Gender Bias in the Diagnosis of Antisocial and Borderline Personality Disorders: A Continuing Education Reading Manual for Psychologists and Mental Health Clinicians

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Gender Bias in the Diagnosis of Antisocial and Borderline Personality Disorders: Clinical, Conceptual, and Systemic Implications for Contemporary Psychological Practice

A Continuing Education Reading Manual for Licensed Psychologists and Graduate-Level Clinicians

Prepared as an integrated synthesis of contemporary empirical evidence, with primary attention to the work of Özel, Karakaya, Köksal, Altinoz, and Yilmaz-Karaman (2025), *Archives of Women's Mental Health*, and the broader body of scholarship on gender bias in personality disorder diagnosis.

Abstract

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has long provided the definitional scaffolding for the clinical identification and classification of personality disorders. Yet, since the early 1980s, scholars and clinicians have consistently raised concerns regarding the gendered assumptions embedded within its categorical structure, particularly in the diagnoses of antisocial personality disorder (ASPD) and borderline personality disorder (BPD). These two disorders share overlapping features of impulsivity, affective instability, and interpersonal dysregulation, yet diverge substantially in their evidence base for treatment, prognosis, and access to mental health services. This continuing education manual presents

an in-depth examination of gender bias in the diagnosis of ASPD and BPD, integrating findings from a cross-sectional case-vignette study of Turkish psychiatrists (Özel et al., 2025) with the wider empirical and theoretical literature on sex differences, diagnostic construct validity, gender role socialization, and clinician cognition. The manual traces the historical emergence of concerns about diagnostic sexism, reviews conceptual models of biased diagnostic constructs, criteria, and thresholds, and explores the psychological mechanisms by which gender stereotypes shape clinical judgment. It further considers the downstream clinical consequences of misdiagnosis, including inappropriate treatment allocation, iatrogenic stigma, self-stigma, and exclusion from mental health services. The manuscript concludes with clinical implications for psychologists, recommendations for reflective practice, and directions for future research aimed at reducing diagnostic disparities in personality disorder assessment.

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1. Introduction

Diagnostic classification systems in psychiatry and psychology have always served a dual function. On one hand, they provide the shared nosological language that permits research, communication among clinicians, insurance reimbursement, and the coordination of care across services. On the other hand, they operate as socially embedded artifacts that reflect the values, assumptions, and hierarchies of the cultures in which they are produced. The Diagnostic and Statistical Manual of Mental Disorders (DSM), across its several editions, exemplifies both of these functions. As Özel et al. (2025) note, the DSM has offered substantial benefits for clinical practice and administrative systems, but it has simultaneously been the target of persistent critique concerning bias, particularly bias organized around gender.

The concern that diagnostic categories may be applied with differential validity across demographic groups is not new. As Garb (2021) has argued, bias occurs whenever diagnostic criteria or clinical judgments are more valid for one group than another. When such differential validity is patterned along gender lines, the diagnostic act itself may become a site at which broader social inequalities are reproduced within clinical practice. Since Kaplan's (1983) foundational critique of the DSM-III, a substantial body of work has examined how the personality disorder section, in particular, may embed gendered assumptions about what

constitutes psychopathology (Samuel & Widiger, 2009). Among the personality disorders, antisocial personality disorder (ASPD) and borderline personality disorder (BPD) have emerged as particularly contested categories, both because of the overlap in their behavioral presentations and because they exhibit the most pronounced apparent sex differences in prevalence (Chun et al., 2017; Skodol & Bender, 2003).

The clinical stakes of these diagnostic distinctions are considerable. ASPD and BPD differ markedly in their evidence base for psychological treatment, their prognosis, and their impact on the patient's access to mental health services. A misdiagnosis is therefore not a neutral event; it shapes what kind of treatment, if any, the patient will receive. The Turkish study by Özel et al. (2025), which forms the empirical anchor of this reading manual, demonstrated that among 250 psychiatrists presented with a case vignette designed to meet criteria for ASPD, a female patient was approximately 5.1 times more likely to be misdiagnosed than a male patient with an identical clinical presentation—and that these misdiagnoses were almost uniformly directed toward BPD.

This reading manual is intended to help licensed psychologists and graduate-level clinicians understand not merely that such bias exists, but why it exists, how it operates, and what can be done to mitigate its influence on clinical judgment. The manual proceeds by tracing the historical and theoretical foundations of the concern about gender bias in personality disorder diagnosis, articulating conceptual models of how such bias operates at the level of constructs, criteria, thresholds, and clinician cognition, integrating the empirical findings of the Özel et al. (2025) study with the broader literature, and finally exploring the clinical, systemic, and ethical implications for contemporary psychological practice.

