within the patient-provider relationship is critical when treating patients with BPD. However, setting boundaries in a way that simultaneously reinforces the therapeutic alliance can be challenging" (Wu, Hu, Davydow, Huang, Spottswood, Huang, 2022, p. 3).

To create a more effective relationship between the therapist and the patient is important to provide a safe space, using warm and welcoming language; doing so will allow the patient to find themselves in a non-judgmental space, contributing to the creation of the fundament of trust in the relation therapist-patient (Menschner & Maul, 2016).

If the treatment initiated seems not to be sufficient, it may be helpful to combine pharmacotherapy. Even if it is not the first-line treatment for BPD, as psychotherapy is the primary approach, medication may be prescribed in certain situations to help manage specific symptoms associated with BPD, such as depression, anxiety, mood instability, or impulsivity (Mayo Clinic, n.d). At a macro-level, the main prescriptions

used are divided into three categories, antidepressants, mood stabilizers, and antipsychotics, each of which is used for a specific purpose.

Antidepressants are predominantly used to treat major depressive disorders and any other disorders characterized by a low mood or anxiety, but due to BPD's high rates of comorbidity with these symptoms, they could be used as well to decrease its symptoms. Most used antidepressants are part of three categories: tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), and selective serotonin reuptake inhibitors (SSRIs) (Zanarini, Frankenburg, Reich, Harned & Fitzmaurice, 2015), which include Effexor (venlafaxine), Nardil (phenelzine), Prozac (fluoxetine), Wellbutrin (bupropion) and Zoloft (sertraline) (Salters-Pedneault, 2023).

Mood stabilizers are medications used to treat bipolar disorder, but they can also be effective in treating symptoms of impulsivity and emotional instability associated with BPD. Lithium (Lithobid) and some anticonvulsants, such as Lamictal (lamotrigine), Depakote (valproate), or Tegretol (carbamazepine), are commonly used mood stabilizers (Salters-Pedneault, 2023). Antipsychotic medications may be prescribed to individuals with BPD who experience symptoms of psychosis, such as hallucinations or delusions, or severe mood instability (Ripoll, 2013). Atypical antipsychotics, such as risperidone, olanzapine, and aripiprazole, are often used to treat BPD (Salters-Pedneault, 2023). Anxiolytics also known as Anti-Anxiety Drugs do not appear as often prescribed as other types of medicine used.

However, they may be useful because they can alleviate some symptoms of anxiety. The most commons ones are Ativan (lorazepam), Buspar (buspirone), Klonopin (clonazepam), Valium (diazepam), Xanax (alprazolam) (Salters-Pedneault, 2023). As regards the use of such drugs, the prescription rates of drug classes for BPD patients show that between 2001 and 2011 both antidepressants and antipsychotics were prescribed on average at a steady rate of 70.3% and 68.7%, as were

anticonvulsants and lithium, at a rate of 31.5% and 4.7%, respectively. In contrast, the use of hypnotics significantly decreased from 21.4% (mean 2001–2003) to 14.6% (mean 2009–2011). Tranquillizers also showed a decreasing statistical trend from 34.1% (mean 2001–2003) to 25.8% (mean 2009–2011) (Bridler, Häberle, Müller, Cattapan, Grohmann, Toto, Kasper & Greil, 2015, sec. Prescription rates of psychotropic drugs).

It is a widely recognized belief that medication should always be used in conjunction with psychotherapy and other forms of treatment for BPD. Notably, some side effects may be considered beforehand such as dizziness, allergic reactions, sedation, dry mouth, constipation, and weight gain (Gartlehner, Crotty, Kennedy, Edlund, Ali, Siddiqui, Fortman, Wines, Persad & Viswanathan, 2021). Studies have shown that benzodiazepines can affect one's risk of suicide and worsen the ability to control aggressiveness and some self-damaging impulses (Dodds, 2017).

Medication should be carefully monitored by a mental health professional to ensure safety and effectiveness.

At least 96% of the population suffering from BPD get at least one psychotropic medicine, although a systematic review shows that no medication is seen as a thorough solution and has been approved by the Food and Drug Administration for the treatment of BPD (Gartlehner et al., 2021). An example to support the statement that medication may not be sufficient nor effective in treating BPD is the feeling of anxiety experienced in BPD patients. Anxiety is one of the most challenging symptoms to treat. What happens is that the patient relates their inner experiences to anxiety and by doing that they could mislabel in terms of what would be a result of fear. BPD patients fear abandonment and being alone. This is what the feeling might mislead them to think they experience anxiety. The difficult part is to reconnect them to their real symptoms, which is "attachment-related anxiety" (Chapman, Jamil & Fleisher,

2023). In this case, pharmacotherapies could operate poorly in working toward the resolution of the state.

Moreover, "current antidepressants may not efficiently target the receptors or mesocorticolimbic brain regions associated with clinically significant amygdala hyper-reactivity. Limited therapeutic effectiveness of antidepressants in BPD may be related to lack of serotonin receptor specificity" (Ripoll, 2013, p. 216). While medication may alleviate some symptoms and decrease their worsening, a systematic review and meta-analysis conducted in 2021 affirms "the evidence indicates that the efficacy of pharmacotherapies for the treatment of BPD is limited" and "despite the use of pharmacotherapies for patients with BPD, the available evidence does not support the efficacy of pharmacotherapies alone to reduce the severity of BPD" (Gartlehner et al., 2021, p. 1).

In terms of diagnoses, assessments, and treatments a systematic scoping review conducted in 2022 also affirms that:

> Substantially more research attention has been given to overall sex differences in baseline BPD symptoms and comorbid disorders. In contrast, there is a dearth of sex-related research about treatment outcomes, developmental factors, and possible biological markers of BPD (Qian et al., 2022, abstract).

The following chapters will look in more detail at the relationship between sex, gender and sexuality, and how research has been conducted into the correlation between BPD and these variables.

# Chapter Two: Sex, sexuality, and gender. Commonly confused concepts and constructs.

Studies on sex, gender, and sexuality have become increasingly widespread in contemporary academic discourse, reflecting society's growing recognition and appreciation of diverse human experiences and identities. These interconnected concepts encompass multifaceted dimensions that shape individuals' personal, social, and cultural identities and their relationships and interactions within broader contexts.

This chapter aims to provide a broad overview of sex, gender, and sexuality, setting the stage for a comprehensive exploration of their intricacies and implications within contemporary academic discourse. Exploring sex goes beyond simplistic binary male and female distinctions and encompasses complex biological traits and sociocultural factors, recognizing a multiplicity of variables involved in categorizing and determining sex, acknowledging the existence of intersex individuals, and highlighting the need for recognizing and respecting unique identities. Understanding gender and the concept of gender identity is crucial for acknowledging the spectrum of gender experiences, embracing individuals who may not conform to traditional gender norms, and advocating for their rights and well-being. In the same way, understanding sexuality entails recognizing the vast range of sexual orientations, desires, and preferences that individuals may possess, fostering a more inclusive and non-judgmental society.

By examining these interrelated concepts and constructs, researchers and practitioners can contribute to the creation of more comprehensive and inclusive theoretical frameworks, policies, and practices that celebrate diversity and promote

equality for all individuals, regardless of their sex, gender identity, or sexuality, going beyond the automatic assumption of binary sex and the presumed normality of heterosexuality and the gender stereotypes that ensue. Moreover, by doing so, psychologists working in fields such as borderline personality disorder can better recognize the complexity and the risks involved in making correlations between sex, gender, sexuality, and BDP in terms of diagnoses, assessment, and treatment.

## 2.1 Defining biological sex.

Sex refers to the biological characteristics that categorize individuals as male, female, or intersex, while sexuality encompasses an individual's sexual orientation, desires, and preferences. Biological sex refers to the classification of individuals into male or female based on their sexual and reproductive anatomy, chromosomal patterns, and hormone levels. It encloses physical attributes such as genitalia, secondary sexual characteristics, and genetic composition. While binary categorizations of male and female are commonly used, it is essential to acknowledge the existence of intersex variations, where individuals possess biological characteristics that do not neatly fit into the traditional male or female classifications.

All human individuals—whether they have an XX, an XY, or an atypical sex chromosome combination—begin development from the same starting point. During early development the gonads of the foetus remain undifferentiated; that is, all foetal genitalia are the same and are phenotypically female. After approximately 6 to 7 weeks of gestation, however, the expression of a gene on the Y chromosome induces changes that result in the development of the testes. Thus, this gene is singularly important in inducing testis development. The production of testosterone at about 9 weeks of

gestation results in the development of the reproductive tract and the masculinization (the normal development of male sex characteristics) of genitalia. In contrast to the role of the foetal testis in the differentiation of a male genital tract and external genitalia in utero, foetal ovarian secretions are not required for female sex differentiation. The basic differences between the sexes begin in the womb and these develop and change throughout the lifetime. Sex can indeed be highly complicated. While at the level of common knowledge, it is considered that chromosome Y is the factor that determines if an individual is male or female, experts steer away from this view:

> Doctors have long known that some people straddle the boundary- their sex chromosomes say one thing, but their gonads (ovaries or testes) or sexual anatomy say another. Parents of children with these kinds of conditions – known as intersex conditions, or differences or disorders of sex development (DSDs) – often face difficult decisions about whether to bring up their child as a boy or a girl. Some researchers now say that as many as 1 person in 100 has some form of DSD (Ainsworth & Nature Magazine, 2018, para. 2).

As a professor at University College London's Institute of Child Health John Achermann stated, "I think there's much greater diversity within male or female, and there is certainly an area of overlap where some people can't easily define themselves within the binary structure". (Ainsworth, 2015, para. 1). In fact, femaleness or maleness is not entirely determined by features such as chromosomes, genes, hormones, vulvas, or penises, and that is because many more aspects play an important role in the organism's development. Not many people consider that:

> During these processes a lot can happen that makes the organism diverge from the usual path (thereby creating diversity which evolution can act upon), but this does not question the biological definition of sex. A prominent example of this

misunderstanding is a news feature published in Nature that summarizes chromosomal and gene regulatory processes resulting in ambiguous sexual differentiation in humans and other mammals. The subtitle of this article states that the idea of two sexes is simplistic. Biologists now think there is a wider spectrum than that, thereby confusing sex with sexual differentiation or sexual development (Goymann et al., 2022, para. 1).

The human genome contains an estimated number of 40.000 genes (protein-coding and RNA) (De Vita, 2022) and this conclusion has come about as a result of countless genetic studies carried out in recent years. Therefore, it can be inferred that both males and females may have very slight differences when it comes to genomic sequences, and this could result in differences within-sexes and between-sexes. Specifically at the level of DNA, there are subsequent variations in autosomes between individuals, but not enough to differ based on the sex of the individual. However, some male-specific and female-specific factors can affect their cells in terms of their biochemistry, as in Figure 1.

