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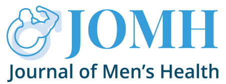

REVIEW

Male homosexuality and borderline personality disorder: a review

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Abstract

Gay and bisexual men are more likely than heterosexual men to be diagnosed with borderline personality disorder (BPD). Evidence also suggests an elevated presence of mental health issues and psychological difficulties among gay and bisexual men. This review of literature evaluated previous attempts to understand the relationship between male homosexuality and borderline personality disorder. It examined various published studies related to gay and bisexual men and BPD since 1964, available on the PubMed database. Of the 67 studies, reviews, and letters to editors that appeared in the search results (excluding 210 duplicate results), 31 were shortlisted, while 36 others were excluded due to incongruence with the study criteria. The selected reports were classified under: (1) Nascent attempts to understand BPD among gay and bisexual men, (2) Epidemiology of BPD among gay and bisexual men, (3) Human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs), (4) Adverse childhood experiences, and (5) Emerging trends. During the review process, the following sub-themes were identified: (1) Exoticization of male homosexuality in BPD research, (2) Parallel pathologization of BPD and homosexuality, (3) A focus on HIV and STDs, (4) Recognition of prejudices and biases, (5) Child sexual abuse, trauma, and bullying, (6) Therapeutic relationship and sexual minority stressors, and (7) Bias by omission in BPD research. The themes underscore the importance of renewing focus on the overrepresentation of gay and bisexual men and the underrepresentation of heterosexual men in BPD research. It also highlights the importance of exploring BPD-specific concerns and psychosocial processes that gay, bisexual, and heterosexual men may experience.

Keywords

Gay; Bisexual; BPD; Homosexuality; Borderline personality disorder; Homosexual; Bisexuality; Men; MSM

1. Introduction

Personality disorders [1] and borderline personality disorder (BPD) [2], in particular, have come under scrutiny due to diagnostic controversies [3]. BPD is a serious mental health condition that results in pervasive patterns of unstable self-image [4], dissociation [5], difficulty in controlling impulses [6], interpersonal difficulties [7], emotional dysregulation [8], suicidal tendencies and self-harm behaviors [9], anger issues [10], and mood difficulties [11]. It was known as emotionally unstable personality disorder (EUPD) in the International Classification of Disease (ICD-10) until the category of personality disorders was restructured in the ICD-11, in which it is coded as "personality disorder (6D10), borderline pattern (6D11.5)" [12]. BPD has an extensive body of literature, but it has not been easy to pinpoint its causes [13]. Multiple studies have shown a higher rate of BPD among women in general [14], and gay and bisexual men in particular [15].

Individuals diagnosed with BPD not only encounter stigma from the general population and healthcare providers [16] but also experience self-stigma [2] and have many unmet needs [17]. BPD is often viewed negatively by both laymen [18] and mental health professionals [19], and it has a stigma level that overarches other mental health conditions [16]. Even family members and caregivers of BPD patients face challenges due to the nature of the disorder [20]. For instance, family members and caregivers of BPD patients experience anxiety and grief [21], in addition to financial difficulties. In particular, they feel they must tiptoe around family members with BPD [22], feel overlooked by mental health professionals [23], and require professional help to ensure their own mental well-being [20]. People with BPD are seldom taken seriously and find it difficult to be respected. These harmful attitudes affect the prognosis of the condition and are made worse by reductionist and simplistic assumptions [24]. Although many clinicians advocate expunging the term "personality disorder" from the diagnostic lexicon to address this issue, BPD and

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other personality disorders are epidemiological realities, albeit not at the level at which they are presumed to exist [24].

BPD-related behaviors are sometimes misconstrued as purposeful misbehaviors, despite being a complex condition to treat. Treating BPD requires supervision and addressing pessimistic beliefs among healthcare providers [2]. Campbell *et al.* [25] discussed the "therapeutic nihilism" that practitioners engage in. The authors also clarified that adequate attention can treat BPD with complete clinical recovery.

It is important to note that those with a BPD diagnosis are mostly female (regardless of sexual orientation) [26] and men who are gay or bisexual [27]. This is probably due to misogyny [28] and homophobia [29] among clinicians who tend to make value judgments about "purposeful misbehaviors" [2]. In the case of gay and bisexual men, these "purposeful misbehaviors" entails having multiple sexual partners [30], using substances [31], experiencing emotional instability as a result of sexual minority stressors [32], instability in relationships due to lack of societal support [33], genuine fears of being alone or rejected (misconstrued with fear of being abandoned) [34], and valid anger towards stigma and discrimination (labeled as anger management issues) [35].

1.1 Male homosexuality's pathologization

The American Psychiatric Association (APA) removed homosexuality as a diagnosis from the second edition of the Diagnostic and Statistical Manual (DSM-II) in December 1973 [36]. However, it was replaced by Sexual Orientation Disturbance (SOD), which considered homosexuality as an illness if a person found it distressing and wished to change one's sexual orientation [37]. The DSM-III replaced SOD with Ego Dystonic Homosexuality (EDH) which allowed mental health professionals to practice sexual orientation conversion therapies if an individual requested for it and experienced distress with one's sexual orientation [37]. Ego Dystonic Homosexuality was removed from the list of DSM-III-R in 1987, marking the acceptance of homosexuality as a normal variant of human sexuality [36].