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2. Historical and Theoretical Foundations

2.1 The Emergence of Concern About Diagnostic Sexism

The introduction of personality disorders as a distinct section within the DSM in the early 1980s coincided with the growing influence of feminist critiques within psychology and psychiatry. Kaplan's (1983) landmark paper, "A Woman's View of DSM-III," argued that the experts responsible for the manual had inadvertently or unreflectively encoded a set of

gender-role stereotypes into its diagnostic criteria. Kaplan contended that certain patterns of behavior more common in women were pathologized, while parallel patterns more common in men were either normalized or assigned to entirely different diagnostic categories with different implications for treatment and stigma.

In the decades following Kaplan's critique, an extensive body of research emerged testing, extending, and refining her claims (Samuel & Widiger, 2009; Widiger, 2011). Several converging lines of evidence indicated that the concern was not merely rhetorical. Studies of clinician judgment using case vignettes, analyses of the diagnostic criteria themselves, and comparisons of dimensional and categorical models of personality disorder all suggested that gender bias operated at multiple levels within the diagnostic enterprise.

2.2 The Distinct Clinical Profiles of ASPD and BPD

Antisocial personality disorder, as defined in the DSM-5-TR (American Psychiatric Association [APA], 2022), is characterized by a pervasive pattern of disregarding and violating the rights of others. Its clinical prevalence ranges widely, from approximately 3% to 30% depending on the setting, and it is diagnosed more commonly in males than in females (Schulte Holthausen & Habel, 2018). ASPD is frequently comorbid with substance use disorders, particularly in men (APA, 2022; Paris et al., 2013). Women who receive an ASPD diagnosis, by contrast, are more likely to have histories of adverse childhood experiences, sexual abuse, and comorbid mood disorders (Alegria et al., 2013; Sher et al., 2015). These differences in comorbidity profiles complicate the clinical picture and may themselves contribute to differential recognition of the disorder across genders.

Borderline personality disorder has historically been described as a "female" disorder, with a widely cited sex ratio of approximately 3:1 (APA, 2022). It is defined by a pervasive pattern of impulsivity, instability in interpersonal relationships, disturbed self-perception, and affective dysregulation, typically emerging in early adulthood. Its prevalence is estimated at approximately 6% in primary care settings, 10% in outpatient mental health clinics, and 20% in psychiatric inpatient populations (APA, 2022). However, more recent epidemiological research has challenged the assumption of a substantially higher prevalence among women, suggesting that the true prevalence rates may not differ significantly between the sexes (Qian et al., 2022; Sansone & Sansone, 2011). The clinical presentations of men and women with BPD appear broadly similar, though men may exhibit somewhat higher levels of externalizing

behavior and women somewhat higher levels of internalizing behavior—a pattern that itself may reflect gender socialization rather than any fundamental sex difference in the underlying pathology (APA, 2022; Qian et al., 2022).

2.3 Gender Roles as Mediators of Symptom Expression

The differential presentation of psychopathology across genders cannot be understood without reference to the concept of gender role socialization. Gender roles, as Kulis, Marsiglia, and Nagoshi (2010) have described, refer to the stereotypical emotions, cognitions, and behaviors culturally associated with being male or female. These roles are acquired through socialization and mediate a substantial portion of the observed sex differences in externalizing and internalizing problem behaviors. Traditional masculinity, with its emphasis on instrumentality, assertion, and control, tends to channel distress into externalizing forms; traditional femininity, with its emphasis on expressivity and emotional attunement, tends to channel distress into internalizing forms.

This theoretical framework has important implications for the diagnosis of personality disorders. If ASPD is defined largely by externalizing features and BPD is defined largely by affectively expressive features, then the diagnostic categories themselves may inadvertently map onto masculine and feminine gender-role stereotypes. A woman who exhibits externalizing, antisocial behaviors deviates from her prescribed gender role; a man who exhibits emotionally dysregulated, unstable interpersonal behavior likewise deviates from his. The question of how clinicians respond to such gender-role-incongruent presentations lies at the heart of the concern about diagnostic bias (Sprock et al., 1990).