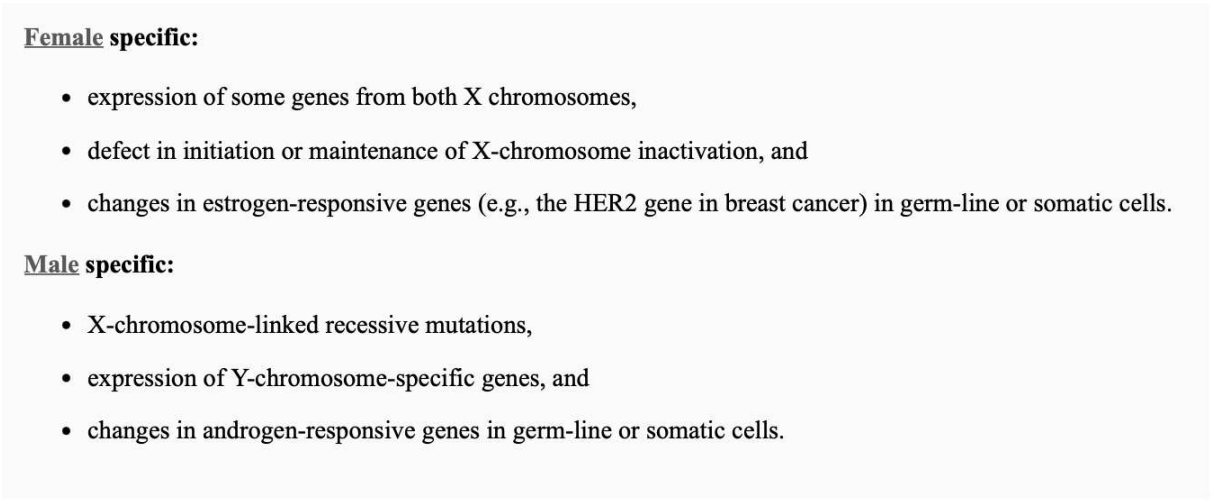


Figure 1. Genetic factors that may differentially affect the basic biochemistry of male and female cells. Source: National Academies Press (2021)

As can be seen, Y chromosomes (SRY) are exclusively expressed in males and this is the reason why they develop male gonadal phenotypes, while X chromosomes are expressed both in females and males but at a higher rate (almost double) in females than in males. Moreover, hormonal differences may influence the expression of genes and sexual dimorphism can be a result of this process. Scientists who support this view believe that "a single gene can have a large effect on the organism that carries that gene" and it could be imaginable that "females and male cells will not differ in at least some aspects of basic biochemistry, given the complexity of most biological pathways." (National Academies Press (US), 2001, para. 3).

"Some differences originate in events occurring in the intrauterine environment, where developmental processes differentially organize tissues for later activation in the male or female" (Institute of Medicine, 2001, p. 45). At the inception of development, all human individuals—regardless of possessing an XX, an XY, or an atypical sex chromosome combination—commence from a single starting point. In the early stages, the gonads of the foetus remain undifferentiated, meaning that all foetal genitalia are initially phenotypically female. However, around six to seven weeks into gestation, a pivotal event occurs – the expression of a gene on the Y chromosome induces changes that lead to the development of the testes. This gene plays a singularly crucial role in initiating this development. Subsequently, around the ninth week of gestation, the production of testosterone ensues, influencing the development of the reproductive tract and initiating the masculinization process, which involves the normal development of male sex characteristics in both the brain and the genitalia.

In contrast to the active role of the foetal testis in differentiating the male genital tract and external genitalia in the uterus, foetal ovarian secretions are not a prerequisite for female sex differentiation. This underscores that while the fundamental differences between the sexes originate from the womb, the mechanism and requirements for

differentiation are distinct. Moreover, these sex differences manifest themselves, evolve, and persist across the lifespan.

In the evolution of vertebrate animals, diverse species have developed unique pathways to determine sex. What is particularly intriguing is that, despite these varied mechanisms, a common thread is present. Across all species, two distinct sexes emerge, each assigned unique roles in both social and reproductive aspects of their lives. The genetic foundation of sex finds its roots in meiosis, a fundamental process where paired chromosomes undergo separation. This intricate interplay of genetic and environmental factors underscores the fascinating diversity and commonality in the determination of sex across the animal kingdom.

At the moment of conception, sex determination and sex differentiation initiate as sequential processes. The first step involves establishing chromosomal sex in the zygote, followed by the determination of gonadal sex based on genetic factors. After that, phenotypic sex is defined by the developed gonads. As puberty unfolds, secondary sexual characteristics emerge, serving to reinforce and visibly manifest sexual dimorphism. Sex determination primarily regulates the development of primary or gonadal sex, while sex differentiation encompasses event post-gonadal organogenesis (referring to testes, and ovaries). Over seventy genes, located on both sex chromosomes and autosomes, orchestrate these processes. They employ diverse mechanisms involving organizing factors, gonadal steroids, peptide hormones, and tissue receptors. It's noteworthy that mammalian embryos maintain sexual neutrality until the critical juncture of sex determination. Early embryos of both sexes share common primordia with an inherent inclination toward feminization unless actively influenced by masculinizing factors.

Puberty, as a transitional period, is a crucial phase where secondary sexual characteristics appear — "resulting in the striking sexual dimorphism of mature individuals" (Institute of Medicine, 2001, p. 62) — and individuals' psychological patterns become more mature. Adolescence is a coming-of-age stage where the individual gradually starts to differentiate their thought process from the other people surrounding them, but also understands what society is and how to behave in it (social roles both played and interiorized). It is important to recognize how behavioural differences in boys and girls could be associated with a particular level of hormones in their bodies. For example:

> Testosterone has been linked to aggression, competitiveness, and risk-taking behaviours […]. It can encourage assertiveness, but when levels are high, it may contribute to aggressive behaviour and impulsivity. Moreover, low testosterone levels have been associated with feelings of fatigue, depression, and a decrease in overall well-being, adding another layer of complexity to emotional regulation during adolescence. And oestrogen is often referred to as a 'mood-modulator' […]. In essence, when oestrogen levels are optimal, it enhances the effect of serotonin, fostering a positive mood. However, a drop in oestrogen […] can potentially lead to lower serotonin levels, contributing to mood swings, feelings of irritability, sadness, or anxiety. While progesterone can have calming effects due to its influence on GABA, a neurotransmitter with a key role in reducing neuronal excitability, an abrupt drop in progesterone levels can also trigger mood swings and exacerbate feelings of anxiety or depression (Claney, 2023, para. 2).

Through the accumulation of experience during life, an individual passes from adolescence to adulthood. While primary and secondary sexual characteristics are developed by everyone by this stage of life, it is important to recognize that there is

natural variation among individuals, and not all people will conform to these generalizations, feeling different from their assigned sex at birth. Conflict can potentially emerge as soon as the individual can understand and explore their true self.

Sex is thus far more intricate than initially perceived. In the basic narrative, the classification hinges on the presence or absence of a Y chromosome: possessing it makes you male, and lacking it makes you female. Nevertheless, medical professionals have long been aware that certain individuals straddle this line—where their sex chromosomes convey one message, but their gonads (ovaries or testes) or sexual anatomy tell a different story. Parents faced with children experiencing intersex conditions or differences/disorders of sex development (DSDs) often find themselves wrestling with difficult choices regarding how to nurture their children, deciding whether to raise them as a boy or a girl. Recent research suggests that as many as 1 in 100 individuals may have some form of DSD (Ainsworth, 2015, p. 2).

Society has yet to catch up with the more nuanced view of sex that biologists have been constructing. Societal acceptance and approval of individuals breaking conventional boundaries in appearance, profession, and the choice of their partners, has not completely extended to the realm of sex and the complex and often confused psychosocial and sociocultural dimensions of sexuality and gender. The pressure to conform to the binary model remains intense, leading to an increasing incidence of individuals deciding to undergo surgical procedures and intervention to rearrange their genitals.

> Such surgery is controversial because it is usually performed on babies, who are too young to consent and risks assigning a sex at odds with the child's ultimate gender identity—their sense of their gender. Intersex advocacy groups have

> therefore argued that doctors and parents should at least wait until a child is enough to communicate their gender identity, which typically manifests around the age of three, or old enough to decide whether they want surgery at all (Ainsworth, 2015, para. 5).

## 2.2 The sociocultural construct of gender.

The relationship between biological sex and gender as a sociocultural construct is complex and by no means dealt with in a univocal way in a by now vast literature. These terms are often confused both within the scientific literature and in the popular press. Moreover, their use varies according to different disciplines, authors, public opinion beliefs, and many other variables, and has also been subject to change over time. Early use of the word gender was synonymous with biological sex. Indeed:

> According to The Oxford English Dictionary, the word gender had been used as early as the 1300s to describe categories of people. The Oxford English Dictionary's earliest record of using the word to specifically refer to men or women, though, did not occur until 1474 when someone used it in a letter to describe what the writer refers to as the masculine gender. Over the next centuries, when gender was used to refer to men or women, it was often synonymous with biological sex. […] According to the Merriam-Webster Dictionary, during the early twentieth century, the word sex became more associated with sexual intercourse. As discussions of sexual intercourse are largely taboo in the US, people began to use the word gender in its place to refer to a person's status as a male or female by the end of the twentieth century, a practice that is still largely common as of 2022 (Schnebly, 2022, p. 2).

Despite this terminological confusion, the majority of scholars working in the field of gender studies share the perspective that gender is a sociocultural construct built on sexual identity and sexual orientation, both of which tend to be assumed from the sex assigned at birth and have historically been determined by norms based on heterosexual orientation and consequent family organization, together with many other stereotypical behaviours and roles associated with masculinity or femininity.

In one of the first attempts to treat the distinction between sex and gender from a feminist perspective, Simone de Beauvoir states that "one is not born, but rather, becomes a woman" (Butler, 1986). As her assertion makes clear, being female and being woman are completely different things which "implies a radical heteronomy of natural bodies and constructed genders" (p. 00). In other pioneering work in the 1950s, Money combined his research as a psychologist and sexologist to study sex as a biological characteristic and gender as a sociocultural construct, thereby totally reframing the latter term's former meaning while creating a framework for research in the domain of sexology and establishing it as a scientific discipline (Bullough, 2003).

As the title of Terry Goldie's bestseller The Man Who Invented the Word Gender suggests, many see Money as the founder of gender studies. Hermaphroditism, Gender, and Precocity in Hyperadrenocorticism: Psychologic findings is Money's first introduction to the concept of gender as it has come to be seen, i.e., associated with a human characteristic. For Money, a gender role is "all the ways a person discloses themselves as being a man or woman" (Schnebly, 2022, sec. 8).

From at least the time of the Ancient Greeks onwards, scientists and philosophers have debated the relationship between nature and nurture. While nature focuses primarily on our evolutionary inheritance, our biology, and our genetic

makeup, as the primary moulder of our development (Cherry, 2022), nurture considers how social and environmental factors constantly intrude into one's life and shape every aspect of our personality, for example, in terms of how parents raise their children or how the community people live in influence them in terms of social norms. As a result of Money's pioneering work, various issues related to this dualism of nature versus nurture have arisen and have been the object of attention of increasing numbers of scholars and researchers.