Men and women who practice homosexuality, both exclusively homosexual (gay and lesbian) and bisexual (attracted to both sexes), face various challenges across the world [38]. BPD is often overrepresented among women because of misogyny and a tendency to view nonconforming women as unstable [28]. Hence, the diagnosis of BPD has been questioned [39]. Some believe there is also a tendency to diagnose patients with BPD when they fail to respond adequately to treatment [40]. This bias percolates to male homosexuality [41]. As homosexuality is no longer a valid diagnosis [36], the reviewers observed clinicians may find BPD to be the most familiar diagnosis available to them when they are unable to comprehend gay men's benign coping mechanisms.

1.2 Stigmatization of homosexuality

Unconscious biases can have an impact on patient-clinician interactions, and it is necessary to recognize and mitigate them to provide wholesome care to at-risk individuals [42], such as men who practice homosexuality. Cultural stereotypes influence clinicians' implicit biases and can negatively affect interactions with gay and bisexual men. Some strategies that can help address implicit clinician bias include continuing education and self-reflection [43]. Studies show that gay men receive below-par healthcare due to bias and ignorance among medical professionals [44]. This is reflected in the tendency among clinicians to be unwilling to prescribe daily antiretroviral pre-exposure prophylaxis (PreP) to men if they suspect men who practice homosexuality will engage in more condom-less anal sex [45].

Atypical sexual behaviors are less pathologized among women, but male sexuality and paraphilic behaviors have a greater tendency to be pathologized by clinicians and mental health professionals [46]. As male homosexuality is viewed as potentially dangerous and problematic, there is a greater tendency for negative bias. For instance, viewing pornography is a part of adults' normal sexual repertoire [47]. However, many clinicians may judge this behavior as dysfunctional when gay and bisexual men reveal this during psychotherapy sessions due to their own discomfort [48]. This could lead to biased management techniques and therapeutic implications [49]. Gay and bisexual men may face discrimination while receiving palliative and end-of-life care as well due to unconscious bias [50]. This shows that clinician bias pervades all aspects of physical and mental health care throughout a gay or bisexual man's life [51].

Clinician bias has persisted among mental health professionals long after homosexuality was removed from the list of psychiatric diagnoses. For instance, it was found that psychoanalysts held a significant negative bias towards homosexual patients, especially if they had serious psychopathology [52]. In this context, BPD as a diagnosis may serve a surrogate purpose for pathologizing male homosexuality continually.

1.3 Adverse living conditions of gay and bisexual men

Attitudes toward homosexuality have changed dramatically in the last few decades [53]. Many countries have decriminalized homosexuality [54], and some have proceeded to legalize gay marriages [55] and offer protections against discrimination and harassment [55]. As a result, recent discourses have posited gay men as privileged [56] while ignoring that male homosexuality in particular is illegal in many countries across Africa [57], the Middle East [58], and Asia [59]. Some of the punishments prescribed to men who have sex with men (MSM) include conversion therapy [60], forced sex change operations, imprisonment [61], and the death penalty [59].

In societies that have moved forward toward complete or partial decriminalization, social stigma, discrimination, high prevalence of sexually transmitted diseases (STDs), and structural barriers continue to exist [62]. Some of the barriers include being unable to marry a person of one's choice, not being able to adopt or opt for surrogacy [63], and being banned from donating blood [64] or serving in the army. Even in nations where full legal protections are guaranteed, homophobic attitudes and stigma persist [65], forcing many gay and bisexual men to live in secrecy and experience self-stigma. These adverse living conditions can result in self-identity is-

sues [66], emotional dysregulation [67], mood disorders [68], and interpersonal difficulties [69], which may mimic signs and symptoms of BPD [70].

1.4 Male homosexuality and therapeutic lacunae in borderline personality disorder

Dialectical Behaviour Therapy (DBT), developed by Marsha Linehan [71], is a popular evidence-based therapy for BPD [72]. Mentalization therapy has often been discussed in the context of BPD interventions as well [73]. However, Skerven noted that traditional interventions for BPD may need to be used in conjunction with gay affirmative therapy to help gay and bisexual men diagnosed with BPD [74]. Further, Kort observed that mental health professionals are not adequately trained in gay and lesbian issues and that many clinicians have not explored their prejudices against this population. He described the experiences of gay men while growing up as "developmental insults" that result in "covert cultural, sexual abuse". He recommended that clinicians be "gay-informed" and that specific training be provided in this regard [75].

