

Threats to Objectivity in Risk Assessment for Individuals with Borderline Personality Disorder

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Borderline personality disorder is unique in many ways from other diagnoses contained in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Most salient, however, are the negative connotations often associated with the label itself and the resulting bias of providers. The ways in which these biases manifest are especially problematic in violence risk assessment, wherein evaluators are tasked with systematic consideration of data, with most data coming from available records. In this article, we describe some of the ways in which bias and objectivity are encountered in risk assessment with this population, describe a relevant case example, and offer practical recommendations for evaluators.

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Borderline personality disorder (BPD), as described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), is “a pervasive pattern of instability of interpersonal relationships, self-image and affect, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (Ref. 1, p 663). Although some have argued that emotional dysregulation makes up the core of this disorder,^{2,3} individuals with BPD also show dysfunction in many other areas, including self-harm behaviors,⁴⁻⁷ interpersonal impairment,⁸⁻¹⁰ promiscuous sexual behaviors,^{11,12} substance abuse,¹³⁻¹⁶ and aggression.¹⁷⁻¹⁹ Although the prevalence of BPD in the community is estimated to be about 1.5 percent, this diagnosis accounts for approximately 15 percent of inpatient psychiatric hospitalizations²⁰ and is the most frequently diagnosed personality disorder in psychiatric settings,²¹ suggesting it is of substantial concern for clinicians.

Complicating matters, BPD is an extremely heterogeneous diagnosis,^{22,23} with disagreement on what

symptoms make up this disorder²⁴ and some referring to it as a “catch-all” diagnosis.²⁴⁻²⁷ Based on DSM-5 criteria, there are 256 ways in which an individual may meet criteria for the disorder,²⁸ such that two individuals with BPD may share only one symptom. There have also been indications of clinician biases, including discussions of a negatively valenced clinical prototype, which includes descriptors such as difficult, treatment-resistant, manipulative, demanding, and attention-seeking.²⁹⁻³¹ Recent research has suggested that, although clinicians are generally in agreement about what symptoms and traits are most prototypical in patients with BPD (e.g., emotional lability, identity instability, separation insecurity, impulsivity), many misidentify traits such as attention-seeking, suspiciousness, or manipulateness as more prototypical of BPD than the definition in DSM-5.³² In sum, prior research indicates that the nature and diagnostic criteria of BPD are subjective and susceptible to bias, which complicates accurate identification in clinical settings.

Although BPD has been a contentious topic, its associated negative stigma has been unarguable.³³ Previous work has demonstrated that mental health professionals fail to separate the illness from the individual³⁴ and perceive individuals with BPD as being emotionally draining^{35,36} or as having self-control

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over their symptoms.^{37,38} Because of these negative perceptions, clinicians may view patients with BPD as less favorable than patients without personality disorders,^{35,38,39} believe self-harm attempts are because of attention-seeking behavior rather than genuine psychological distress,³⁷ and potentially change their behavior toward patients who are diagnosed with BPD versus other severe mental health problems.⁴⁰ A further complication is that data suggest that individuals with BPD are more challenging to treat, as evidenced by receipt of more psychological treatment and medication than other individuals with mental illnesses⁴¹ and an increased likelihood of premature termination or shopping around for providers.⁴²

BPD in Forensic Psychiatric Settings

BPD is particularly prevalent in forensic hospitals and correctional settings, with some research⁴³⁻⁴⁶ suggesting up to 30 percent of those institutionalized in those settings meet criteria for BPD. Beyond this, there are generally high comorbidity rates between BPD and other mental health problems,^{7,12,19,47-53} with comorbidity rates as high as 71 to 87 percent for depression,^{50,53} 56 percent for posttraumatic stress disorder (PTSD),⁵⁴ and 52 to 72 percent for substance abuse disorders.¹³⁻¹⁶ In considering bias as it relates to BPD in forensic and correctional settings, it is important to also consider the ways in which psychiatric comorbidities may cloud the clinical presentation.