2.4 Attitudes Toward Personality Disorders Among Clinicians

Compounding the specific problem of gender bias is the broader phenomenon of clinician negativity toward patients with personality disorders. Lewis and Appleby's (1988) influential study demonstrated that psychiatrists held systematically more negative attitudes toward patients with personality disorder diagnoses than toward patients with other psychiatric conditions, and that the diagnostic label itself, more than the patient's gender or social class, drove these negative attitudes. Chartonas et al. (2017), revisiting this question nearly three decades later, found that personality disorder diagnoses continued to function as barriers to compassionate care, generating stigma both within the clinician and within the mental health

system more broadly. The convergence of clinician negativity toward personality disorders and the presence of gender-based diagnostic bias creates a situation in which certain patients—particularly women incorrectly labeled with BPD instead of ASPD, or men incorrectly labeled with ASPD instead of BPD—may face compounded barriers to receiving appropriate treatment.

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3. Conceptual Models and Mechanisms

3.1 Widiger's Framework: Three Pathways to Diagnostic Bias

Widiger (2011) has articulated a conceptual framework that has become foundational for understanding how gender bias may enter the diagnostic process. He identified three distinct pathways: biased diagnostic constructs, biased diagnostic criteria, and biased diagnostic thresholds.

Biased diagnostic constructs refer to the categorization of behaviors as pathological when they reflect culturally prescribed patterns for one gender. If the very concept of a disorder is built around behaviors that are also stereotypically feminine—such as emotional expressivity or dependence—then women who exhibit these behaviors, even at socially prescribed levels, may be more readily classified as disordered. Biased diagnostic criteria refer to the possibility that behaviors conforming to traditional gender roles may be viewed as less pathological, thus setting a higher threshold for one gender than another. Biased diagnostic thresholds involve the differential application of criteria such that clinicians require more or less evidence of a symptom to make a diagnosis depending on the patient's gender.

Skodol and Bender (2003) extended this framework, applying it particularly to the question of why women are diagnosed with BPD more often than men. They suggested that all three pathways may operate simultaneously, and that their interaction generates the systematic patterns of over- and under-diagnosis observed clinically.

3.2 Assessment Bias and Clinician Cognition

Alongside the structural features of the diagnostic system, individual clinician cognition contributes to biased diagnosis. Morey, Warner, and Boggs (2002) introduced the concept of assessment bias to capture the phenomenon by which the diagnostician's interpretation of a diagnostic criterion is shaped by preconceived notions about the patient. Assessment bias operates through the automatic activation of stereotypes during clinical encounters. When a clinician encounters a female patient with impulsive, dysregulated behavior, the availability of the "borderline woman" schema may cause them to interpret ambiguous information in a manner consistent with that schema, even when the presenting features would more accurately be classified as antisocial. Conversely, when a clinician encounters a male patient with similar features, the "antisocial man" schema may guide interpretation, again in a manner that overrides the specific features of the case.

Sprock, Blashfield, and Smith (1990) provided early empirical support for this phenomenon by demonstrating that clinicians tend to weight diagnostic criteria differently depending on the gender of the patient. They found that certain criteria could be considered prototypically masculine (such as antisocial or sadistic features) or prototypically feminine (such as dependent or histrionic features), and that these gender weightings influenced diagnostic decisions.

3.3 The Role of the DSM Working Groups

A further layer of concern involves the composition of the DSM working groups themselves. Disney (2013), in a critical review of dependent personality disorder, raised the concern that a predominantly masculine perspective within DSM working groups may have inadvertently shaped diagnostic criteria in ways that reflect gendered assumptions about healthy and pathological behavior. If the framers of a diagnostic system implicitly hold traditional gender-role expectations, they may pathologize behaviors that violate those expectations—labeling assertive women as histrionic or dependent men as pathological, for example—while normalizing the same behaviors when they conform to expectations. This concern connects individual-level assessment bias to systemic-level construct bias in a manner that suggests the problem is not merely one of "biased clinicians" but of a diagnostic architecture that reproduces cultural gender norms.

3.4 Dimensional Alternatives to Categorical Diagnosis

One of the most productive theoretical responses to the problem of gender bias in personality disorder diagnosis has been the development of dimensional models of personality pathology. Samuel and Widiger (2009) compared gender biases in categorical DSM-based diagnostic methods with those in the Five Factor Model, a dimensional framework that assesses personality across the traits of neuroticism, extraversion, openness, agreeableness, and conscientiousness. Their findings suggested that dimensional models reduce gender bias in personality disorder diagnosis relative to categorical DSM criteria. The mechanism appears to be that dimensional assessment reduces the reliance on prototype-matching and stereotype-driven judgment, requiring the clinician to evaluate the patient across a broader range of traits rather than fitting the patient into a category shaped by cultural gender norms.