As the issue of gender slowly came more and more to the foreground in social behaviours and public debate, Robert J. Stroller, an academic and psychiatrist, together with his colleague Ralph Renson. consolidated and developed Money's ideas, until the moment when the term gender identity made its first appearance during the 1963 Psychoanalytic Congress in Stockholm. They defined gender identity as a feeling of belonging to one biological sex, rather than another, whereas gender role concerns the way people act in society and how they carry themselves around other people (Parker & Aggleton, 1999; Schnebly, 2022).

Judith Butler's work seeks to reinterpret gender in terms of an emerging social context in which there was an increasing focus on delving deeper into gender and social issues. She proposes "that gender is not biological, but performative. The term performativity does not simply mean performance". People tend to reproduce gender:

> Not only through repeated ways of speaking but also of doing. We dress in certain ways, do certain exercises at the gym, use body language, visit particular kinds of medical specialists, and so on. Through such repetitions, gender is reinforced, layer by layer, until it seems inescapable (Szorenyi, 2022, para. 2).

In the same vein, Vivien Burr affirms that "gender is the backcloth against which our daily lives are played out. It suffuses our existence so that, like breathing, it becomes invisible to us because of its familiarity" (Burr, 1998, p. 2). In a conversation between Gayle S. Rubin (an American activist, anthropologist, and pioneer of queer and feminist studies) and Judith Butler, they discuss Rubin's latest works, including *The Traffic in Women and Thinking Sex*. As Rubin puts it:

> Our usual understandings posit gender as in some ways binary; even the continuums of gender differences often seem structured by a primary binary opposition. But as soon as you get away from the presumptions of heterosexuality, or a simple hetero-homo opposition, differences in sexual conduct are not very intelligible in terms of binary models (Rubin & Butler, 1994, p. 70,71).

This perspective extends through the 1990s and 2000s as the concept of gender began to be increasingly broadened as a continuum. The term 'transgender' is introduced to indicate a situation of non-conformity with one's assigned gender, referring to a lack of identification with one's biological sex. Not only is it possible to identify as both a transgender woman and a transgender man, but for those who feel the need, there is the option of undergoing surgery on the sexual organs to completely alleviate gender dysphoria.

It is also understandable that observing these types of changes emphasizes collective awareness and their historical and cultural significance. Even though identification and determination play an important role in one's life, meaning the empowerment of individuals' characteristics and qualities and the development of a functional identity (La Guardia, 2009), for others it may lead to general confusion and emotions of nothingness. Since the early 2000s, new categories for gender

identification began to emerge highlighting this feeling, such as 'non-binary', an "umbrella term that includes those whose identity falls outside of or between male and female identities; as a person who can experience both male and female, at different times, or someone who does not experience or want to have a gender identity at all" (Monroe, 2019), a-gender, used by people who reject "the societal gender binary, which is male and female, and do not align themselves with either gender" (Horne, 2023, sec. 2) and gender-fluid, which falls into the spectrum of non-binary and it describe a relatively wide experience of non-confirmative pattern to a fixed gender (possible changes of gender during the day, year and so). (Cuthbert, 2019).

As work in the field of gender studies has progressed, an ever-increasing number of terms have emerged that can be used to describe an individual's gender identity, reflecting a wide variety of cultural settings. As of 2023, researcher Chris Drew affirms that it is possible to count almost 80 cultural terms to describe one's gender, a number which gives concrete embodiment to the + in the common LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual) acronym, as can be seen in Table 1.

Having so many options could also mean that these societal borders are not as heavily distinct as society could let people think. Although labels are an ongoing subject of evolution, paralleling society's newer needs, "they can be a misleading feature in understanding the content and strategy of gender equality politics". (Lombardo, Meier & Verloo, 2009, p. 1) So, after years of debates, a precise and unambiguous definition of what gender is still lacking. Nevertheless, despite this, various positions converge on the definition provided by the World Health Organization, namely that "Gender […] is a social construct that establishes the social norms and roles based on what a society deems appropriate for individuals based on their sex assigned at birth" and it involves "differences and inequalities between

women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities" (Kaufman, Eschliman & Karver, 2023, p. 3, para. Acknowledging diversity).

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| 1. Acault (Myanmar) | Gender from Buddhist people of Myanmar. It describes people who are AMAB (assigned male at birth) who have been possessed by a female spirit god named Manguedon who has imparted femininity to them. Acaults are often seen as wise shamans and seers. |
| 2. AFAB | Assigned female at birth'. It is a gender identity often assigned to people if there is for any reason a need to know a person's birth gender, especially if that person no longer associates with that gender. It acknowledges that birth genders are assigned through cultural inscription. |
| 3. Agender | Agendered people do not have a gender. They are considered genderless or gender-free and do not fit on a masculine-feminine spectrum. |
| 4. Aliagender | Aliagendered people are neither male, female, nor agendered. They are people who experience a gender identity that does not fit on the masculine-feminine spectrum but feel a gendered identity. |
| 5. Alyha and Hwame (Mohave) | The Mohave people of the southwestern United States have two non-cis genders, alyha and hwame. Alyha are male-assigned people who dress and behave like women. Hwame are female-assigned people who dress and behave like men. Both Alyha and Hwame take on traditionally non-gendered roles. |
| 6. AMAB | Assigned male at birth'. Like AFAB, it is a gender identity often assigned to people if there is for any reason a need to know a person's birth gender, especially if that person no longer associates with that gender. It acknowledges that birth genders are assigned through cultural inscription. |
| 7. Androgynous | An androgynous person is neither male nor female. Their identity is considered ambiguous. Often, androgynes express elements of both masculine and feminine identities at different times. |
| 8. Aporagender | Aporagender people are those who do not identify with any specific gender. They may feel that they have no gender, or that their gender is undefined. This can be due to a variety of reasons, such as feeling like one does not fit into any existing gender categories, or feeling like all existing gender categories are equally valid and none stand out as feeling more 'right' than the others. |
| 9. Aravani (India) | The Aravani are people from Tamil Nadu, a state in the south of India. They are people who display femininity in a masculine body but often go through physical transformations, so their bodies match their genders. |

| | |
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| 10. Ashtime (Maale, Ethiopia) | The Ashtime gender from the Maale culture of Ethiopia is a third gender that is neither male nor female. Ashtime people are seen as having special spiritual powers and as being more in tune with the natural world than other people. They often take on traditional roles such as healers, storytellers, and shamans. They were generally assigned male at birth. |
| 11.Burrnesha (Albania) | The Burrnesha gender from Albanian culture has taken a vow of celibacy to live as men. Burrneshas dresses and behaves like men, takes on male roles such as being the head of the household, and often takes a wife. They are more spiritual than other people and are seen as having special powers. |
| 12. Bakla | Bakla are people from the Philippines who are effeminate biological men who dress and behave in ways traditionally associated with women. They are often seen as a third gender, distinct from men and women. |
| 13. Bigender | Bigender people experience two genders, either simultaneously or at different times. These genders can be any combination of male, female, agender, etc. |
| 14. Calabai, Calalai, and Bissu (Indonesia) | Calalai are seen as being born female but take on a masculine role, while Bissu are neither male nor female. Both Calabai and Calalai may undergo surgery to remove their breasts (called 'top surgery'), while Bissu often wear both traditional masculine and feminine clothing. |
| 15. Chuckchi Ne'uchika Shamans (Siberia) | The Chuckchi ne'uchika shamans are assigned male at birth but are believed to have been ordered by a spirit to undergo a gender transformation. They often marry males from the tribe and take on both traditionally male and female roles within the tribe. |
| 16. Cisgender | A cisgendered person is a person who identifies with the same gender as the gender with which they were assigned at birth. |
| 17. Cis Female | A cis female is a female who was assigned the female gender at birth and continues to identify with that gender identity. |
| 18. Cis Male | A cis male is a male who was assigned the male gender at birth and continues to identify with that gender identity. |
| 19. Demiboy | A demiboy is a person who identifies as partially male. They may feel that they are neither fully male nor fully female, or that they are a mix of both genders. Demiboys may or may not undergo hormone therapy or surgery to change their bodies to match their gender identity. |
| 20. Demigender | Demigender people are those who identify as partially male or female. They may feel that they are neither fully male nor fully female, or that they are a mix of both genders. |

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| 21. Demigirl | A demigirl is a person who identifies as partially female. They may feel that they are neither fully male nor fully female, or that they are a mix of both genders. Demigirls may or may not undergo hormone therapy or surgery to change their bodies to match their gender identity. |
| 22. Fa'afafine | Fa'afafine are a third gender in Samoan and Tongan culture. Fa'afafine are born male but identify as female and take on typically female gender roles in society. They play an important role in Samoan families and communities, and their visibility challenges traditional Western notions of gender and sexuality. |
| 23. Fakaleiti | Fakaleiti are a third gender in traditional Polynesian societies. They are biological males who dress and behave in a feminine manner. Fakaleitis often occupy positions of respect and play an important role in Polynesian cultures, serving as healers, seers, mediators, and caretakers. In recent years, the fakaleiti identity has been adopted by many LGBTQ+ people in Polynesia to express their gender and sexuality. |
| 24. Female | The traditional or conservative definition of "female" is a person who is biologically born with ovaries and typically has the capacity to produce eggs. Increasingly, we are defining a female as a person who identifies as a woman, regardless of their biological sex. This is because we're moving toward separating the concepts of biological sex and culturally defined genders. |
| 25. Femme | Femme is a term used to describe a person who identifies as a woman, and/or expresses themselves in a feminine way. Femme can be used as a noun, adjective, or verb. It is often used in the LGBTQIA+ community to describe a lesbian whose comportment is traditionally feminine. |
| 26. Femminiello (Italy) | The femminiello are a third gender from Italy. They are assigned male at birth but typically dress and behave like women. Femminiellos are often seen as lucky charms and are believed to have special powers, such as the ability to ward off evil spirits. Femminielli are sometimes considered to be cross-dressers, androgynous, or even transgender, although most femminielli see themselves as a distinct third gender. |
| 27. Guevedoche (Dominican Republic) | Guevedoche translates to "penis at twelve". There is an ethnic group in remote areas of the Dominican Republic who, through genetic developments, can give birth to children who are born looking like girls but grow male genitalia around age 12. This often leads to gender questioning and gender fluidity as the children age. |
| 28. FTM | FTM is a term used to describe a person who was assigned the female gender at birth but identifies as a man. This acronym stands for 'female-to-male.' |