The focus of the present manuscript is on the unique influence of BPD independent of comorbid conditions. We opted to focus on BPD exclusively, given the well documented nature of bias associated with the disorder. Although the literature on bias in forensic contexts has reached a position of prominence and extant discussion in recent years,⁵⁵⁻⁵⁸ our specific focus on BPD was selected in response to the greater stigma relative to other forms of psychopathology, as well as the uniqueness of the clinical presentations and treatment and risk mitigation needs relative to the typical violence risk assessment referral.

Research has supported the relationship between BPD and risk for violence in inpatient settings. Rasmussen and Levander⁵⁹ examined factors among a physically aggressive group of male and female patients within a maximum security psychiatric hospital. According to their study, inpatient aggression was positively correlated with psychotic symptoms, BPD, and patients requiring daily living activities assistance. Personality disorders have long been associated with

increases in violence,^{60,61} including within inpatient settings. Even when controlling for psychosis, antisocial, borderline, and histrionic traits have been associated with repeated acts of inpatient aggression.⁶² Thus, beyond evidence of bias associated with BPD, research suggests that individuals with BPD or BPD traits may have an increased potential for aggression in inpatient settings, complicating the assessment of violence risk and supporting particular discussion for this group of patients.

Violence Risk Assessment and BPD

The past three decades have established the need for empirically supported approaches to evaluate (and mitigate) an individual's risk for future violence.^{63,64} Broadly categorized as nondiscretionary (e.g., actuarial) or discretionary (e.g., structured professional judgment) procedures,⁶⁵ an extensive research literature has established risk assessment guidelines as the standard of practice within forensic settings. Initially referred to as structured clinical judgment,⁶⁶ the structured professional judgment (SPJ) approach was developed to provide clinicians with a set of evidence-based guidelines to identify risk factors, develop risk formulations for the management of violence, and minimize the influence of bias.⁶⁷

Although these approaches have significantly improved the reliability and validity of violence risk assessment, a considerable body of research has indicated that cognitive biases affect the interpretation of data and formation of opinions in the field of forensic sciences (e.g., fingerprint analysis, ballistics),⁶⁸⁻⁷⁰ as well as in the context of forensic evaluations, including violence risk assessment.^{55,56,71} With respect to forensic evaluations, factors that interfere with objective observations, data collection (e.g., record review), or decision-making have the potential to introduce bias into the evaluation process. The factors derive from a variety of sources, which have been organized into three broad domains, including case-specific materials (e.g., data, contextual information); the interaction between the evaluator and the environment, culture, and experience (e.g., organizational factors, base rates, education and training); and human nature (e.g., personal factors, information processing system, and the brain).^{70,72,73}

One of the challenges that arises in the context of violence risk assessment is the highly vivid content (e.g., graphic descriptions in police reports) and complex, although sometimes contradictory, information, especially regarding previous violence, which the evaluator must somehow resolve. This concern is

especially complicated for individuals with BPD, who oftentimes elicit strong negative reactions among staff, which can, in turn, exert powerful influences on the interpretation of behavior as well as broader perceptions of risk and dangerousness.

From a psychoanalytic perspective, BPD is conceptualized as a disruption in one's capacity to achieve object constancy during childhood, resulting in reliance on immature defenses, such as splitting (or perceiving others as all good or all bad), thereby evoking strong negative countertransference reactions and biased responses from others.⁷⁴ Indeed, prior studies indicate BPD often elicits strong negative countertransference reactions in clinicians, defined broadly as the collection of conscious and unconscious reactions to clients.^{33–37,74} In turn, these biased perceptions and negative attitudes toward individuals with BPD lead to heightened expectations for violence, especially in forensic settings, that inherently affect how information is interpreted and perceived (e.g., confirmation bias; salience of evidence that aligns with beliefs).⁷⁵ The following section reviews additional factors relevant to violence risk assessment in forensic settings.