Meyer coined the term minority stress to refer to the chronic stress experienced by individuals belonging to sexual minorities [76]. Sexual minority stress includes internalized homophobia [77], stigma [78] and actual experiences of violence [79] and discrimination. Together, Meyer hypothesized that each of these stressors leads to high levels of distress [76]. Kulkarni noted that complex post-traumatic stress disorder (C-PTSD) may be a more accurate diagnosis than BPD for individuals who have experienced multiple traumatic incidents in their lives [80]. However, C-PTSD is currently not adopted by the DSM-5 as a diagnosis [80]. In addition, it has been proposed that "gender minority stress" [81] often mimics the symptoms of BPD, but a similar study has not been conducted among homosexual men. Moreover, clinical psychologists may have an inclination to diagnose gay and bisexual men with BPD [82].

2. Method

This review of literature was conducted between September 2023 and June 2024. The following questions encouraged the authors to conduct this review:

1. Why are gay and bisexual men overrepresented among those diagnosed with BPD?
2. Is there a clinician bias or general error in diagnosis that leads to these diagnoses?
3. What factors of gay and bisexual lifestyle factors may contribute to BPD diagnoses?
4. What are the implications of BPD diagnosis among gay and bisexual men?
5. What treatment strategies can be adopted for better outcomes among gay and bisexual men with BPD?

After reviewing the initial questions, an initial keyword search was conducted on the PubMed database by the first author. The search results were later scrutinized by the second and third authors for their relevance and eligibility.

Eligible case studies, original articles, letters to editors, original research studies, panel reports, reviews, retrospective case control studies, guest columns, and retrospective reviews were identified with the help of a comprehensive keyword search that covered all aspects of male homosexuality and borderline personality disorder. The keyword phrases included: bisexual borderline personality disorder, bisexual BPD, bisexuality borderline personality disorder, bisexuality BPD, bisexuality emotionally unstable personality disorder, gay borderline personality disorder, gay BPD, homosexual borderline personality disorder, homosexual BPD, homosexuality borderline personality disorder, homosexuality BPD, bisexual emotionally unstable personality disorder, bisexual EUPD, bisexuality EUPD, gay emotionally unstable personality disorder, gay EUPD, homosexual EUPD, and homosexuality emotionally unstable personality disorder. Fig. 1 describes the identification and selection process, and Table 1 displays the selected reports.

Retrieved records were simultaneously vetted by the second and third authors based on mutually agreed inclusion and exclusion criteria. Selected articles were then evaluated for underlying themes and sub-themes by each author separately. All the three authors arrived at the final list of themes and sub-themes after much deliberation.

2.1 Inclusion criteria

1. Included samples of gay and/or bisexual men, and mentioned borderline personality disorder either in the abstract or the full-text.
2. Included samples of BPD-diagnosed individuals, and mentioned gay and/or bisexual men, or male homosexuality in general either in the abstract or the full-text.
3. Either the abstract or the full text discussed gay and/or bisexual men, or male homosexuality in general, in the context of borderline personality disorder.
4. Either the abstract or the full text discussed borderline personality disorder in the context of gay and/or bisexual men, or male homosexuality in general.

2.2 Exclusion criteria

1. Studies that included minors either in the review or the sampling process.
2. Studies that included only female participants (lesbian, bisexual and heterosexual).
3. Studies that included only trans and gender dysphoric individuals.
4. Studies in foreign languages without an abstract in English.

2.3 Reasons for choosing PubMed

1. Popular and easily accessible for researchers.
2. Access to many free full text papers.
3. Easy to conduct keyword research.
4. Medical-oriented indexed journals, with a greater emphasis on psychiatry and clinical psychology.

2.4 Excluded articles

View **Supplementary Table 1**.

Identification of studies via PubMed database

Identification

Records identified from*:
Databases (n = 1)

Records removed *before screening*:
Duplicate records removed (n = 210)

Screening

Reports assessed for eligibility (n = 67)

Reports excluded: (n = 36)
Reason 1: Trans issues – (n = 9)
Reason 2: Included/described minor samples of either/both sexes – (n = 7)
Reason 3: Not relevant – (n = 7)
Reason 4: Focus on women – (n = 5)
Reason 5: Focus on lesbians – (n = 3)
Reason 6: Not able to access – (n = 3)
Reason 7: Foreign language, no English abstract – (n = 2)

Studies and other literature included in review (n = 31)

FIGURE 1. Flowchart describing the process of identification of studies. Of the 67 reports assessed for eligibility, 31 were included in the review. *: Only the Pubmed database was used.

TABLE 1. Articles included during the review process, along with the reason for inclusion.