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4. Empirical Findings Across Studies

4.1 The Özel et al. (2025) Case Vignette Study

The centerpiece of contemporary empirical work on gender bias in the diagnosis of ASPD and BPD is the cross-sectional study conducted by Özel and colleagues (2025) among Turkish psychiatrists. The study was designed as a case-vignette experiment in which participants were presented with three vignettes drawn from the DSM-IV Case Studies (Frances & Ross, 1996). The first vignette depicted a patient with schizophrenia and served as a control to verify participants' diagnostic competency. The second vignette depicted a patient meeting criteria for ASPD, and the third depicted a patient meeting criteria for BPD. Crucially, the gender of the patient in each vignette was randomly assigned by the online survey platform, holding the clinical content constant. This design isolated the influence of patient gender on clinician diagnostic decisions.

Two hundred fifty psychiatrists—both consultant psychiatrists and psychiatry residents with at least one year of residency experience—correctly diagnosed the control vignette and were included in the final analysis. The sample was predominantly female (64%) and averaged 33.9 years of age with approximately 7.8 years of professional experience.

The findings were striking. For the ASPD vignette, 92.3% of participants correctly diagnosed the male version, while only 70% correctly diagnosed the female version. The predominant

misdiagnosis for the female ASPD case was BPD, applied by 29.2% of participants who viewed the female version. A binary logistic regression confirmed that a female patient with ASPD was approximately 5.1 times more likely to be misdiagnosed than a male patient with identical clinical features (odds ratio = 5.143; 95% CI [2.419, 10.932]; $p < .001$). Post-hoc power analysis using Cohen's *h* yielded a value of 1.04, indicating an adequate effect size.

For the BPD vignette, results were more equivocal. Male BPD cases were correctly diagnosed in 90.8% of instances, while female BPD cases were correctly diagnosed in 92.2%. The difference did not reach statistical significance (odds ratio = 1.194; 95% CI [0.488, 2.923]; $p = .698$). However, a striking qualitative pattern emerged: every clinician who misdiagnosed a male BPD case diagnosed the patient with ASPD, whereas misdiagnoses of female BPD cases were distributed across ASPD, histrionic personality disorder, and narcissistic personality disorder.

These findings support and refine the general hypothesis of gender bias in personality disorder diagnosis. The bias appears to operate asymmetrically. Female patients with ASPD are strongly susceptible to being reclassified as having BPD—a diagnosis more culturally consonant with traditional femininity. Male patients with BPD are not more likely to be misdiagnosed overall, but when they are misdiagnosed, they are uniformly reclassified as having ASPD—a diagnosis more culturally consonant with traditional masculinity.

4.2 Convergence with Earlier Research

The Özel et al. (2025) findings converge with a substantial prior literature. Henry and Cohen (1983), in an early study on labeling processes in BPD diagnosis, found no gender differences in the diagnosis of BPD—a finding they interpreted with caution, noting that fictitious vignettes may not fully capture the perceived gender characteristics that operate in real clinical encounters. This caveat is important: if bias is muted in the artificial context of case vignettes, then the true bias in real clinical practice may be even larger than the already substantial effect observed in Özel et al.'s (2025) study.

Skodol et al. (2003) similarly documented the tendency for clinicians to diagnose women with BPD and men with ASPD when presented with similar problem behaviors, reinforcing the sense that the two diagnoses function partly as gendered variants of a shared underlying construct. Chun et al. (2017), in a psychometric investigation of gender differences and

common processes across BPD and ASPD, found evidence for substantial shared variance between the two disorders, further supporting the view that they may represent overlapping presentations that are then sorted into gendered categories at the moment of diagnosis.

Sher et al. (2015) and Alegria et al. (2013) examined sex differences in the clinical characteristics of patients with ASPD, finding that women with the disorder show distinct patterns of comorbidity and adverse life experience, including higher rates of childhood abuse and comorbid mood disorders. These distinctive presentations may further contribute to under-recognition, because clinicians may attribute the mood symptoms to a primary affective or borderline pathology and miss the underlying antisocial features.

Amerio et al. (2023) and He et al. (2022), in more recent work, have examined how gender shapes the presentation of BPD and other personality disorders in different cultural contexts. Their findings suggest that while some aspects of gendered presentation may be culturally universal, others are shaped by the local expectations of masculinity and femininity—reinforcing the point that gender bias in diagnosis is inseparable from the cultural context in which the clinician is trained and practices.