Bias in Records and Interpretations

Record review frequently accounts for the greatest proportion of time and effort when conducting forensic evaluations, reflecting a reduced emphasis on self-report (relative to records), given the demand characteristics of forensic settings (e.g., potential motivation to over- or underreport, depending on the referral question). This is especially the case for violence risk assessments, as this information is ultimately the basis for ratings of the presence and relevance of empirically derived risk factors. One of the defining features of violence risk assessment, particularly the SPJ approach, is the substantial reliance on information from records. It is therefore imperative to ensure the veracity of details contained in records.

As noted previously, staff and providers often have affectively negative responses toward individuals with BPD,^{33,34,38,76} such that staff documentation of patient behaviors, particularly those perceived as driven by difficult personality features or behaviors, may inappropriately include pejorative, biased language. It is not uncommon for individuals with BPD to be described as manipulative or attention-seeking, often with little further explanation. Moreover, the information that evaluators review first can result in an anchoring bias,⁷⁷ resulting in greater emphasis on

information obtained earlier in the process, including details regarding the request for the evaluation from the referral source. Case information that is irrelevant to the referral question or the legal question may also bias the evaluator's interpretations and conclusions,⁷¹ such that careful attention should be given to relevance of any information that is reviewed. Further complicating this is the tendency for regular inpatient hospital documentation reports (e.g., daily, weekly, or monthly progress logs) to be recycled, with identical statements being repeated and retained week after week. Although tempting to perceive this as convergence of data across time, the validity of these recycled statements must be critically examined, as the potential for the bias snowball effect⁷⁸ is increased as more irrelevant information is incorporated and integrated into the formulations of risk. Although forensic clinicians often have training in the appropriate maintenance and documentation of records (e.g., using unbiased language, reliance on overt behaviors in reporting, etc.), some staff members in forensic inpatient settings may not have received this crucial training and therefore may fall short of these ideals.

Beyond limitations in training, however, negatively valenced attitudes toward individuals with BPD may influence the ways in which documentation occurs as well as the content of that documentation, reflecting potential negative countertransference reactions among providers toward patients with BPD.^{36,37,74} Consider, for example, an incident wherein a patient with BPD is involved in a problematic interaction with a peer. This patient is disliked by most staff and other patients and responds negatively when confronted. Records documenting the confrontation, particularly when written by an individual with already negative attitudes toward this individual, may include statements such as "defensive when confronted," "ongoing maladaptive behaviors," and "poor response to redirection." Statements describing the actual and explicit behavior of the individual would be more useful, descriptive, and relevant to the construction of an appropriate risk formulation.

Records may also include biased interpretations of a patient's behavior, such as speculation regarding a patient's motivation or attributions of blame. Consider a man who is seen as a difficult patient who is involved in a verbal altercation with a staff member concerning his canteen, a common situation in an inpatient setting. Consider that this patient has requested documentation of his canteen balance, as he has concerns that there

was a mathematical error in calculating his previous balance. The staff member who is asked to do this may respond with aggravation, questioning the motivation of the patient. If this patient has a history of accusing staff of targeting him in some way or questioning the authority or competence of staff (which is also common in forensic inpatient settings), staff may interpret this behavior as an example of inappropriately accusatory behavior. The staff member may feel justified in labeling this behavior as manipulative and demanding, given prior experience with this patient. Imagine, however, that the patient was correct and that there was a mathematical error in calculating his balance. Because of his self-advocacy, and in light of his history of questioning authority, a benign (and arguably prosocial) request was therefore converted to aggravating evidence of manipulation. Well beyond the initial note documenting the incident, this potentially inappropriate interpretation of the patient's behavior has the potential of being recycled for weeks, months, and possibly years, to be used as evidence of an individual's failure to respond to intervention.