Serial Number	Article Title	Article Type	Reason for Inclusion
1.	Liebermann LP. Case history of a borderline personality. Br J Med Psychol. 1964; 37: 301–312.	Case study	Discussed male homosexuality in the context of BPD [83].
2.	Blum HP. The borderline childhood of the wolf man. J Am Psychoanal Assoc. 1974; 22: 721–742.	Case study	Discussed male homosexuality in the context of BPD [84].
3.	Gonsiorek JC. The use of diagnostic concepts in working with gay and lesbian populations. J Homosex. 1981; 7: 9–20.	Original article	Discussed BPD in the context of male homosexuality [85].
4.	Stone MH. Homosexuality in patients with borderline personality disorder. (letter). Am J Psychiatry. 1987; 144(12): 1622–1623.	Letter	Discussed male homosexuality in the context of BPD [86].
5.	Zubenko GS, George AW, Soloff PH, Schulz P. Sexual practices among patients with borderline personality disorder. Am J Psychiatry. 1987; 144: 748–752.	Original research	Quantified male homosexuality among BPD patients [87].
6.	Silverstein C. The borderline personality disorder and gay people. J Homosex. 1988; 15: 185–212.	Original article	Discussed BPD in the context of male homosexuality [88].
7.	Gabbard GO, Horwitz L, Frieswyk S, *et al*. The effect of therapist interventions on the therapeutic alliance with borderline patients. J Am Psychoanal Assoc. 1988; 36: 697–727.	Case study	Discussed male homosexuality in the context of BPD [89].
8.	Michels R, Oldham JM. The relationship of models of the mind to clinical work: object relations theory. Panel report. J Am Psychoanal Assoc. 1988; 36: 749–757.	Panel report	Discussed male homosexuality in the context of BPD [90].
9.	Seidler C, Katzberg H. (The diagnosis of borderline disorders: criteria and their empirical evaluation). Psychiatr Neurol Med Psychol (Leipz). 1988; 40: 395–404.	Original research	Male homosexuality among BPD patients [91].
10.	Beitchman JH, Zucker KJ, Hood JE, daCosta GA, Akman D, Cassavia E. A review of the long-term effects of child sexual abuse. Child Abuse Negl. 1992; 16: 101–118.	Review	Discussed BPD and male homosexuality in the context of child sexual abuse [92].
11.	Ellis D, Collis I, King M. A controlled comparison of HIV and general medical referrals to a liaison psychiatry service. AIDS Care. 1994; 6: 69–76.	Retrospective case-control study	Included gay and bisexual men as samples. Quantified BPD [93].
12.	Pergami A, Gala C. Personality disorder and HIV disease. Am J Psychiatry. 1994; 151: 298–299.	Letter	Discussed BPD and male homosexuality in the context of HIV [94].
13.	Zucker KJ. Sexism and heterosexism in the diagnostic interview for borderline patients (letter). Am J Psychiatry. 1996; 153(7): 966.	Letter	Discussed male homosexuality in the context of BPD [29].

TABLE 1. Continued.

Serial Number	Article Title	Article Type	Reason for Inclusion
14.	Hagiwara E, Katsuse O, Okubo T, Shirai A, Itoh A, Ishigatsubo Y. (Two cases of HIV infection accompanied with borderline personality disorder). Kansenshogaku Zasshi. 2000; 74: 1077–1080.	Case studies	Discussed BPD and male homosexuality in the context of HIV [95].
15.	Molina Ramos R, Carrasco Perera JL, Pérez Urdaniz A, Sánchez Iglesias S. (Factors associated to the diagnoses of borderline personality disorder in psychiatric out-patients). Actas Esp Psiquiatr. 2002; 30: 153–159.	Original research	Discussed male homosexuality in the context of BPD [96].
16.	Eubanks-Carter C, Goldfried MR. The impact of client sexual orientation and gender on clinical judgments and diagnosis of borderline personality disorder. J Clin Psychol. 2006; 62: 751–770.	Original research	Discussed male homosexuality in the context of BPD [82].
17.	Ivanov I. Common problems in psychotherapy training for psychiatry residents. J Psychiatr Pract. 2007; 13: 184–189.	Guest column	Discussed male homosexuality and BPD in the context of psychotherapy training [97].
18.	Sharma B, Dunlop BW, Ninan PT, Bradley R. Use of dialectical behavior therapy in borderline personality disorder: a view from residency. Acad Psychiatry. 2007; 31: 218–224.	Case study	Discussed male homosexuality and BPD in the context of psychotherapy [98].
19.	Neeleman AJ. (The relevance of sexuality in the treatment of borderline personality disorder). Tijdschr Psychiatr. 2007; 49: 233–240.	Review	Discussed male homosexuality in the context of BPD [99].
20.	Reich DB, Zanarini MC. Sexual orientation and relationship choice in borderline personality disorder over ten years of prospective follow-up. J Pers Disord. 2008; 22: 564–572.	Original research	Quantified male homosexuality among BPD patients [27].
21.	Hansen NB, Vaughan EL, Cavanaugh CE, Connell CM, Sikkema KJ. Health-related quality of life in bereaved HIV-positive adults: relationships between HIV symptoms, grief, social support, and Axis II indication. Health Psychol. 2009; 28: 249–257.	Original research	Discussed male homosexuality and BPD in the context of HIV [100].
22.	Grant JE, Flynn M, Odlaug BL, Schreiber LR. Personality disorders in gay, lesbian, bisexual, and transgender chemically dependent patients. Am J Addict. 2011; 20: 405–411.	Original research	Quantified BPD among gay and bisexual men alongside lesbians and transgender individuals [101].
23.	Sansone RA, Sansone LA. Sexual behavior in borderline personality: a review. Innov Clin Neurosci. 2011; 8: 14–18.	Review	Discussed male homosexuality in the context of BPD [102].
24.	Sansone RA, Sellbom M, Songer DA. A survey of same-sex sexual experiences among psychiatric inpatients with and without borderline personality symptomatology. Prim Care Companion CNS Disord. 2016; 18.	Original research	Quantified homosexuality among BPD patients of both the sexes [103].