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| 29. Gender Apathetic | A person who is gender apathetic is someone who does not strongly lean towards identifying with one gender or another. Furthermore, they are often apathetic (or non-committal) about their attraction to one specific gender, meaning they are often bisexual. |
| 30. Gender Fluid | A person who is gender fluid may fluctuate between genders, or they may feel like they are a mix of both genders. In one context, they may identify more strongly as male, but in another context, they may identify more as a female. It is often very much context dependant and may change over time. This is different from being bisexual because gender fluidity is about gender identity, not sexual orientation. |
| 31. Gender Neutral | A person who does not identify as either a man or woman. They may have a non-binary gender identity, or they may simply not identify with any gender, and reject the dualistic thinking of the male-female binary. |
| 32. Gender Nonconforming | A person who does not identify with the traditional gender roles assigned to their biological sex |
| 33. Gender Questioning | someone who is exploring and questioning their own gender identity. This may be a person who is unsure if they are transgender, or it may be a cisgender person who is curious about what it would be like to experience life as the opposite gender. |
| 34. Gender Variant | A gender variant person is someone whose gender expression does not conform to traditional ideas about how men and women are supposed to look and behave. This could be a person who simply expresses their gender in a creative or non-traditional way. |
| 35. Genderqueer | Genderqueer is a term that describes people with non-binary gender identities. Genderqueer people may identify as neither male nor female, or they may identify as a mix of both genders. They may also use gender-neutral pronouns such as them/they, ze/hir, or xe/xem |
| 36. Hermaphrodite | Hermaphrodite is an outdated and now generally disavowed term used to describe people who are intersex. Generally, this term is now strongly discouraged and often used to offend intersex people. The term intersex is now more acceptable. |
| 37. Hijra (Kinnar) | A hijra is a person from South Asia who may be born with male genitalia but identifies as female. Hijras are sometimes considered to be a third gender, and they have a long history in many South Asian cultures such as Bangladesh, India, and Pakistan. In 2013, the government of Bangladesh officially recognized hijra as a gender. |
| 38. Intergender | Intergender is a term used to describe people who have both male and female characteristics, or who fall somewhere in between the two genders. Intergender people may identify as neither male nor female, or they may identify as a mix of both genders. |

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| 39. Intersex | The term intersex describes people who are born with genitals or other sex characteristics that do not conform to normative definitions of 'male' or 'female.' Intersex people may choose to identify as male, female, or non-binary. |
| 40. Kathoey | A kathoey is a person from Thailand who may be born with male genitalia but identifies as female. Kathoeys are sometimes considered to be a third gender, and they have a long history in Thai culture. Since 2015, they have enjoyed enhanced legal protections in the country. |
| 41. Lhamana (Zuni) | A lhamana is a person from the Zuni tribe in North America (primarily, western New Mexico) who may be assigned male at birth but transitions to living as a female. The lhamana are a third gender in Zuni culture. Interestingly, in Zuni culture, gender roles are traditionally firmly set, but not connected to assigned sex at birth, opening space for fluid gender expression. |
| 42. Mahu (Hawaii) | A mahu is a person from Hawaii who may be born with male genitalia but identifies as female. Mahus are also known to wear women's clothing and may take on feminine roles in their society. In ancient Hawaiian culture, mahu were revered as keepers of knowledge and skilled in the arts. Some modern scholars believe that the term "mahu" is no longer an accurate description of Native Hawaiian transgender people and prefer to use the term "wahine maoli" (Native Hawaiian woman) instead. |
| 43. Male | The term male is a term to describe cisgendered people who were assigned male at birth and embrace that identification for themselves. |
| 44. Maverique | A maverique is a person who defies traditional gender roles and expectations. Maveriques may identify as being of their own gender, but not male or female. Unlike other classifications, maveriqes are not agendered as they believe them to be of a distinct gender that does not fit on a spectrum of male-female. |
| 45. Metis (Nepal) | Metis are from the Nepalese culture. They are people who display femininity in a masculine body. They have been officially recognized as a third gender in Nepal since 2007. |
| 46. MTF (Male-to-Female) | MTF is a term used to describe a person who was assigned the male gender at birth but identifies as a woman. may choose to undergo hormone therapy and/or sex reassignment surgery to transition living as a woman. |
| 47. Muxe (Mexico) | The Muxe are a third gender people from the Zapotec indigenous people of Oaxaca, Mexico. Muxes are assigned male at birth but typically dress and behave in ways that are traditionally associated with women. |
| 48. Neither | People who identify as being of neither gender generally do not wish to be placed on a traditional gender spectrum or may identify as a third gender. 'Neither' as a gender designation is regularly used as a catch-all category on government forms for anyone who is not cisgendered. |

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| 49. Neutrois | Neutrosis was a gender identity first described in 1995. It is made up of the french terms neutre, meaning "neutral" trois meaning "three." It is used by people to explain that they are of a non-binary unidentified gender or no gender at all. |
| 50. Ninauposkitzipxpe (Blackfoot) | The Ninauposkitzipxpe are a third gender people from the Blackfoot tribe of North America (Southern Alberta). The Ninauposkitzipxpe are assigned female at birth and typically dressed as women. However, they often took on traditionally cis-male roles within the society. The word translates to "manly-hearted women ". |
| 51. Nadleehi and Dilbaa (Navajo) | The Navajo Native American tribe has four genders, with the two non-cis genders being Nadleehi and Dilbaa. The Nadleehi are assigned male at birth while the Dilbaa are assigned female at birth. However, both genders may take on traditionally feminine or masculine roles and dress according to their chosen gender. |
| 52. Non-binary | Non-binary is a term used to describe people who do not identify as exclusively male or female. |
| 53. Novigender | Novigender can be used to describe people who find it difficult to describe or understand how they experience gender. |
| 54. Other | Other' is a formal classification people can select on gender forms to indicate that they do not fit into a binary gender construction. It is often used on official government forms, like 'Neither' |
| 55. Paṇḍaka | Paṇḍakas are a gender of people who are born without the male sex organ. In ancient India, they were not considered to be men or women, but rather a third gender. They typically dress and behave like women, and many Paṇḍakas even undergo surgery to make their bodies look more female. |
| 56. Pangender | Pangender is a term used to describe people who identify as multiple genders. Pangender people may feel like they are a combination of genders, or that their gender is constantly changing. It is often used to mean "all genders". |
| 57. Polygender | polygender is a gender identity which refers to feeling multiple genders simultaneously or over time. Polygender people may feel like they are a combination of two or more genders, that their gender changes over time, or that they have no specific gender. |
| 58. Quariwarmi (Inca, Peru) | Quariwarmi was a third gender in pre-colonial Incan society. They were neither male nor female, but instead something in between. They typically dressed and behaved in ways that were more feminine than masculine. In some cases, they may have also been intersex or transgender people. |
| 59. Sekrata (Madagascar) | The Sekrata gender is a third gender in Madagascar society. People who identify as Sekrata are generally assigned male at birth but may dress and behave in ways that are traditionally associated with women and are often respected and revered dancers. |

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| 60. Sistergirl (Aboriginal Australian) | Sistergirl is a term used in Aboriginal Australian society to refer to transgender women. It is considered a respectful and positive term by those within the community.<br>Sistergirls are often born male but identify as female and may undergo a traditional coming-of-age ceremony. This ceremonious event signifies their official transition into womanhood. |
| 61. Brotherboy (Aboriginal Australia) | Brotherboys are Aboriginal Australians who are trans men. They were assigned female at birth but identify as male. They may also undergo a traditional coming-of-age rite to be recognized as males in society |
| 62. Third Gender | The third gender is a concept in which individuals are categorized, either by themselves or others, as neither man nor woman. |
| 63. Tom and Dee Identities | Tom and Dee identities are those of people assigned male or female at birth, respectively, who identify as the opposite gender. These identities are named after the Tom and Dee characters in the children's book The Gendered Society Reader. The book was written by two sociologists, Michael Kimmel, and Amy Aronson, and it explores how gender impacts everyone's lives, regardless of their assigned sex. |
| 64. Trans* | Transgender describes people whose gender identity does not match their assigned gender at birth. Often, we simply write Trans* (with an asterisk) to be more inclusive of all transgender people, including trans men and trans women. |
| 65. Transmasculine | Transmasculine people are AFAB (assigned female at birth) but identify as masculine (they may be a masculine woman). |
| 66. Trans Man | A trans man is a person who was assigned female at birth but identifies as a man. Trans men may or may not go through surgical transitions or take medications, so their body matches their gender identity. |
| 67. Trans Woman | Trans woman people are AMAB (assigned male at birth) but identify as a woman. They may or may not go through a surgical transition. |
| 68. Transfeminine | Transfeminine people are AMAB (assigned male at birth) but identify as feminine (they may be a feminine man). Note that feminine and female are not the same, where feminine is a collection of behaviours while female is a gender identification. |
| 69. Transsexual | Transsexual is a term used to describe someone who has undergone a surgical transition to change their physical appearance to match their gender identity. This could include things like chest reconstruction (top surgery) or vaginoplasty (bottom surgery). Not all transgender people choose to have surgery, and not all who do identify as transsexual. |
| 70. Transsexual Female | A transsexual female is a person who was assigned male at birth but has transitioned to live as a woman. This could include undergoing surgery and/or hormone therapy to change their physical appearance. |

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| 71. Transsexual Male | A transsexual male is a person who was assigned female at birth but has transitioned to live as a man. This could include undergoing surgery and/or hormone therapy to change their physical appearance. |
| 72. Travesti | Travesti is a Latin American term for people who were assigned male at birth but identify as a woman. They often live and work in all-travesty environments, such as nightclubs and brothels. |
| 73. Trigender | Trigender is a gender identity that refers to people who experience three genders: male, female, and something else that is neither of those two. This third gender can be a combination of both male and female, somewhere in between the two, or something entirely different. Trigender people may identify as any combination of genders, including but not limited to: agender, bigender, genderfluid, or pangender. |
| 74. Two-Spirit | Two-Spirit Female is a term used to describe a Native American gender identity. Two-Spirit people are those who have both male and female spirits and are often seen as having special powers as a result. It explains gender non-conformity in spiritual terms, seeing the person as having a spirit that spans traditional gender constructs. |
| 75. Two-Spirit Female | Two-Spirit females are often women who identify as having both a male and female spirit |
| 76. Two-Spirit Male | Two-Spirit males are men who identify as having both a male and female spirit. This term (as with two-spirit female) often differs depending on the Native American culture, remembering that there were a wide range of cultures in existence before colonization |
| 77. Waria (Indonesia) | Waria is a term used in Indonesia to describe people who are assigned male at birth but identify as women. The term itself is an Indonesian language portmanteau of woman (wanita) and man (pria) |
| 78. Whakawahine (New Zealand) | Whakawahine is a Maori term used to describe people who are assigned female at birth but identify as men. It's one of the many traditional gender identities still present in Maori culture. |
| 79. Winkte (Lakota) | The Lakota people of the Sioux Native American tribe have a gender known as winkte. Winkte translates to 'two-souls person' and is used to describe someone who is assigned male at birth but has a female spirit. |
| 80. Xanith (Oman) | The Xanith are a third gender found in Oman culture. They are assigned male at birth but undergo a social transition to live as women. This includes learning feminine gender roles and occupations typically associated with women |

Table 1: Source: Drew, (2023). 81 Types of Genders & Gender Identities (A to Z List).

## 2.3 The biopsychosocial dimensions of sexuality.

The complex and often confused relationship between sex and gender is inextricably linked to an individual's sexuality the presumed normality of heterosexuality and the associated roles in sexual reproduction and family structure. Alongside the use of the word sex as a noun to describe distinctions based on primary and secondary sexual characteristics, the verbal construct *to have sex* has developed related to physical and psychical questions involving human relationships in terms of developing bonds and experiencing pleasure, promoting health and wellbeing, and sexual reproduction.