Objectivity of Other Parties

In addition to recognizing and appreciating bias contained in available documentation, evaluators should consider the nature of the referral for risk assessment. In most forensic settings, violence risk assessment is conducted in an enduring fashion, often upon admission, at various intervals during the course of hospitalization, and immediately prior to release. In general, referrals for violence risk assessment are often made in response to concerns, with the goal of identifying appropriate interventions to address and mitigate risk. In some cases, particularly when a patient presents traits characteristic of BPD, the referral may reflect this bias, with the referring party mistakenly linking these personality traits to risk. A common occurrence, illustrated in the following case example, is the tendency for treatment providers to interpret perceived interpersonal manipulation as a direct indication of violence risk, even if there is little evidence to support this claim. In sum, it is imperative for evaluators to consider the nature of the referral, to clarify its contextual basis, and to systematically consider the view of the referring source as well as various alternatives.

Case Example

We provide a fictionalized case example, reflecting a composite of several clinical cases, to illustrate how

these dilemmas materialize and threaten the objectivity of the assessment at nearly every stage. In this example, a 50-year-old female was referred for a violence risk assessment by her treatment team at the forensic hospital where she was committed after being found not guilty by reason of insanity (NGRI) for attempted murder six years prior. The team expressed concern about the patient's level of risk in the context of pervasive interpersonal difficulties, persistently maladaptive relationships, a repetitive pattern of risky sexual behavior, and frequent conflict with peers and staff on the unit, which sometimes escalated to verbal (although never physical) altercations.

According to records, the index offense occurred in the context of a discrete episode characterized by psychotic and mood symptoms, which had since completely resolved. Prior to the incident, she had been psychiatrically hospitalized several times because of acute mood instability, extreme hostility, and self-destructive behavior. At the time of the referral, she was diagnosed with BPD and major depressive disorder, which were well managed with antidepressant medication, case management, and group therapy. Because of the prominence of her maladaptive personality patterns and the relative absence of psychiatric symptoms since her admission, the team questioned whether she met criteria for any mental health conditions other than BPD, which led some to also doubt the validity of the NGRI acquittal. Indeed, the prevailing opinion of the treatment team was that this patient was manipulative, narcissistic, demanding, and "incredibly borderline." From the outset, there were questions about the objectivity of the referral source, as the collective opinion was obvious (i.e., "We don't like her.") and there was a presumption among the team that the outcome was also obvious (i.e., "She's manipulative and therefore dangerous."). This inherently resulted in pressure on the evaluator to confirm the teams' notions, not unlike those discussed in the context of allegiance effects.⁵⁵ Staff possessed similarly negative views of the patient, describing her as "unlikeable" and "difficult." Interestingly, these reports focused exclusively on concerns stemming from the patient's pervasive personality disorder, but there was never an explicit connection to a risk for violence. Records documented frequent moves between units because of interpersonal conflicts (i.e., verbal altercations) with peers and staff, but there was no other documented history of disruptive, aggressive, or violent conduct. Although there were multiple references

Table 1 Practical Recommendations for Forensic Evaluators

<i>Systematic Methodological Approach</i>	
Consider each data point individually and systematically	
Categorize data points as evidence for or against each risk factor	
Document risk ratings to aid decision-making (and testimony preparation)	
Postpone forming opinion until all data are collected and reviewed	
<i>Secure Additional Information</i>	
Request detailed description of behaviors labeled as “manipulative”	
Corroborate collateral information early and often, with multiple sources	
Consult with colleagues regarding decision-making and clinical opinions	
Monitor negative countertransference reactions (and potential bias)	
<i>Resolve Inconsistencies Wherever Possible</i>	
Consider “if . . . then” statements to account for missing or inconsistent data	
Be forthright regarding uncertainty and impact on opinion	
Do not provide opinion without sufficient basis to do so	

to “manipulative,” “demanding,” and “entitled” behavior, details were rarely provided.