TABLE 1. Continued.

Serial Number	Article Title	Article Type	Reason for Inclusion
25.	Frías Á, Palma C, Farriols N, González L. Sexuality-related issues in borderline personality disorder: A comprehensive review. Personal Ment Health. 2016; 10: 216–231.	Review	Discussed male homosexuality in the context of BPD [104].
26.	Rodriguez-Seijas C, Morgan TA, Zimmerman M. Is there a bias in the diagnosis of borderline personality disorder among lesbian, gay, and bisexual patients. Assessment. 20201073191120961833.	Original research	Explored bias against male homosexuality in the context of BPD [41].
27.	Rodriguez-Seijas C, Morgan TA, Zimmerman M. A population-based examination of criterion-level disparities in the diagnosis of borderline personality disorder among sexual minority adults. Assessment. 20211073191121991922.	Original research	Frequency of BPD diagnosis among sexual minorities including gay and bisexual men [105].
28.	Shahpesandy H, Mohammed-Ali R, Oakes M, Al-Kubaisy T, Cheetham A, Anene M. Management of 201 individuals with emotionally unstable personality disorders: A naturalistic observational study in real-world inpatient setting. Neuro Endocrinol Lett. 2021; 42: 200–212.	Retrospective review	Transdiagnostic factor differences between sexual minority and heterosexual individuals in the context of BPD. Included male samples [106].
29.	Jacob L, Smith L, McDermott D, Haro JM, Stickley A, Koyanagi A. Relationship between sexual orientation and psychotic experiences in the general population in England. Psychol Med. 2021; 51: 138–146.	Original research	BPD and homosexuality in the context of psychotic experiences [107].
30.	Chang CJ, Kellerman JK, Fehling KB, Feinstein BA, Selby EA. The roles of discrimination and social support in the associations between outness and mental health outcomes among sexual minorities. Am J Orthopsychiatry. 2021; 91: 607–616.	Original research	Included gay and bisexual men. Discussed BPD [108].
31.	Lin HC, Chang YP, Chen YL, Yen CF. Relationships of homophobic bullying victimization during childhood with borderline personality disorder symptoms in early adulthood among gay and bisexual men: mediating effect of depressive symptoms and moderating effect of family support. Int J Environ Res Public Health. 2022; 19.	Original research	Studied gay and bisexual men and BPD symptoms [109].

BPD: borderline personality disorder; HIV: human immunodeficiency virus.

3. Results

3.1 Nascent attempts to understand BPD among gay and bisexual men

Initial research on BPD among gay and bisexual men was limited to case studies and panel discussions. These attempts were primarily psychoanalytical and viewed both BPD and homosexuality from a pathologizing perspective. Blum recalled Sigmund Freud's Wolf Man, a famous case history often taught to analytical students [84]. He highlighted the Wolf Man's supposed homosexual desires toward his father while discussing BPD. Liebermann similarly documented the case history of her analytic patient, whom she treated for stammering and psychotic features. She described the patient's homosexual "confusions" as "problems" [83]. In a panel chaired by Michels *et al.* [90], the authors described the homosexual fantasies of a borderline patient in lurid details while attempting to present it as a subtext within their understanding of BPD, neurotic personality organization, and object relations theory.

Gonsiorek addressed similarities and differences between true borderlines and homosexual individuals. The author stated that splitting operations may occur temporarily among those who experience sexual identity crises but that splitting tends to be a more pervasive defense mechanism among true borderlines [85]. Sharma *et al.* [98] attempted unsuccessfully to use DBT to treat a homosexual man's BPD symptoms while acknowledging that BPD is often over-diagnosed among men struggling with "sexual identity".

Silverstein evaluated BPD from a cultural perspective and used object relations theory to explain overlapping identity-related confusions that gay men and BPD-diagnosed individuals share. Silverstein suggested they may be more prone to be diagnosed with BPD as a result. He also emphasized the importance of clinical psychologists being able to direct their professional competence toward cultural freedom so that it reflects in the personal liberties of homosexual and bisexual men [88]. Gabbard presented a psychoanalytical framework to overcome difficulties in maintaining a therapeutic relationship with BPD clients [89]. Although much of the paper discussed transference and counter-transference in a therapeutic relationship as per the psychoanalytical model, it did present an early understanding of establishing a collaborative relationship during psychotherapy. In addition, it hinted at what might be described as "sexual minority stressors", such as expectations of discrimination and structural stigma being part of the therapeutic process [89].