According to the World Health Organization, "sexual health, when viewed affirmatively, requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled". Moreover, sexuality is considered:

> A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors (WHO, 2006a).

As regards the interaction between biological, psychological, and social factors, Barker and Scheele (2021) define sexuality as "a multidimensional, biopsychosocial, intersectional, fluid, ever-changing set of reinforcing/resisting stories which enable

and/or block the flow of embodied feelings like desire and shame" (p. 132). Such a definition clearly demonstrates the complex and dynamic nature of human sexuality.

The first recorded use of the noun sexuality dates to 1789, and it is described as an "action or fact of being sexed or having distinctions between the sexes" (Online Etymology Dictionary, n.d.). Today sexuality is considered as the sphere of individuals' preferred ways of expressing their sexual identity and orientation, but what is considered normal or abnormal, judged to be permissible or outrageous, may vary greatly across cultures and countries. Society can either promote or contrast the ability to develop a healthy and flourishing sexuality and what constitutes this can always change during one's lifetime.

A historically controversial example is that of premarital sexual relationships. While a country like Sweden considers premarital sex quite acceptable (as expressed by 89% of a sample studied) and encourages sexuality education from an early age as essential for autonomous and responsible expression of one's sexuality, a country like the United States still has widespread heavily restrictive beliefs concerning young people's sexual freedom (Rahman, Bowman, Jackson, Lushtak, Newman & Sunder, 2023). Moreover, there is an evident double standard in the true nature of such prohibitionist attitudes, whereby male responsibility is largely unconsidered while females are incited to restrain themselves from having any form of premarital sexual activity.

The history of sexuality shows my differences in the evolution of attitudes and behaviours (Lakritz, 2022). For example, in Ancient Rome sexuality was not attached to same-sex relationship norms that subsequently developed and are still deeply rooted today. The primary role of sexuality was exhibited by men as an act of power and dominance (active role) toward the other person (passive role), since "the role of the Roman man in sex is to find sexual pleasure by penetrating the body of another

whom he finds beautiful. It does not matter whether the other person in question is biologically male or female" (Goetting, 2017, p. 5). Further back in Ancient Greece, the same view of sexual relationships is held, but Aristotle also warns of females' insatiable desire and their lack of self-control, from which terrible consequences can derive.

Moreover, "the assimilation of woman to the world of raw nature is [based on] sexuality. In Greek thought the presexual or asexual female is part of the wilderness, an untamed animal who given a choice, prefers the wildlife of Artemis, roaming the woods undomesticated and unloving of men" (Halperin, Winkler & Zeitlin, 1990, p. 144). Such a perspective has remained largely consistent and is evident in the portrayal of women both in the arts and the sciences for many centuries.

At the same time, the expression of same-sex sexual relationships has grown to be considered aberrant or at least inappropriate behaviour. A deeply rooted sociocultural construct, whereby sexual intercourse was merely conceived as an act of procreation and consequently any other types of sexual acts deemed as unnatural, became dominant (Boswell, 1980). Christianity did not create the stigma but was a strong force in perpetuating it. In fact:

> Toward the end of the 13th century, when it became commonplace for the law to stipulate torture, castration, and death for homosexual conduct. Boswell attributes this radical suppression of gay culture to (1) the needs of the emerging corporate states, (2) the development of legal codes based on misunderstood aspects of Roman law, and (3) the accumulated effects of the Crusades on the medieval psyche (Patricca, 1983, p. 1335).

Moreover:

> During the last 100 years, deviant or abnormal sexual attraction has been explained as sickness and psychopathology, and people who engaged in same-sex erotic activity were viewed as mentally ill. Thus, the term abnormal, in the moral perspective sense, sets apart and stigmatizes people who violate community acceptable standards of acceptable sexual behaviour (Kauth, 2012, p,11).

Sexuality is often associated with the word desire: a non-specific object of desire is what differentiates longings (e.g. longing for a partner's kiss) from wants (e.g. wanting to eat steak), where it implies many unconscious mechanisms at work (Mayer & McHugh, 2016). According to the authors, sexual desire can be associated with

1. A state of physical arousal that may or may not be linked to a specific physical activity and may or may not be the object of conscious awareness.

2. Conscious erotic interest in response to finding others attractive (in perception, memory, or fantasy), which may or may not involve any of the bodily processes associated with measurable states of physical arousal.

3. Strong interest in finding a companion or establishing a durable relationship.

4. The romantic aspirations and feelings associated with infatuation or falling in love with a specific individual.

5. Inclination towards attachment to a specific individual.

6. The general motivation to seek intimacy with a member of some specific group.

7. An aesthetic measure that latches onto perceived beauty in others.

(Mayer & McHough, 2016, p. 17 s.).

Much research supports the thesis that sexual desire might be pre-determined both by genes and early developmental habits. A study by Bearman and Brückner (2002) concludes that sexuality seems to be influenced by heritability but there is no concrete evidence of genes being the sole cause of it. Many factors play an important role in moulding one's sexuality and therefore one's sexual orientation, such as hormonal influences, socialization, the environment (Wang, Wu & Sun, 2019), cognitive processes, (Tavares, Moura & Nobre, 2020) and neurobiological patterns (Kruger & Kneer, 2020). From each study emerges a different form of convergence between three aspects of sexuality: attraction, behaviours, and identity.

What is common to recent studies is the fact that sexual attraction is not predetermined or fixed. Many supporters of interactionist theories believe that psychosocial or biomedical causes are the basis of the development of sexual attraction, which is influenced by hormonal activity. According to Money, there must be an interplay of factors resulting in building the scaffolding that shapes one's sexuality (LeVay, 2017). Age is considered a significant factor in terms of how sexual orientation emerges with self-awareness, generally associated with non-conformist behaviours in childhood and pre-adolescent years (Bailey, Vasey, Diamond, Breedlove, Vilain & Epprecht, 2016). Age appears to be "more closely associated with sexual identity for women than for men. Women at the upper end of the 18-44 age range were more likely to report themselves as heterosexual and less likely to report themselves as bisexual. Among men aged 18-44, no such pattern was seen" (Chandra, Copen & Mosher, 2013). As a result, the percentage of individuals who identify as "non-heterosexual" is estimated to be an overall minority (about 5%) both in Western and Oriental countries.

Additionally, in studies related to biological sex, women appear to be more likely to identify as bisexual, due to developing a feeling of closeness even in a non-

romantic relationship, whereas men tend to express the opposite, replying according to arousal stimuli reported as prevalently heterosexual (Bailey et al., 2016, para. 2-3).

Even though sexual identities, orientations, and behaviours are commonly considered linked one to another, these aspects of individuals' sexuality do not always follow a linear development or expression in a particular context. This can be the case in same-sex institutions such as prisons or schools, or in different cultures and sub-cultures, where, for example, heterosexual expression of one's sexuality may not be possible or necessarily a norm to rigidly adhere to. Moreover, Bailey et al., (2016), demonstrate that it is common practice for individuals to indulge in same-sex sexual acts and still consider themselves heterosexuals while growing up, and how, even if the majority of them are heterosexual when they go to clubs together perfectly acceptable for girls to kiss each other and it is in no way considered cheating even if they have a partner.

In his pioneering work, Alfred Kinsey posits how "sexual behaviour is either normal or abnormal, socially acceptable or unacceptable, heterosexual or homosexual; and many persons do not believe to believe that there are gradations in this matter from one to another extreme" (Kinsey et al., 1981, p. 469). Kinsey published *Sexual Behavior in the Human Male* in 1948, where he first introduced the Kinsey Scale, and in 1981 *Sexual Behavior in the Human Female*, in an attempt to go beyond taboos and reach a broader audience on the subject to raise awareness and help educate the younger generations.

The Kinsey Scale, also known as Heterosexual-Homosexual Rating Scale, was compiled from interviews with his students regarding their sexual behaviours and identity (Kendall, 2023). The data gathered were incorporated into a scale with six categories, where at the polar opposites there were homosexuality and heterosexuality, and bisexuality was placed in the middle. Kinsey believed that these

sexual orientations were not constant over time but could fluctuate for various reasons. On the scale zero represents individuals who identify as heterosexuals and are attracted to the opposite sex; one refers to mainly heterosexual individuals who are occasionally attracted to the same sex; two refers to individuals who are more than occasionally homosexuals but still labelled as heterosexuals; three represents individuals who are attracted to both sexes and identify as bisexuals; four refers to individuals who are predominantly homosexuals but occasionally heterosexuals; five refers to main homosexuals who are more than occasionally attracted to the opposite gender; six represents individuals who identify as homosexuals and are attracted to the same gender. The category, X represents individuals who did not report sexual interactions or attraction (Kinsey Institute, n.d.). The Kinsey Scale is still used today in online questionnaires, but many scholars criticize its lack of range and variety of categorisation, whereby it tends to become a mere classification based on individuals' sexual histories (Kendall, 2023).

The Klein Sexual Orientation Grid was introduced in 1985 in an attempt to fill in some of the blind spots of the Kinsey Scale, introducing more variables into the categories for the data collected: Attraction, Behavior, Fantasy, Social and Emotional preference, Self-identification, and Lifestyle. All these variables were considered not only at the moment of the survey but in a dynamic time frame, comprehensive of the past and the ideal future (Klein, Sepekoff & Wolf, 1985). In this way, participants are asked to respond to 21 items with a 7-point bipolar scale, where zero indicates individuals who identify as heterosexual and seven indicates individuals who identify as homosexual, considering past, present, and ideal. The efficacy of this tool can be assessed in terms of its ability to encompass a wider range of participants' sexual orientations while offering characteristics of brevity and ease of use (Sager, 2005).

However, sexual orientation as a concept, remains difficult to clarify, with earlier literature in the field being contradicted by more recent studies where the

fluidity of sexuality emerges. One study focused on what is commonly called the coming out phase. This follows sexual orientation identity development during four phases: the first phase of awareness is followed by exploration, deepening or commitment, and internalization/synthesis. This model was developed by Fassinger, Miller, and McCarn (Fassinger & Miller, 1996; Fassinger & McCarn, 1996) to follow the "phase of both individuals and group membership identity", but its attention is solely concentrated on gay and lesbian identity. Individuals might label themself as lesbian but not identify in the lesbian community (Dillon, Worthington & Morandi, 2011, p. 653). Thus, the study has been criticized as having many limitations such as the inability to generalize the results to both bisexuals and heterosexual people.

In general, what has emerged in the literature is a form of linearity between men's sexual arousal patterns and their sexual orientation. This is based on results that tend to show how the way men react to different stimuli will be a clear representation of their sexual development and identity. On the contrary, for women, this process seems to be less defined and univocal. Some studies show a high probability of women being sexually aroused by both women and men (although with lower percentages for the former) but only disclose how exciting stimuli from men were (Chivers, Seto & Blanchard, 2007). The conclusion reached is that women have a higher chance of being more diverse than men in their sexual excitement and expression.