Interestingly, staff also perceived this patient in other ways. There were multiple records that described the patient as “attractive,” “feminine,” or “done up,” which are clearly inappropriate to appear in a medical record. Providers described her personality as “charismatic,” “charming,” and “captivating.” She was also provided with various benefits not afforded to other patients, including extra visits with family and maintaining a seat on a selective patient committee despite disciplinary incidents that have precluded others from remaining in the same role. It is notable that these remarks, although positive, were equally as unbalanced as those in the opposite direction.

As noted previously, members of the treatment team expressed doubt about the legitimacy of the patient’s NGRI acquittal based on her pervasive personality disorder and the absence of psychiatric symptoms in the years following, yet this failed to account for the collection of data from multiple sources, including witness statements, police reports, collateral informants, jail records, and mental health records that documented her behavior at the time of the incident. In addition, providers seemed to make a second inappropriate leap of logic, reflecting the untenable connection between her pervasive personality dynamics and a heightened risk for violence, although this similarly ignored evidence to the contrary. It is important to highlight that, in addition to the polarized perspectives of the examinee reflected in records and staff comments, the examiner had to remain mindful of the potential for similarly extreme countertransference reactions to the patient. Consistent with descriptions elsewhere, the interaction during the

evaluation was largely superficial, with a quality of defensiveness and occasionally exaggerated emotional displays. At times, she seemed to deliberately interfere with completing the evaluation, a pattern that staff routinely documented elsewhere as evidence of her manipulateness (and perhaps rightly so). Naturally, this fostered some frustration toward the patient, as well as greater understanding of the perspective of staff, which were important data points to consider together. Remaining mindful of, and closely monitoring, the potential for negative countertransference, along with other unprocessed emotions, reflected yet another unique consideration of this type of evaluation.⁷⁹

The evaluation ultimately concluded that the patient was at a relatively low risk for future violence. Although some risk-relevant items were present (i.e., grandiosity, superficial charm, relationships, lack of insight on both the Psychopathy Checklist Revised (PCL-R)⁸⁰ and Historical Clinical Risk Management-20, Version 3 (HCR-20V3),⁸¹ they were few in number and their relevance was low. As might be expected, the treatment team was surprised and somewhat dismissive of the feedback, suggesting that perhaps this was just another example of her successful manipulation of those around her. In this case, threats to objectivity were evident at nearly every stage, from receipt of the referral to the delivery of feedback to the team. There were questions regarding the validity of records and the objectivity of the referral source, combined with notable pressures to conform to the collective opinion of staff, along with the evaluator’s own negative affective response to the patient (countertransference), all of which heightened the potential for bias in this evaluation. Throughout, the evaluator remained committed to a systematic methodological approach whereby the data guided the process, which provided a framework that served to protect the objectivity of the evaluation. The following section proposes several practical recommendations for evaluators conducting risk assessments of individuals with BPD in similar settings, which are summarized in Table 1.

Solutions and Practical Recommendations

Systematic Methodological Approach

As scientist-practitioners, professionals are most often trained to approach clinical work systematically, with an ongoing commitment to objectivity, and our professional ethics explicitly enjoin us to maintain our objectivity, regardless of the circumstances.^{82–85}

One way to do this in forensic evaluations, particularly violence risk assessments wherein data are secured from multiple, competing sources with varying degrees of subjectivity and affective responses, is to take a systematic approach to the method and interpretation, such that each piece of information is individually considered and systematically reviewed. One method of doing so is to categorize each piece of data as evidence for or evidence against each enumerated risk factor, which is a well established practice that has been described in test manuals. Constructing an electronic document to consider, intentionally and systematically, information as it relates to each factor is one safeguard in ensuring that bias is reduced.