3.2 Epidemiology of BPD among gay and bisexual men

Among several reports in this review, gay and bisexual men were overrepresented among those diagnosed with BPD. However, a few were skeptical of the high prevalence rates quoted by other researchers.

Grant studied 145 sexual minority individuals (73.8% male) who were admitted at a residential unit for a dual-diagnosis substance use treatment program. Ninety-four percent of the sample was diagnosed with at least one personality disorder, with BPD being the most common at 64.1%. The authors suggested screening sexual minority individuals for personality disorders regardless of their presenting complaints [101]. Reich *et al.* [27] proposed that close to one-third of BPD patients may experience same-sex attraction and intimate relationships and that this may be a crucial factor in addressing interpersonal issues among BPD patients. Other studies noted a higher prevalence of same-sex activity among BPD-diagnosed individuals, too [87, 103].

Rodriguez-Seijas *et al.* [41] found that sexual minority individuals were diagnosed with BPD more frequently than heterosexuals, even after controlling for age, "gender", PTSD and maladaptive personality domains. Bisexual individuals experienced the highest diagnostic disparity when compared with heterosexuals, and the authors believed that it was due to clinician bias and their predisposition to diagnose sexual minority patients with BPD independent of presenting psychopathology. Rodriguez-Seijas *et al.* [105] noted that the tendency to diagnose sexual minority individuals with BPD might not be related to criterion-related bias but to transdiagnostic factors. However, the authors admitted that they were forced to combine sexual minority individuals into a single group despite within-group differences.

Seidler *et al.* [91] found homosexual activity to be a predictor of BPD. Molina *et al.* [96] noted that in addition to the symptoms of BPD, homosexuality and sexual identity disturbance were correlated with BPD. They also recognized the diagnostic difficulties associated with BPD because of its heterogeneous character. Additionally, the likelihood of familial homosexuality or bisexuality was found to be a significant predictor of BPD patients' same-sex relationships [27]. Jacob *et al.* [107] observed a higher prevalence of psychotic experiences among non-heterosexual individuals, with BPD traits being the strongest mediator, followed by loneliness and stressful life events. Some also observed problems in sexual functioning among those diagnosed with BPD [99].

In contrast, Sansone *et al.* [103] compared participants with and without BPD and found that BPD was not significantly associated with a history of same-sex sexual experiences. They noted that this was a novel finding and that mental disorders, in general, might predict homosexual experiences at higher levels. Silverstein [88], Stone [86] and Pergami *et al.* [94] raised doubts about the high BPD prevalence rates among gay and bisexual men. Pergami *et al.* [94] noted that only 13% of homosexual men in their study met the criteria for a personality disorder, a considerably lower figure. As early as 1988, Silverstein suggested that BPD as a diagnosis is a metaphor for the complexities and confusions of "modern life". Silverstein noted that these confusions were more relevant to gay men in a transitional society [88]. Stone observed that in his study of 61 men who met the criteria of BPD, only six (9.8%) were exclusively homosexual. He suggested that this figure implied homosexual men do not have higher rates of BPD but that they may be predisposed to the condition due to parents' extreme lack of acceptance of their homosexual sons. He also observed that these homosexual men were brought up in home environments that are typically associated with BPD, rendering any association between BPD and homosexuality weak [86]. Eubanks-Carter attributed high BPD prevalence

rates among gay and bisexual men to clinician bias [82].

3.3 HIV and other STDs

In this review, BPD among gay and bisexual men was often discussed in the context of HIV and other sexually transmitted diseases. As STDs are associated with risky sexual behaviors, and BPD is associated with impulsivity and risk-taking, researchers might have focused on STDs while studying BPD among gay and bisexual men. Hagiwara *et al.* [95] seemed to equate risky sexual behaviors among BPD-diagnosed men with same-sex sexual activity. Hansen *et al.* [100] noted that regardless of sexual orientation, BPD was strongly correlated with HIV. Ellis *et al.* [93] observed that BPD was more prevalent among HIV patients, while Sansone *et al.* [102] urged BPD patients to seek prophylaxis against STDs.

Ellis *et al.* [93] conducted a retrospective case-control study to compare the patterns of psychiatric illness among 70 HIV-positive individuals. The study also included age and sex-matched 70 controls referred for psychiatric assessments. The most common disorders were mood, adjustment, personality, and organic disorders. Although personality disorders were equally prevalent among the two groups, BPD was more commonplace in the HIV-positive group. This study further noted that the prevalence of past psychiatric contact among HIV-infected individuals was less than in the control group. However, gay men were over-represented in the HIV-infected group. The authors also observed a higher level of risk-taking behaviors and substance use among gay men.