Despite a multiplicity of research in the field of sexual orientation, the possibility of clearly defined categories and individuals remains highly problematic. According to Neilson (2020), "In a society obsessed with sexuality", little consideration is given to individuals who may not fall into the already well-renowned categories. A clear example of this is the question of asexuality, generally taken to represent the lack of sexual interest, from little to none, and commonly described with the term Ace Umbrella and sub-divided into the categories of demisexual, grey asexual and asexual. The opposite of asexual is allosexual, which defines individuals who feel romantic and

sexual attraction and arousal towards others and act based on this. On the other hand, it is widely believed that asexuals would not take the initiative toward another person, whether of the same sex or the opposite sex. This has recently been criticized precisely because asexuality exists as a continuum on a spectrum (Rahman, Bowman, Jackson, Lushtak, Newman & Sunder, 2023) and misconceptions about it are due to the lack of studies regarding its aetiology and history.

Overall, many researchers believe that "the journey to understand sexuality is still long and tortuous" (Nimbi, Briken, Abdo & Carvalho, 2021, p. 2), although public awareness and sources of information (albeit more or less reliable) have greatly increased as people feel gradually able to recognise and delve into their sexual orientation identity.

# Chapter Three: Borderline personality disorder and sex, gender, and sexuality. Focuses and biases in research and practice.

BPD is a highly complex personality disorder that can be challenging to diagnose due to its overlapping symptoms with other personality disorders. In the past, during clinical evaluations it was not uncommon for the criteria for BPD to not be clearly defined, making it difficult to distinguish it from other disorders (Widiger & Frances, 1987). This complexity and lack of clarity surrounding the diagnosis can also lead to confusion and misunderstanding in society, making it difficult for individuals to differentiate between BPD and other disorders such as bipolar disorder (Ruggero et al., 2010).

While it is crucial to gain a better understanding of BPD to improve diagnosis and treatment for those who are affected by this disorder, it is equally important to recognise how relating it to variables such as sex, gender and sexuality involves a mix of biological, psychosociological, and sociocultural constituents, meaning that diagnoses may be biased by biological or sociocultural factors or by both. “Far from neutral or objective, sex classification and definition rely on cultural norms about the “appropriate” relationships between sex, gender, and sexuality, and work in tandem with power to support social norms and goals as well as socio-political hierarchies that determine opportunities, rights, and privileges.” (Karkazis, 2019, p. 1898).

## 3.1 Evolving perspectives on disorder diagnoses related to sex, gender, and sexuality.

There has been a gradual evolution in the field of sex and gender-related disorder diagnoses from the DSM-II (APA, 1968) through the DSM-IV-TR (APA, 2000) up to the DSM-V (2013), characterized by disputes and increasing attempts to avoid discriminatory classifications or biases. For example, the revised version contained in the DSM-III eliminated reference to homosexuality from the previous version of the DSM-II, despite criticism of a "backdoor manoeuvre" to present the term in a more veiled way (Zucker & Spitzer, 2005), introducing the three dimensions of transsexualism, non-transsexualism, and other variants. At the same time, the emerging discrepancy between biological sex and gender identification was identified as a psychopathological condition with its concomitant criteria (Koh, 2012). In the DSM-IV, this condition is considered a gender identity disorder in adults and adolescents.

However, such a formula continued to receive criticism both from the scientific community and civil society, because of stigmatizing individuals rather than helping with a diagnosis and eventual treatment. Finally, the DSM-V (APA, 2013) introduced the term gender dysphoria disorder, indicating the following criteria related to marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months duration, as manifested by at least two or more of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed

gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)

- A strong desire for the primary and secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Introducing additional perspectives that allowed for more in-depth diagnoses was a significant factor in determining progress in the field. This included introducing a more specific reference to age ranges, for example, gender dysphoria in children, but also to categories containing particular individuals, for example, those undergoing sex reassignment surgery who consequently could not yet be placed in any other category and were considered as post-transitioner (Yarbrough et al. 2017).

Another important development is the new diagnosis of disorders for sex development (DSD), which contains people with XXY/Klinefelter Syndrome, 45XO/Turner Syndrome, or Androgen Insensitivity Syndrome and others, a group of people that generally people would be described as intersex (APA, 2013).

Despite such attempts to introduce and apply such new perspectives, there is still considerable disagreement and dissatisfaction regarding how sex, gender and

sexuality are defined in terms of their relevance to and relationship with disorders and diagnoses in a wide range of fields. As Karkazis (2019) puts it:

> Not surprisingly, there is a long history of using—and misusing—discrete biological criteria to determine sex and thereby include or exclude certain people from categories. […] It is long overdue that we understand sex not as an essential property of individuals but as a set of biological traits and social factors that become important only in specific contexts, such as medicine, and even then, complexity persists. If we are concerned with certain cancers, for example, knowing whether someone has a prostate or ovaries is what's important, not their "sex" per se. If reproduction is the interest, what matters is whether one produces sperm or eggs, whether one has a uterus, a vaginal opening, and so on. For those arenas where it's not clear what purpose sex designation serves, we might question whether we need it at all. Doing so could lead to better science and health care, and, crucially, less harm (p. 1899).

In this respect, the complex challenges involved in searching for correlations between BPD and sex, gender, and sexuality within healthcare systems, have increasingly led researchers and practitioners to strive to achieve "equal treatment for patients irrespective of their gender or sex" (Modeste, 2020, p. 1).

Significant advances have been made in the field, and society has progressed accordingly. The results regarding such a correlation initially published by the DSM-III-R were strongly criticized. Consequently, the subsequent versions of the DSM, 4th Ed. and 5th Ed., (DSM-IV, APA, 1994 & DSM-V, APA, 2003), welcomed the criticisms and revised their literature, acknowledging the prevailing trend of diagnosing BPD more frequently in females as opposed to males and setting out to understand why this should occur and thereby modify practices.

## 3.2 Focuses and biases regarding BPD and sex, gender and sexuality.

Research has consistently reported a higher prevalence of BPD among females compared to males, raising questions about the nature of this sex disparity and the future path of psychological treatment (Merced, 2015). The DSM-III-R (APA, 1987) gave rise to the apparently ground-breaking revelation that each sex tends to exhibit different personality disorders. This finding not only appeared to shed more light on the whole question, but it also provided a crucial turning point in determining the direction of further research and understanding of human behaviour. It commonly followed that histrionic, borderline, and dependent personality disorders (PDs) had a higher rate of prevalence in women, whereas obsessive-compulsive disorder (OCD), antisocial, and paranoid disorders had a higher rate of prevalence in men.

It has subsequently been revealed that this phenomenon can be explained by understanding the role played by bias. Research bias can lead to systematic errors in sampling or testing, which can compromise the integrity and validity of research findings. Researchers' subjective opinions can influence research and compromise the validity and reliability of the research paradigm and methodology. Bias is potentially and often omnipresent and can occur at any stage of the research process: including pre-trial bias (study design and data collection), bias during trial (analysis), and bias after trial (publication).

Early in the 1990s, Widiger and Spitzer (1991) observed that diagnostic bias can be categorized into two sub-classifications: criterion bias and assessment bias. The first one comprehends an incorrect application of the diagnostic decisions (nomenclature). The second refers to the incorrect criteria of instruments that are used to assess and define the disorder. However, it is only relatively recently that awareness has spread of the risks and consequences of bias, and proactive measures to mitigate it have begun

to be taken to ensure that research findings are dependable, trustworthy and contribute meaningfully to our understanding of the world (Pannucci & Wilkins, 2010).

Specifically, the issue of potential sex bias in BPD diagnostic criteria is a matter of utmost importance that requires careful consideration and attention. It raises critical questions about the fairness and accuracy of diagnoses, which can have significant implications for patients and healthcare providers alike. Above all, there must be a distinction between sex bias and differential sex prevalence rate:

> Conclusions regarding the differential sex prevalence of PDs should, of course, be based on empirical research rather than clinical assumptions or theories. However, a review of empirical research reveals very little relevant data. Surprisingly, very few authors report the demographic data of any PDs diagnosed in their study (Corbitt & Widiger, 1995, p. 225).

As a result, the diagnostic criteria for any potential biases should be reviewed and steps should be taken to promote unbiased and accurate diagnoses, minimizing any type of possible prejudice, thereby freeing the behaviour of clinicians with clients from conditioning (Chapman et al., 2013). The authors argue that, by doing so, healthcare providers can ensure that all patients receive the highest standard of care, regardless of their sex, gender, and sexuality, as well as personal characteristics, circumstances, race, ethnicity, or other conditions. Additionally, this can lead to promoting social awareness of existing healthcare disparities or treatment practices in clinical services.

In 1994, Dana Becker and Sharon Lamb conducted a study (Becker & Lamb, 1994) that proposed that gender may play a role in how certain symptoms of borderline personality disorder (BPD) are perceived, with a particular emphasis on how they can lead to a biased representation of women in clinical samples. The study

set out to investigate the potential influence of gender bias on clinical diagnoses of both BPD and PTSD, accounting for factors such as the client and clinician's sex and the profession of the clinician. The authors argue that an exploration of the social and cultural biases embedded in diagnostic criteria is imperative for a more accurate understanding of the disorder, affirming that "it may be that the difficulty in demonstrating the existence of sex bias empirically can be explained by the fact that sex is a variable that achieves its primary significance in interaction with other variables" (Becker & Lamb, 1994, p. 56). Further research has posited that, as an assessment tool, it could be helpful to use the Bem Sex-Role inventory to juxtapose predictions of adults' mental health and gender research, specifically spontaneous traits of femininity and masculinity exerted by individuals (Davis, 2017).

The results of Becker and Lamb's study showed quite clearly that "female cases were seen as more borderline than male cases lending credence to the notion that sex bias is responsible for the much greater frequency with which this diagnosis is assigned to women than to men. Even if clinicians are influenced by previously established base rates if they overdiagnose a disorder is thought to be more prevalent in women than in men, the result is a further biasing of the base rate" (p. 58).

From several different studies, it emerges that in clinical environments there exists an observable tendency for medical professionals to classify patients solely based on the criterion of their sex or gender (both when the terms are used interchangeably or distinctly) when arriving at a diagnosis. A female-to-male ratio of 7:1 was identified in Walthall's study (2013) of inpatients with BPD. The data collected demonstrated women as 75% more probably diagnosed with BPD than men. Such a high percentage seems particularly marked when clinicians' negative behaviour toward clients with BPD and gender bias and stigma in the client-practitioner relationship are intertwined and feed off each other.

This phenomenon is due to preconceptions and stereotypes that are associated with a particular underlying disorder (Ford & Widiger, 1989) and can be generally summarized in terms of sex-role labelling. Since BPD is frequently associated with symptoms of incapacity in displaying and regulating emotions, and this is often considered a feminine trait, women are therefore seen as the primary subjects of this condition. The same can also happen to men. As regards aggressive behaviours, clinicians often inevitably tend to associate this characteristic with men during the evaluation process (LaRue, 2019). Such stereotypical criteria are set by society, culture and clinicians themselves, who tend to set different standards for men and women when diagnosing PDs in general or, more specifically, BPD (Etaugh & Bridges, 2017). It has recently emerged how in America, out of more than 1.4 million people who are affected by BPD (Healthy Life Recovery, 2023) at least 550,000 people have received an erroneous diagnosis, and that a principal cause is the tendency to rely heavily on sex-gender as a diagnostic tool, rather than prioritize individuals' symptoms, thereby potentially leading to misdiagnosis and inadequate treatment plans.