4.3 Table 1: Synthesis of Key Findings Across Studies

Study	Focus	Key Finding
Kaplan (1983)	Foundational critique	DSM-III labeled women as pathological based on gender-role stereotypes
Henry & Cohen (1983)	BPD labeling	No gender difference in BPD diagnosis in vignettes; noted external validity concerns
Lewis & Appleby (1988)	Clinician attitudes	Personality disorder diagnosis itself elicits negative clinician attitudes
Sprock et al. (1990)	Criterion weighting	Diagnostic criteria carry gender weightings (masculine/feminine prototypes)
Morey et al. (2002)	Assessment bias	Diagnostic constructs and interpretations both reflect gendered assumptions

Study	Focus	Key Finding
Skodol & Bender (2003)	BPD gender ratio	Multiple biases contribute to over-diagnosis of BPD in women
Samuel & Widiger (2009)	Dimensional vs. categorical	Five Factor Model reduces gender bias relative to DSM categorical criteria
Widiger (2011)	Conceptual framework	Three pathways: biased constructs, criteria, thresholds
Chun et al. (2017)	Shared processes	ASPD and BPD share substantial psychopathological variance
Chartonas et al. (2017)	Stigma persistence	Personality disorder patients continue to elicit negative clinician attitudes
Qian et al. (2022)	BPD sex ratio	Prevalence may not differ significantly by sex; presentation varies
Özel et al. (2025)	Direct experimental test	Female ASPD cases 5.1× more likely to be misdiagnosed as BPD

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5. Psychological Pathways and Stress Responses

5.1 Stereotype Activation in Clinical Judgment

The mechanism by which gender bias enters clinical decision-making is best understood through models of social cognition. Under conditions of time pressure, cognitive load, or ambiguity—all of which are ubiquitous in clinical practice—decision-makers rely on heuristic processing that draws on readily available schemas. Gender is one of the most salient social categories in most cultures, and its activation is largely automatic. When a clinician encounters a patient, the patient's perceived gender activates a rich set of associations about typical emotional expression, typical behavioral repertoires, and typical patterns of psychopathology.

In the context of personality disorder assessment, the schemas for the "borderline woman" and the "antisocial man" are particularly well developed within the psychiatric imagination. These schemas are reinforced by textbook representations, by clinical training experiences that emphasize prototypical cases, and by the epidemiological statistics that themselves may partly reflect prior biased diagnosis. The result is a self-reinforcing cognitive system in which observed sex differences in prevalence justify the schemas that then produce further sex differences in diagnosis.

5.2 The Psychological Impact of Being Misdiagnosed

For the patient, being on the receiving end of a biased diagnostic system carries substantial psychological consequences. A woman with ASPD who is misdiagnosed with BPD may be offered a course of treatment—dialectical behavior therapy, mentalization-based therapy, or similar—that is not designed for her actual pathology. When such treatment fails to produce the expected results, the failure may be attributed to her rather than to the mismatch between diagnosis and disorder. This attribution can reinforce the perception that BPD is "treatment-resistant" and can produce iatrogenic effects on the patient's self-concept.

Sheppard, Bizumic, and Calear (2023) have documented the substantial prejudice faced by individuals with BPD from both the general public and mental health professionals. Grambal et al. (2016) have further shown that people with BPD are particularly vulnerable to self-stigma, in part because their diagnostic label carries such heavy pejorative connotations within the clinical community. A woman incorrectly diagnosed with BPD is exposed to this stigma without benefit of an accurate treatment plan.

For the male patient with BPD who is misdiagnosed with ASPD, the consequences may be even more severe. As van Dam, Rijckmans, and van den Bosch (2022) have documented, an ASPD diagnosis frequently functions as an exclusion criterion for admission to mental health services. Even when the patient seeks help for comorbid conditions, the ASPD label may deny them access. Thus, misdiagnosis in this direction is not merely a matter of receiving the wrong treatment but of receiving no treatment at all.

5.3 Clinician Stress and Emotional Reactions to Personality Disorders

Van Dam et al. (2022) applied the theory of planned behavior to understand clinicians' willingness to work with patients with ASPD, finding that emotional reactions—including fear, frustration, and moral disapproval—play a central role. These emotional reactions can operate as feedback loops that reinforce bias. If a clinician finds working with ASPD patients aversive, they may be unconsciously motivated to diagnose women with the more "treatable" BPD, thereby preserving their sense of clinical efficacy. Conversely, they may be motivated to diagnose difficult male patients with ASPD, thereby justifying exclusion from services.