Although there remains some subjectivity in terms of deciding which information to include and under which factor it resides, the systematic completion of the table reduces the likelihood that the evaluator will rely on a one-sided interpretation of an examinee's behavior or be inappropriately swayed by the relative salience of one or a few pieces of data. It can sometimes be difficult to identify and consider the counternarrative or to challenge confirmation bias given the extent and salience of information the evaluator must consider. This is like another strategy designed to counteract bias by considering the opposite, which involves asking why an initial judgment may be incorrect and then considering possible alternatives.^{86,87} Notably, such a table outlining a defensible rationale for each factor inherently increases the transparency of the evaluation process and the evaluator's reasoning, which is crucial for the fact-finder, which could also serve as a useful preparation aid if called to testify, for both the evaluator and the attorney(s).

Another example is the CHES Method, which is a well ordered and systematic approach to data analysis in the formation of forensic opinions, which includes a series of five steps.⁸⁸ First, a preliminary opinion (claim) is formed after the data are reviewed (C), which is then examined by organizing the evidence into a hierarchy (H). Next, the opinion and associated evidence are reviewed to identify potential areas of exposure or vulnerability (limitations), including the presence and strength of any opposing arguments (E). This evidence is then studied to best identify how to respond to any weakness, and additional data may be requested, if needed (S). At this point, weak evidence may be omitted, whereas concessions may be incorporated. The last step is to synthesize a revised opinion with a stronger list of supporting evidence (S).

The process may be repeated until satisfied that it contains reasonable opinions, supporting arguments, and necessary concessions.

Relatedly, and consistent with the scientist-practitioner model, evaluators are encouraged to postpone the formation of an opinion until all the information has been collected and reviewed. Postponing the final judgment limits the potential detrimental impact of allowing certain pieces of information to unduly burden one side or the other. In addition, foreclosing on an opinion before the information-gathering phase is complete increases the likelihood that the examiner will engage in confirmation bias, whereby information is selected and considered as more consistent with the prematurely formed opinion; this effect has been discussed in the literature specific to forensic assessment.⁵⁷ This advice is certainly not specific to assessing individuals with BPD, as forensic evaluators would benefit from this approach in all circumstances. The propensity toward negative evaluation of individuals with BPD, however, indicates that strict adherence to heightened standards and judgment practices is needed to ensure ethical practice and safeguard against the myriad sources of bias that threaten the objectivity of the evaluation.

Secure Additional Information

One of the ways that an evaluator can counter the presence of value-laden judgements in documentation is to seek behavioral descriptions. In inpatient settings, providers are often a phone call away. Requesting that documenters provide behavioral descriptions of incidents singularly described as manipulative and demanding, for example, reduces the likelihood of relying on inadequate or biased data, and it facilitates the collection of potentially relevant detail that may otherwise not be available in records. We recommend that evaluators reach out to treatment providers to ask for explicit definitions of behaviors that were characterized in records as demanding, for example (e.g., "What exactly happened?," "Did you witness the behavior?," "When you say 'demanding,' what do you mean?"). This approach is particularly relevant because of the problems with appropriate and accurate documentation specific to patients with BPD, reflecting the previously mentioned problems of recycled documentation, biased interpretations, negative countertransference, etc.

Another crucial source of information is the opinion of trusted colleagues, especially those who are

further removed from the evaluation itself. Indeed, case consultation provides an opportunity to receive feedback on one's decision-making and clinical opinions as well as the opportunity to explore additional hypotheses with a fresh set of eyes. This may range from informal discussion to formal case review, although the presentation of data should be structured in such a way to safeguard against biasing the impressions of colleagues. For example, it may be beneficial to disguise the details of the case or examinee to reduce the impact of preexisting impressions. Consultation with colleagues is also a valuable mechanism for monitoring one's own negative countertransference and any resulting biases that may arise.

Resolve Inconsistencies Wherever Possible

Like the recommendation that evaluators postpone opinions until the final pieces of data are reviewed, evaluators are encouraged to tolerate uncertainty. Rarely is every piece of data available to an evaluator, sometimes requiring evaluators to make inferences from other relevant information. Evaluators are encouraged to embrace this uncertainty, to recognize the limits of their data, and to appreciate how this may interfere with opinion formation.