A study carried out by LaRue (2019), highlights the role of setting bias in general and in particular, its effect in terms of augmenting or mitigating the effect of sex bias. The study posits that setting bias plays a significant role in predicting the prognosis of a personality disorder within a correctional environment. Additionally, the research also reveals that clinicians tend to overlook the impact of setting bias themselves, which makes it inadequately appreciated as a factor that can significantly affect the results. Therefore, it is important to recognize the significance of setting bias and take it into account while making clinical decisions to ensure accurate and effective assessments.

It is indeed crucial to consider other factors that may influence the patient's condition, such as age, medical history, lifestyle, and environmental factors. Investigations into the neurobiological underpinnings of BPD often overlook specific

potential sex differences rather than general assumptions based on binary sex distinctions. For example, hormonal influences, particularly in females during different phases of the menstrual cycle, are emerging as crucial factors affecting BPD symptomatology: higher levels of sex steroids (Bailey & Hurd, 2005), fluctuations in oestrogen (E2; ovulation and in the luteal phase) and progesterone's levels (P4; increase in the luteal phase) can predict and modulate BPD features (Eisenlohr-Moul et al., 2015). "Measures of hormonal change from week 1 to week 2 of the menstrual cycle, a time of follicular development and increasing oestrogen levels", were found to be heavily associated with symptoms of BPD (Evardone & Alexander, 2007, p. 6).

Sexual Selection-Sex Hormone theory posits the importance of distinguishing between the historical (evolutionary or ultimate) and immediate (functional or proximal) causes of sex-related differences in diseases and disorders. In this respect, the role of male and female sex hormones can be significant in exacerbating the appearance of BPD symptoms in subjects already at risk (Singh et al., 2021), leading to maladaptive behaviours. Researchers have suggested that future research should target a large sample of women diagnosed with BPD and their physical symptoms to achieve a greater understanding of the menstrual cycle and how it might affect women's health, in particular, how distress can vary (increase or decrease) during the menstrual cycle. This would involve tracking even small fluctuations in hormones that may be linked to the expression of BPD symptoms and can be either less or more noticeable. To support this, "female patients with high trait BPD features may benefit from an understanding of their greater sensitivity to cyclical changes in hormones." (Eisenlohr-Moul et al., 2015, p. 19). Moreover, there could be greater revelations that may help women who deeply suffer during the menstrual cycle to defy the pain, also involving recognition of the importance of techniques such as the ability to exercise non-judgmental present-centred awareness of physical symptoms, rumination, or emotional lability, commonly associated with approaches such as mindfulness.

By considering a more comprehensive range of factors, clinicians can ensure that their diagnoses are accurate and that their treatment plans are tailored to meet the specific needs of each patient. In general, patients who report positive experiences with medical practitioners do so with more experienced clinicians, but this does not always happen, and it is more frequently reported that clinicians may have negative attitudes toward BPD patients, therefore being less empathetic at the moment of the interview and later follow-ups. Not only does it affect the professional-patient relationship, but it can increase the severity of the patient's symptoms since "misdiagnosed forensic patients may experience a delay in recovery and, in some cases, be denied early parole due to insufficient progress in recovery" (Modeste, 2020, p. 11).

Social expectations and cultural norms regarding emotional expression and relationships might contribute to the differential manifestation and identification of BPD symptoms in males and females. This type of bias, defined by Widiger and Spitzer (1991) as social-cultural etiologic bias, can be summarized by the stereotypical view of females as more emotionally expressive and relationally oriented, which may lead to an increased likelihood of diagnosis, potentially contributing to the higher prevalence observed in women. Diagnostic bias in BPD can be manifest in various ways, from the perception of symptoms to the actual criteria used for diagnosis, therefore "being aware of these biases can help with promoting the facilitation of appropriate and effective mental health treatment in correctional settings" (LaRue, 2019, p. 63).

A critical examination of diagnostic criteria reveals further potential biases that may favour the identification of BPD symptoms in females and be significant factors "particularly important given the apparent gender prevalence imbalance in clinical settings; the DSM-IV describes a gender distribution of 3:1 (women to men)" (Boggs, Morey, Skodol, Shea, Sanislow, Grilo, McGlashan, Zanarini, Gunderson, 2005, p. 496).

For instance, criteria related to unstable interpersonal relationships, fear of abandonment, and a history of neglect or abuse during childhood may resonate more with stereotypical female experiences, potentially leading to an overemphasis on these aspects in diagnostic assessments resulting in the development of BPD (Zanarini, Williams, Lewis, Reich, Vera, Marino, Levin, Yong & Frankenburg, 1997). Recognizing and addressing how emotions, impulsivity, and interpersonal relationships are perceived and interpreted may vary across genders and this can be crucial for mitigating bias in both research and clinical practice.

Much recent research has emphasized how the impact of cultural and societal influences on diagnostic bias in BPD cannot be overstated. Societal norms that dictate acceptable emotional expression and interpersonal behaviours may inadvertently shape the diagnostic process, not only for BPD diagnosis but in general for many other personality disorders (La Rue, 2019). Cultural expectations play a pivotal role in that they can influence the interpretation of symptoms, further complicating the accurate identification of BPD across genders, contributing to amplifying women's distress and, therefore, stigmatizing their reactions and consequent actions, rather than recognizing how it is society that has exacerbated them (Shaw & Proctor, 2005).

Researchers have also focused on how the Psycho-Social Stress Theory (PSS Theory) reinforces that males and females experience different social stress. This may shed light on the predominance of female-biased mental disorders and some other overrepresentations in research findings (Brown, Wong, Thakur, et al., 2022). In this respect, it would be essential to gather information on the developmental history of gender during childhood to gain a comprehensive understanding of the individual subject in question. For example, it has been suggested that persistent cross-gender behaviour in childhood has the potential to result in social stigma and, when present, can serve as a psychosocial stressor that may contribute to the development of borderline personality disorder (Singh, McMain & Zucker, 2011).

Some research suggests that males diagnosed with borderline personality disorder (BPD) may display a higher propensity for externalizing behaviours, such as aggression, impulsivity, and indecisiveness (DeShong & Kurtz, 2013; Hoertel et al., 2014) when exposed to stressors that result in heightened cortisol levels (Inoue et al., 2015). The manifestation of these behaviours may be exacerbated by the physiological response to stress as evidenced by the release of cortisol, a hormone commonly associated with the body's stress response.

These findings suggest that the management of stress may be a critical factor in mitigating the effects of BPD in male individuals, particularly those who display a tendency towards externalizing behaviours. Moreover, they could display symptoms of addiction (substance abuse), which might not conform to traditional expectations of the disorder and violence, potentially leading to problems with the justice system (LaRue, 2019). As a result, these individuals may be less likely to be diagnosed or may receive alternative diagnoses, contributing to the underrepresentation of males in clinical samples (Boggs et al., 2005).

On the other hand, it is suggested that females may exhibit internalising behaviours, including self-harm, feelings of emptiness, suicidal thoughts, affective instability (LaRue, 2019; Richetin et al., 2018), many attempts to avoid a partner's abandonment and negative self-image (Corey, 2020), and generalized anxiety validated by mood swings and binge eating (Banzhaf et al., 2012). This, in turn, has been linked to higher levels of testosterone (Bertsch et al., 2018), the use of oral contraceptives (DeSoto et al., 2003) and an inferior concentration of grey matter in the areas of the hippocampus and the amygdala, with reductions in other regions, such as pituitary, anterior cingulate cortex and hypothalamus (Rausch et al., 2015). Although it is beyond the scope of this thesis, it should be noted that much research purporting to discover basic differences between the male and female brain has been shown to be the result of neurosexist bias (Fine, 2017; Rippon, 2018).

Many researchers affirm that tailoring therapeutic interventions based on gender-specific characteristics is essential for optimizing treatment outcomes because generally women's symptoms are linked with depression, and various comorbid disorders, such as co-occurring disorders (COD), post-traumatic stress disorder (PTSD) or eating disorders, and generalized feelings of anxiety (Sansone & Sansone, 2011; Silberschmidt et al., 2015). Awareness of potential gender-related disparities in the response to various therapeutic modalities can inform more effective and personalized treatment plans. "Sex biases may be diminished by an increased emphasis in training programs and clinical settings on the systematic use and adherence to the criteria and diagnostic rules presented in the DSM-III" (Ford & Widiger, 1989, p. 304).

Studies often draw samples from clinical settings where females seeking mental health treatment outnumber their male counterparts, who tend to ask for help in rehab. The overall tendency for women is to report having poorer health and difficulty in managing relationships, which can affect the balance between work and social life (Carey, 2020). This imbalance can be attributed to the internalising or externalising nature of symptoms females and males exhibit (Qian, Townsend, Tan & Grenyerd, 2022) that can skew prevalence rates and reinforce the notion that BPD is predominantly a female disorder, overlooking potential cases in males that might go undiagnosed (Morey, Warner & Boggs, 2004). Eventually:

> the differential tendencies of men and women to meet BPD criteria could be important in explaining why clinical samples show a preponderance of women diagnosed with BPD [….] Women displaying more characteristics or prototypical features of BPD than men, may be more likely to receive a referral to a secondary case specializing in personality disorders" (Carey, 2020).

Some research has also shown that, in many cases, both psychiatrists and psychologists find working with females harder compared to males, confirming the gender stigma of women generally being more unable to regulate emotions and feelings whilst in treatment (Woodward, Taft, Gordon, & Meis, 2009).

The same tendencies concerning BPD and sex and gender also emerge from studies that investigate a correlation between BPD and sexuality. Although, as Northey et al, (2016) affirm, "extant research connecting borderline personality disorder (BPD) to sexuality is sparse" (abstract), those studies that have been conducted have tended to show that people with BPD are more likely to have a sexually diverse orientation than people with other or no psychiatric disorder. There has generally been an attempt to link the BPD symptoms of impulsivity (causing an increase in varied sexual behaviours) and identity disturbance (causing changes in sexual identity) to this finding. As Nolan et al. (2022) put it, "This however can be stigmatizing and possibly suggest sexual diversity orientation as a pathology" (abstract).

An example of this can be seen in a literature review by Sansone & Sansone (2011), as a result of which the authors conclude:

> From a psychiatric perspective, these findings suggest that sexual impulsivity and victimization are practical clinical concerns in patients with BPD, both in terms of relevant psychological themes as well as health risks. From a primary care perspective, findings suggest that clinicians in these settings need to maintain a high index of suspicion about the possibility of multiple sexual partners, sexual traumatization, and sexually transmitted diseases in these patients as well as the need to address contraception and prophylaxis against sexually transmitted diseases. Likewise, patients who present with promiscuity

> in primary care settings may need to be evaluated for BPD and possibly referred for treatment by a mental health professional (conclusion).