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6. Mental Health Outcomes and Severity Spectrum

6.1 Divergent Treatment Trajectories

The clinical significance of accurate differentiation between ASPD and BPD is grounded in the substantially different treatment landscapes for the two disorders. A recent Cochrane systematic review by Gibbon et al. (2020) documented the limited state of evidence for psychological interventions targeting antisocial behavior. Currently, there is no fully evidence-based treatment for ASPD. Symptom remission may occur in middle adulthood, but prognostic expectations for treatment remain modest, and interventions must be tailored to the individual (Martens, 2000).

The treatment landscape for BPD, by contrast, has developed substantially over the past three decades. Dialectical behavior therapy, mentalization-based therapy, transference-focused psychotherapy, and schema-focused therapy have all accumulated evidence for efficacy. Gillespie, Murphy, and Joyce (2022) have documented that the effects of DBT for BPD are maintained for at least one to two years post-intervention, indicating durable rather than transient benefit.

Pharmacological approaches, by contrast, remain limited for both disorders. Kantojärvi et al. (2020) and Timäus et al. (2019) have documented that psychotropic medications have little effect on the core features of either ASPD or BPD, and are primarily used for target symptoms such as impulsivity.

6.2 The Downstream Consequences of Misdiagnosis

Placed against this backdrop of divergent treatment options, the clinical stakes of accurate diagnosis become clear. As Özel et al. (2025) observed, misdiagnosing a woman with BPD when her actual condition is ASPD initiates a treatment trajectory that is unlikely to succeed for her actual pathology. When such treatment fails, the failure may be misattributed to the patient's "resistance" or "treatment-refractoriness," rather than to the diagnostic error that preceded it. This pattern contributes to the broader cultural perception of BPD as an intractable disorder—a perception that is unfair to women who genuinely have BPD and that further stigmatizes the diagnosis.

Misdiagnosing a man with ASPD when his actual condition is BPD, conversely, may deny him access to treatments that would likely have been effective. The exclusion of ASPD patients from many mental health services (van Dam et al., 2022) means that this misdiagnosis carries especially severe consequences for care access. The male BPD patient labeled as ASPD may be turned away from services that could have helped him substantially.

6.3 The Severity Spectrum and Diagnostic Overlap

The differentiation of ASPD and BPD is complicated by the substantial overlap in their clinical presentations. Chun et al. (2017) demonstrated psychometrically that the two disorders share considerable common variance in the underlying dimensions of impulsivity, affective dysregulation, and interpersonal instability. This overlap is not merely a nuisance to be eliminated through refined criteria; it may reflect a genuine shared underlying pathology that manifests differently depending on the patient's temperament, developmental history, and gender socialization. If this is the case, then the categorical decision between ASPD and BPD is not simply a matter of correctly identifying a distinct entity but of choosing between two frameworks for understanding a partially shared psychopathology—a choice that is inevitably susceptible to gender-based assumptions.

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7. System-Level and Contextual Psychological Effects

7.1 The Diagnostic System as a Cultural Product

Cook et al. (2018), in their review of disparities research in mental health, have argued that gender-based inequalities in mental healthcare persist not merely because of individual clinician bias but because of structural features of the healthcare system: how services are funded, how communities influence help-seeking, and how social networks shape care trajectories. These structural forces interact with individual-level bias to produce compounded effects.

The DSM itself, as Özel et al. (2025) note, functions as both a clinical tool and a cultural document. Its categories reflect the historical moment of its creation and the demographic composition of its framers. When the diagnostic categories embed gender-role stereotypes—as when antisocial or sadistic features are prototypically masculine and dependent or histrionic features are prototypically feminine (Sprock et al., 1990)—the manual itself operationalizes a set of cultural assumptions about gendered psychopathology.

7.2 Cultural Context: The Turkish Setting

The Özel et al. (2025) study was conducted in Turkey, a country whose particular sociocultural context bears on the interpretation of the findings. As the authors note, Turkey ranks 129th out of 146 countries in the Global Gender Gap Report (World Economic Forum, 2022), reflecting substantial gender inequality across multiple domains. Turkey has faced significant challenges related to violence against women and femicide (Y■lmaz-Karaman et al., 2022a) and displays a notable gender gap in professional advancement, including within academic psychiatry (Y■lmaz-Karaman et al., 2022b). Y■lmaz-Karaman et al. (2023) have documented, through the adaptation of gender awareness measures, that internalized gender attitudes vary substantially among medical professionals.

This context matters because the internalization of cultural gender expectations by clinicians is a plausible mediator of diagnostic bias. In a patriarchal cultural context, where aggression and hostility are strongly associated with masculinity, an aggressive woman may be seen as anomalous in ways that push the diagnostic interpretation toward more "feminine" categories such as BPD. The Özel et al. (2025) findings, though produced in Turkey, likely have parallels in other cultural contexts where similar gender expectations obtain, though the specific magnitude of bias may vary.