3.4 Adverse childhood experiences

Some reports studied the relationship between adverse childhood experiences and BPD among MSM. Beitchman *et al.* [92] reviewed the long-term effects of child sexual abuse (CSA) and concluded that it has severe long-term sequelae. The authors also noted that although women who experienced CSA tended to have more same-sex experiences, only male victims of CSA experienced disturbed sexual functioning as adults. It was noted that long-term harm was exacerbated by sexual abuse involving a father or stepfather and penetration. The review made several conclusions about the effects of child sex abuse among women but cited the lack of available research as the reason for providing further explanation. The study also observed that male victims of CSA tended to display confusion about sexual identity, report sexual dysfunctions, practice homosexuality, and have an increased risk of becoming perpetrators themselves. This observation may have fed into the popular trope that homosexual men are sexual predators who were once victims of sexual abuse themselves.

A systematic review of literature published between 1980 (month not specified) and November 2014 suggested that childhood sexual trauma could be a non-specific risk factor for BPD. The review found that those diagnosed with BPD tended to have elevated levels of sexual identity disturbances and homosexual relationships when compared with individuals who were not diagnosed with BPD. The authors observed that those with BPD tended to have a higher degree of sexual impulsivity, increased risky sexual behaviors, and a greater prevalence of sexually transmitted diseases, rape, unwanted pregnancies, and sex work. The authors suggested that sexuality-related issues formed a significant clinical component in the BPD population [104].

A Taiwanese study recruited 500 gay and bisexual men aged between 20 and 25 to study the relationship between homophobic bullying during childhood and BPD symptoms during adulthood [109]. The study found that all kinds of homophobic bullying during childhood were directly correlated with BPD symptoms during adulthood and indirectly through the mediation of depressive symptoms. Family support moderated the relationship between homophobic bullying during childhood and BPD symptoms during early adulthood, underscoring the importance of supportive family environments. This was also the only study in the last ten years (2014–24) to recruit only gay and bisexual men in BPD research.

3.5 Emerging trends

Recent developments in BPD research among gay and bisexual men include exploring the effects of sexual minority stress, sexuality in BPD research, clinician bias and questioning BPD as a diagnostic label. It's important to note that therapists' discomfort with sexuality in general, and homosexuality in particular, can contribute to misdiagnoses and poor outcomes among gay and bisexual men.

Chang *et al.* [110] identified outness as a psychosocial factor that impacted psychological well-being. Outness, or the degree to which an individual conceals or discloses their sexual orientation, may affect their mental health. Sexual orientation concealment is one of the many sexual minority stressors. It was noted that "being out" could have positive outcomes, such as access to social support, and adverse outcomes, such as being discriminated. The study found that "being out" was correlated with fewer depressive and BPD symptoms as long as they received greater social support. However, being out and experiencing more significant discrimination was associated with higher levels of BPD symptoms. The study suggested that being out could both be a risk and a protective factor for BPD, depending on the kind of support or discrimination one experiences [108].

Neeleman noticed that published literature in the previous 25 years on BPD had not received much attention in terms of sexuality [99]. The author hypothesized that sexual functioning might be relevant to the disorder's treatment. He attempted to seek evidence for what he termed as "problematic sexuality" in borderline patients. The literature search was conducted on PubMed and PsycInfo using the following terms: BPD, sexuality, and research. The author only found six empirical studies about sexual functioning, with the major themes being sexual impulsivity, sexual boredom, reduced satisfaction, preoccupation with sex, and sexual avoidance [99].

Eubanks-Carter *et al.* [82] conducted an analog study in which 141 psychologists assessed hypothetical clients whose psychological issues mimicked the symptoms of BPD. Male clients who were perceived to be gay or bisexual by therapists were likely to be diagnosed with BPD. Male clients whose partners were of unspecified gender were also more likely to be diagnosed with BPD. The study further found that therapists

were more willing to work with female clients, and they were less likely to receive a BPD diagnosis. Sexual orientation had an effect on the diagnosis of BPD among men but not among women.

Shahpesandy *et al.* [106] noted that BPD is a simplistic and stigmatizing label for a complex pathology that encompasses many symptoms and characteristics. This was also the only study to use the term emotionally unstable personality disorder (EUPD) in the selected reports, underscoring a lack of BPD-related research pertaining to homosexuality emerging from countries that use the ICD.

3.6 Diminishing interest in male homosexuality in recent years

Of all the BPD-related studies indexed in the PubMed database between 2014 and June 2024, only eight included gay and bisexual men in their study samples. Of these, only one study specifically focused on gay and bisexual men [109]. Five other included gay and bisexual men as part of larger populations consisting of both heterosexual and non-heterosexual male and female participants [41, 103, 105, 107, 108]. Another recruited only five gay or bisexual men out of 201 participants (113 women and 68 men) [106], while one was a review [104]. On the other hand, during the same period, seven studies explored trans and other gender-dysphoric individuals [81, 111–116] while three concerned women [117–119]. It must be noted that there is a significant research thrust on issues related to trans-identifying individuals. At the same time, there is a dearth of scientific literature related to BPD in the context of gay and bisexual men.