Because of such problems, Nolan et al. conducted a new study designed to investigate the tendency to overrepresentation further and "examine whether sexually diverse and non-sexually diverse people with BPD differ significantly in demographics, overall BPD symptomatology, identity disturbance, and impulsivity" (Nolan, et al., 2022, abstract). They conclude that:

> Survey data analysis suggested that sexually diverse individuals with BPD were younger than their non-sexually diverse (heterosexual) peers and were more likely to have changed their self-labelled sexual identity during the previous year. There were no significant differences in other demographic factors, BPD symptomatology, identity disturbance or impulsivity (abstract).

Furthermore, the authors affirm that their study:

> Highlighted the challenges of using a single criterion to define sexual diversity, as the groups differed markedly according to whether classification was based on current and past relationship history, sexual attraction, or self-labelled sexual identity. The findings also suggest that BPD symptoms of identity disturbance and impulsivity may not explain the overrepresentation of sexual diversity in people diagnosed with BPD, and that further investigation is warranted (abstract).

## 3.3 Open questions and future directions.

The focus of this thesis is on the intersecting biological, psychological, and sociocultural constructs of BPD, sex, gender, and sexuality. At the same time, it is clearly necessary to consider a wide range of factors and variables for an overall assessment of the current situation and consider directions to move in for a constant improvement in both diagnoses and treatments.

A growing body of researchers now concurs that in order to establish the potential impact of sexualised and gendered patterns of secondary service use on rates of BPD diagnosis among both male and female populations, it is essential to conduct further research and obtain more comprehensive information on service utilisation. There is widespread agreement that when an adequate multidimensional approach is adopted the plausible positive outcome is to become more aware of implicit biases and therefore regulate how to minimize them, to avoid harming unintentionally (e.g. being a victim of biases during therapy) individuals or groups.

According to the American Psychological Association (2013), "clinicians must be cautious not to overdiagnose or underdiagnose certain personality disorders in females or males because of social stereotypes about typical gender roles and behaviours". Adopting a multidimensional approach to gathering and analysing data, should enable a deeper understanding of the complex interplay between gender, secondary service use, and BPD diagnosis rates, identify any potential disparities or patterns that may exist, and develop more effective treatment strategies for those affected by it.

Thus far, problems emerging from epidemiological studies have been identified in terms of overrepresentation and conflicting data about the prevalence of BPD regarding sex, gender and sexuality in the samples studied (Grant et al, 2008; Banzhaf et al., 2012; Leichsenring, 2024). In this respect, different types of hypotheses have been

advanced as explanations for possible errors and discrepancies. These can be summarized in terms of:

- deficiencies in the population sampling used for the studies.
- the presence of bias in the diagnostic criteria employed.
- differences in the instruments of evaluation (clinician versus self-report measures).
- inadequacies in the diagnostic construct of BPD itself, particularly in terms of the presence of intersecting or correlated variables.

In general, most of the studies considered during the research for and writing of this degree thesis, highlight the inadequacy of the samples used to enable significant generalisation of the results to the entire population, principally due to their composition of almost solely American or Caucasian young adults. This is by now a widely acknowledged limitation that implies the necessity of broadening the samples used in future research, not only geographically but also in terms of age range. Within the scientific literature, there is both a lack of representation of Asian cultures and research within samples of young, middle-aged, and older adults (Garcia-Ramon & Monk, 2007).

As well as increasing the overall validity and reliability of the studies, redressing this imbalance would permit more specific focuses on variables such as how sexuality in BPD individuals evolves through their lifetime, or how clinical samples differ from outpatients. Obviously, such a longitudinal study requires considerable investment both in time and funds and this may be one of the reasons why limitations persist.

Another important aspect to consider as a limitation in sex-gender-sexuality-related literature is the fact that because statistics on illness or disorder rates are

generally publicly available only in higher-income nations, most of the data accessible for the study originated from these nations. Smaller, poorer, underdeveloped, or third-world nations are therefore left outside the scope of the research, and this causes a gap in the data and a failure to build a complete picture of the current situation.

Even within higher-income countries, the same kind of limit presents a socioeconomic bias. Practitioners who showed biases based on the patient's socioeconomic level were less likely to recommend that patient for additional treatment, such as counselling. Increasingly researchers affirm that there should be more research into the impact of medical prejudices on vulnerable populations, including women and those with lower socioeconomic status. The recognition that stigmatization and discrimination are social processes intertwined with the persistence of inequality and exclusion necessitates a departure from the behavioural and psychological models that have dominated research in this field (Bozzatello et al, 2021).

The diagnostic criteria for BPD have been criticized for being gender biased, as they primarily reflect female traits and behaviours. Some researchers argue that future diagnostic manuals should be improved by clarifying or even redefining terms within the diagnostic criteria for BPD to be more inclusive of a wider range of male and female traits and behaviours and a less rigid set of distinctions. Alternatively, others argue that diagnostic criteria should be made more gender-neutral by using terms that do not reflect gendered traits (Foiles, 2021).

Moreover, a dimensional approach that quantifies the degree of impairment may be used to diagnose BPD and other personality disorders, instead of merely labelling certain traits as pathological. Researchers assert that such an approach will help to reduce gender bias in diagnosis and provide a more accurate representation of the disorder. It is often emphasized that gender bias in diagnosis is not only a concern

for BPD but also other personality disorders (Leichsenring, 2024). Therefore, the use of a dimensional approach may be beneficial in reducing gender bias in the diagnosis of these disorders as well. Although there are many studies on BPD, it should be recognized that most of them do not necessarily report findings related to gender.

While studies that do report specifically on gender differences are relatively limited, they also lack substantial information on differences in other sociodemographic factors like race, family history, marital status, and level of education. This lack of information is either because research data lacks evidence that significant differences exist between these groups, or they were not reported in detail. Researchers today more frequently urge caution when collecting and interpreting retrospective data, while emphasizing the need to expand their perspectives on reporting by using multiple reporters and repeated assessments to get a more comprehensive understanding of BPD (Rodriguez-Seijas et al., 2021).

At the same time, some researchers affirm that recognizing the risks involved and the errors committed through bias related to sex, gender, and sexuality stereotypes, does not mean that reference to all such factors should be eliminated. "As much as the concept of biological sex remains central to recognising the diversity of life, it is also crucial for those interested in a profound understanding of the nature of gender in humans. Denying the biological sex, for whatever noble cause erodes scientific progress. In addition, and probably even worse, by rejecting simple biological facts influential science journals may open the floodgates for alternative truths." (Goymann et al., 2022, p. 5).

However, the diagnosis of BPD must always entail that, if it considers issues related to sex, gender, and sexuality, then this is done carefully and with due consideration for longitudinal factors. For example, in this respect, when treating clients with BPD, researchers affirm that clinicians need to investigate the individual's

sexual history to create a comprehensive treatment plan. Though this does not imply that assumptions should be made, a thorough exploration of sexual history can be helpful. In couples counselling, specific issues may arise that involve disclosure and secrecy. Further research is necessary to achieve a complete understanding of the intersection of BPD and sexuality for individuals and couples alike.

As regards the question of treatment, the marked gender disparity in the prevalence of BPD, whether attributable to biases and stereotypical differences between men and women or to other factors related to research methodology, may result in clients developing a perception that their issues are inherent in their personality, thereby hampering the possibility of change. Implicit assumptions about the treatability of specific symptoms or problems can significantly influence the clinician or counsellor's approach to working with the client and can also be subtly communicated to the client. It is therefore essential to exercise caution and approach clients with an open mind, considering the unique needs and circumstances of each individual. By doing so, more non-judgemental, empathetic, and thereby effective care can be provided to those who need it most (Day et al., 2028).

Clinicians working in primary care, mental health, sexual health, and sexual assault services need to exercise extreme care in diagnosing BPD, due to the risk of overemphasizing and perpetuating factors related to these issues. BPD patients are often considered more violent and hostile to practitioners, antagonistic with suicidal behaviours (e.g. suicide threats and self-harm) and registering a higher percentage of dropouts (Bodner et al., 2015; Shaik et al., 2017). Especially clients with self-harm episodes encounter complications. Their struggle to seek medical help collides with what has by some called visible discrimination from practitioners themselves (Gopal et al., 2021). As such inpatients are consequently labelled as manipulative, or being particularly difficult to work with, clinicians need to keep in mind the true nature of their request for medical assistance to be able to differentiate between conduct

symptomatic of BPD conditions from conscious aggressive behaviours. The clinician's conduct in response to clients is key in terms of shaping future communication and the outcome of treatment.

In particular, many researchers emphasize how important it is to avoid reiterating stigma and stereotypes which may lead to the worsening of the disorder. In this respect, it is increasingly underlined how fundamental it is for clinicians to have a high level of initial and in-service training in terms of being able to infuse clients with an overall feeling of optimism, confidence, and reassurance. Through Trauma Informed Care (TIC), is it possible to alleviate self-guilt and distress from patients when showing maladaptive behaviours and understanding the causes (Friesen et al., 2022). A study by Vollmer, Spada, Caspar and Burri (2013), demonstrated the gap between inexperienced and experienced practitioners in terms of the set of skills that enable them to be more effectively performative. As well as being able to perform faster, experts could do so more accurately and flexibly both due to previous knowledge acquired through study and professional learning and development promoted by practice.

As research on sex and gender differences in BPD expands, it is increasingly recognized how crucial it is to conduct more research and literature reviews to gain a deeper understanding of the topic in all its dimensions because current data available on mental illness might still derive from sex-biased research (Ussher, 2013). A growing body of research is necessary "because even for the same disease, there are differences between men and women, and a different approach is necessary to identify the causes and provide treatment […] considered in two aspects: the sex aspect due to the differences in hormones or genes, and the gender aspect due to the difference in social and cultural roles between men and women […]. Fortunately, with the discovery of various sex/gender differences, research on sex/gender bias of disease occurrence is being actively conducted" (Kim, 2023, p. 5-6).

We are still learning more about how the constructs of sex, gender, and sexuality impact health outcomes, as well as how these factors overlap. To gain further and as precise as possible information, future efforts should thus guarantee that the contrasts between these conceptions based on biological and psychological focuses (sex) and socio-cultural and psychological focuses (gender) are acknowledged and applied in health research. As Mayer & McHugh (2016) put it:

> Critiquing and challenging both parts of the 'born that way' paradigm - both the notion that sexual orientation is biologically determined and fixed, and the related notion that there is a fixed gender independent of biological sex - enables us to ask important questions about sexuality, sexual behaviours, gender, and individual and social goods in a different light (p. 116).

Finally, to achieve and consolidate advances in the field, it is important to first focus on training health researchers and other experts in recognizing the differences between sex and gender, as well as how to effectively record and show these differences in health data collection, analysis, and usage and how those can affect practitioner-client relationships. If clinicians' attitudes and practices are informed by constant ongoing professional learning experiences and development, then clients will be better helped to feel at ease in the moment of the interview and during the subsequent stages of therapy (Day et al., 2018. This should enhance the accuracy of diagnoses and the efficacy of treatment, by helping clients to understand the nature and functioning of their disorder, thereby boosting their ability to face and overcome it.

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