7.3 The Non-Effect of Clinician Gender

One notable finding of the Özel et al. (2025) study is that clinician gender was not a significant predictor of accurate diagnosis. Female psychiatrists were no less likely than male psychiatrists to misdiagnose the female ASPD case. This finding, though counterintuitive, is consistent with prior research indicating that both women and men can internalize sexism (Y■lmaz-Karaman et al., 2023). It suggests that gender bias in diagnosis operates at a level that is not simply reducible to the clinician's own demographic characteristics. Rather, it reflects the internalization of cultural assumptions that are shared across genders and reinforced by professional training.

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8. Clinical Implications for Psychologists

8.1 Reflective Practice and Diagnostic Humility

The most immediate implication of the literature reviewed in this manual is the imperative of reflective practice in personality disorder assessment. Psychologists who conduct diagnostic assessments should cultivate a habit of pausing at the moment of diagnostic decision, particularly when the presenting features could plausibly meet criteria for either ASPD or BPD. At such moments, the clinician should ask whether their emerging impression is being shaped by the patient's demographic characteristics rather than the clinical features themselves. A useful thought experiment is to mentally reverse the patient's gender and ask whether the same diagnostic conclusion would be reached.

8.2 Structured and Dimensional Assessment

The evidence that dimensional assessment reduces gender bias (Samuel & Widiger, 2009) suggests that psychologists should incorporate dimensional measures, such as those based on the Five Factor Model, into their diagnostic protocols. Structured diagnostic interviews, though not immune to bias, generally produce more reliable and less bias-prone assessments than unstructured clinical impression. The use of self-report measures that quantify specific trait dimensions, combined with structured behavioral observation, can help anchor diagnostic

decisions in observable features rather than in gestalt impressions shaped by stereotype.

8.3 Attention to Trauma and Comorbidity

Given the finding that women with ASPD have particularly high rates of trauma history and comorbid mood disorders (Alegria et al., 2013; Sher et al., 2015), psychologists should be attentive to the possibility that a woman's presentation combining trauma sequelae, mood dysregulation, and antisocial features may be misread as pure BPD when a more accurate formulation would recognize both antisocial and post-traumatic components. Comprehensive assessment of trauma history, current mood symptoms, and antisocial behaviors—including behaviors that may be minimized or reframed by female patients—is essential.

8.4 Treatment Planning Beyond the Label

Regardless of whether the diagnostic decision ultimately favors ASPD or BPD, treatment planning should be guided by a formulation of the specific mechanisms driving the patient's presentation rather than by the diagnostic label alone. Impulsivity, affective dysregulation, interpersonal instability, and antisocial behavior can each be targeted with evidence-informed strategies. For patients whose diagnostic classification is ambiguous, an approach that draws on the transdiagnostic elements of DBT and related therapies may be more useful than one that adheres rigidly to a single diagnostic protocol.

8.5 Advocacy Against Exclusion

Given the finding that ASPD diagnoses often function as exclusion criteria for mental health services (van Dam et al., 2022), psychologists have a role to play in advocating against such blanket exclusions. Even patients who meet criteria for ASPD frequently have comorbid conditions that could benefit from treatment, and the categorical denial of access on the basis of a personality disorder diagnosis is ethically problematic. Psychologists should work within their institutions to ensure that diagnostic labels do not automatically translate into denial of care.

8.6 Attending to Countertransference

Chartonas et al. (2017) and Lewis and Appleby (1988) have documented the persistence of negative attitudes toward personality disorder patients among clinicians. Psychologists should attend carefully to their own emotional reactions when working with patients who have or may have personality disorder diagnoses. Feelings of frustration, fear, or moral disapproval are not merely private reactions; they can shape diagnostic decisions and treatment behaviors in ways that reinforce systemic bias. Regular consultation, supervision, and personal reflective practice are essential safeguards.

8.7 Training and Continuing Education

At the level of the profession, the findings reviewed here indicate a need for continued attention to gender bias in clinical training curricula. Case-based training that deliberately varies the demographic characteristics of patients and asks trainees to reflect on their diagnostic reasoning can help make implicit bias more visible. Continuing education courses that address the intersection of gender, culture, and diagnosis serve an important professional function.