There are several possible ways examiners can do this, the first of which is to determine whether an if . . . then statement might apply. This may be helpful when presenting information absent relevant collateral data. For example, "If Mr. Jones's self-report is accurate, and he has satisfactorily completed the requirements of his prior probation sentences without difficulty, then it is appropriate to rate this item a '0.' If additional information were to suggest this is not the case, however, and that he has violated the terms of his conditional release in the past, the rating should reflect this as either a '1' or a '2,' depending on the frequency and severity of the violation(s)." Here, the evaluator tolerates the ambiguity of the data and acknowledges uncertainty in the conclusion while also providing enough information to address the consideration of such information, if it were to materialize later.

Another way to resolve such limits is to be forthright about the uncertainty and its associated impact on the examiner's ability to form an opinion. There is nothing wrong with concluding that an accurate opinion cannot be formed, and such an outcome is arguably more appropriate and ethically responsible than attempting to opine without sufficient basis.

While the pressure to form an opinion can be extraordinary in situations where administrative bodies (e.g., courts, hospital release boards) depend on it for decision-making, it is imperative to resist this influence and instead embrace the resulting uncertainty.

As described throughout, clinical documentation and records for patients with BPD are sometimes replete with biased interpretations and descriptions, which could range considerably, with staff responses falling at opposite ends of the spectrum. This process, known as splitting, is a defense mechanism that effectively creates divides among providers, resulting in polarized opinions and occasional discord among staff and can ultimately lead to intense and self-destructive behaviors.⁸⁹ Consistent with psychoanalytic conceptualizations of BPD, this arises from the characteristic tendency of individuals with BPD to see the world as black and white, reflecting an inability to hold opposing thoughts or feelings simultaneously (i.e., poor object constancy). Thus, individuals (including staff) are perceived as all good or all bad, contributing to the polarization of perspectives of the individual with BPD. Ultimately, such pervasive discrepancies may be unresolvable without access to other, less biased sources of information. In these instances, the evaluator should openly communicate this uncertainty, both to the referral source and in any formal documentation, which is true to the reality that sometimes a solid opinion is simply unknowable without better data.

Conclusion

We sought to highlight some of the unique complications in evaluating violence risk for patients diagnosed with BPD in forensic inpatient settings. Drawn from the literature on bias, we clarified some of the specific threats and sources of bias and described how this ultimately manifests across different situations and contexts. Various examples were provided to highlight these biases across the entire evaluation process, from receipt of the referral to providing feedback, to clearly demonstrate how these threats may impede fair and equitable evaluation for individuals with BPD.

Consistent with the Specialty Guidelines for Forensic Psychology,⁸² the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association,⁸³ and the Ethics Guidelines for the Practice of Forensic Psychiatry from the American Academy of Psychiatry and the Law,⁸⁴ we encourage forensic practitioners to commit to objectivity by adhering to a systematic methodological approach and

making explicit efforts to safeguard against biases that threaten the objectivity of the process. Postponing conclusions until the data have been reviewed in their entirety and embracing the uncertainty of conclusions by remaining tentative, examiners remain steadfast in their commitment to ethical practice, consistent with the emphasis on honesty and objectivity in the ethics guidelines for forensic practice.^{82,84}

Although the threats to bias and objectivity discussed here are not necessarily exclusive to this context, nor this population, we view them as sufficiently pervasive to warrant special discussion. Indeed, it is ultimately the collection of interacting factors that uniquely threaten the objectivity of risk assessment with individuals with BPD that necessitates separate discussion. As we move toward dimensional models in understanding and explaining personality and psychopathology, perhaps we will see a decrease in this bias and negatively valenced attitudes toward individuals with BPD. Until it is no longer synonymous with manipulative and attention-seeking behavior, however, we must recognize the potential influence of bias and counter it strategically if we are to engage in the equitable practice of forensic mental health and accurate assessments of violence risk.

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