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9. Future Directions and Research Gaps

9.1 Beyond Case Vignettes

The Özel et al. (2025) study, though methodologically rigorous within its design, relied on case vignettes. Henry and Cohen (1983) noted decades ago that vignette-based studies may underestimate the true magnitude of bias in clinical practice, because the fictional nature of the case removes the perceptual cues—vocal tone, physical presentation, interpersonal manner—that carry substantial gender information in real encounters. Future research should employ methods with greater ecological validity, such as standardized patient encounters or naturalistic studies of clinician diagnostic decisions in real-time practice.

9.2 Beyond the Binary

The Özel et al. (2025) study, following standard practice, utilized a binary gender framework. The authors themselves acknowledge this as a limitation, noting that gender is fluid and that binary approaches cannot fully capture the diversity of gender identity and expression. Future research should examine how diagnostic bias operates in relation to non-binary and transgender patients, whose presentations may be interpreted through gendered lenses in complex ways.

9.3 Cross-Cultural Comparison

Because the Özel et al. (2025) study was conducted in Turkey, its findings must be considered in relation to Turkey's specific cultural context. Comparative studies across cultural settings—including settings with lower and higher levels of gender equality—would help clarify which aspects of the observed bias reflect universal features of clinical cognition and which reflect culturally specific gender ideologies.

9.4 Dimensional Models in Practice

While Samuel and Widiger (2009) have demonstrated that dimensional models such as the Five Factor Model reduce gender bias in laboratory-based diagnostic studies, less is known about the practical effects of implementing dimensional models in routine clinical practice. Research examining whether the adoption of dimensional assessment tools actually reduces diagnostic disparities in real-world settings is needed.

9.5 The True Prevalence Question

A persistent question in the field concerns the true prevalence of ASPD and BPD across genders. Qian et al. (2022) and Sansone and Sansone (2011) have raised doubts about the classical 3:1 female-to-male ratio for BPD, but definitive epidemiological work using unbiased ascertainment methods remains needed. Such work would help disentangle genuine sex differences in the underlying disorders from artifacts of biased diagnostic practices.

9.6 Interventions to Reduce Bias

Perhaps the most pressing research need is for empirical evaluation of interventions to reduce diagnostic bias. Training programs, structured assessment protocols, decision-support tools, and reflective practice interventions have all been proposed, but rigorous evaluation of their effects is limited. The development of evidence-based approaches to bias reduction is essential if the concerns raised across four decades of research are to translate into meaningful improvements in clinical practice.

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10. Conclusion

The evidence reviewed in this reading manual converges on a clear conclusion: gender bias in the diagnosis of antisocial and borderline personality disorders is a real and consequential phenomenon that affects clinical practice, patient outcomes, and the broader landscape of mental health service delivery. The empirical work of Özel et al. (2025) provides direct experimental evidence that, even when the clinical features are held constant, patient gender substantially shifts the probability of accurate diagnosis. Women presenting with clinical features of ASPD face approximately five times the risk of misdiagnosis relative to men with identical features, and their misdiagnoses are directed almost uniformly toward BPD—a diagnosis more culturally consonant with traditional femininity. Men presenting with clinical features of BPD, while not overall more likely to be misdiagnosed, are exclusively reclassified as antisocial when misdiagnosis does occur.

These patterns cannot be understood as artifacts of individual clinician failure. They reflect the interaction of biased diagnostic constructs, biased diagnostic criteria, biased diagnostic thresholds, biased assessment processes, and broader cultural gender ideologies that are internalized by clinicians of all genders. The DSM itself, as a cultural document as well as a clinical tool, participates in this system. Efforts to address the problem must therefore operate at multiple levels: in the reform of diagnostic constructs and the movement toward dimensional models, in the training of clinicians in reflective practice and structured assessment, in the design of institutional policies that do not use diagnostic labels as automatic exclusion criteria, and in ongoing research that makes the operation of bias visible and identifies effective interventions to reduce it.

For psychologists in contemporary practice, the take-home message is one of humility and vigilance. Every diagnostic decision is embedded in a cultural context, shaped by cognitive processes that operate outside conscious awareness, and consequential for the patient's subsequent access to care. The categorical distinction between ASPD and BPD, though widely used and administratively necessary, sits atop a substantial zone of clinical overlap and gender-based interpretive variation. Recognizing this reality and building clinical practices that acknowledge it—through dimensional assessment, reflective consultation, and formulation-driven treatment planning—represents the current state of the art in ethical and evidence-informed personality disorder diagnosis. The work of realizing genuinely gender-equitable diagnostic practice remains ongoing, but the empirical foundation and conceptual tools for that work are now firmly in place.

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