4. Discussion

4.1 Exoticization of male homosexuality in BPD research

In the 1950s, borderline personality disorder would have been described as a character disorder and was believed to be a form of latent schizophrenia. Douglas suggested that people with BPD were mild schizophrenics for whom providing therapeutic assistance was challenging [120]. Some attempted to identify "homosexual signs" through the Rorschach Inkblot Test among schizophrenics who were also believed to be borderline patients [121]. Brody observed that a borderline patient's neurotic ways tend to become "ego-syntonic" [122], a term closely associated with homosexuality. Schmideberg described people with BPD as those who neither suffer from typical neuroses nor psychoses and that they were "erratic individuals" who were "not reliable" [123].

Homosexuality was similarly viewed with suspicion in the 1960s and was believed to be the primary reason for the spread of sexually transmitted diseases, including syphilis [124]. Much later, around the time homosexuality was removed from the DSM, genetic predisposition for BPD was discussed [125]. Curiously, although women have historically been diagnosed with BPD at higher levels than men, Cohen *et al.* [126] suggested that "normal men" displayed more BPD traits than "normal women" and that women were overrepresented due to labeling processes as early as 1983. Other studies implied poor parental relationships during childhood among homosexual men [127]. Poor parental relationships have also been implicated in the genesis and maintenance of BPD [128].

The current review identified similar patterns in the selected studies. While Blum discussed a BPD-diagnosed patient's homosexual desires toward his father [84], Liebermann explored her borderline patient's "homosexual confusions" [83]. Others focused on the sexual behaviors of homosexual patients in great detail while attempting to understand BPD at the same time [90]. Gonsiorek urged a nuanced approach toward "ego-dystonic" homosexuality, a term that fell out of use during the 1980s [85]. Another case report described a BPD-diagnosed homosexual man troubled by intrusive thoughts related to his sexuality [98].

Between 1981 and 1990, there were multiple attempts to understand sexual orientation and personality disorders. While homosexuality was considered a psychiatric illness until 1973, when the DSM-III removed it from its list [36], BPD was still a grey area for most clinicians [129]. Exoticization of both phenomena informed the initial understanding of BPD in the context of homosexuality. Although some researchers still use the term "ego-dystonic" in the context of BPD, using it in the context of sexual orientation fell out of favor a long time ago. Moreover, attempts to change one's sexual orientation are ineffective, dangerous and unethical [130].

4.2 Parallel pathologization of BPD and homosexuality

The authors of this review propose the term "parallel pathologization" for the following phenomenon: it is possible to pathologize normal feelings and behaviors among gay and bisexual men and conflate them with existing mental health classifications, as seems to have happened with benign attributes of homosexual men that resemble BPD symptomatology. For instance, most studies in this review tend to highlight the high prevalence of BPD among gay and bisexual men. By highlighting elevated figures of gay and bisexual men in BPD-related epidemiological datasets, researchers inadvertently pathologize male homosexuality as well. Grant *et al.* [101] noted that of the 145 lesbian, gay, bisexual, and transgender (LGBT) individuals admitted to a psychiatric institution, 64.1% were diagnosed with BPD. Reich *et al.* [27] found that 290 out of 362 hospitalized individuals were diagnosed with BPD. A large percentage of these individuals also reported same-sex activity. Rodriguez-Seijas *et al.* [41] noted that clinician bias may play a role in the high prevalence of BPD among gay and bisexual men. Rodriguez-Seijas *et al.* [105] pointed out that the tendency to diagnose sexual minority individuals could be due to trans-diagnostic factors. Grant [101], Reich *et al.* [27], Sansone *et al.* [103], and Molina *et al.* [96] focused their research on the high prevalence of BPD among gay and bisexual men without addressing the context of the diagnosis or the fact that many of the BPD symptoms such as substance use, multiple sexual partners, chronic emptiness, interpersonal difficulties, unstable self-image, mood swings, *etc.*, are lived realities of gay and bisexual men. Pathologizing

these behaviors and feelings, which are sometimes attempts at coping, may inadvertently result in BPD diagnoses. Further, Molina *et al*. [96] suggested creating a profile to help make accurate BPD diagnoses. However, this suggestion probably would have the unintended effect of pathologizing homosexuality by identifying it as part of the BPD diagnostic profile.

It must also be noted that BPD patients experience inner turmoil due to stigma [131] and a weakening of relationships with friends and family. These themes are also common to gay and bisexual men coming to terms with their sexuality. A BPD diagnosis may entail secrecy, which may manifest in the form of concealing one's disease status, hiding hospitalizations, and being excluded from others [132]. These themes resonate with gay and bisexual men who conceal their sexual orientation from their family members and others [133] and feel excluded and alienated [134]. Similarly, gay and bisexual men experience inner turmoil if they have not come to terms with their sexuality [135].

Even in countries like Australia, where there are national guidelines regarding BPD treatment and sexual minority individuals [136], patients experience stress and frustration while navigating healthcare systems. They often perceive their feelings and experiences as not being understood [137]. Although there are clear guidelines in most liberal countries regarding gay and bisexual men's mental [138] and physical well-being [139], men often find it difficult to navigate healthcare systems [140]. Parallel pathologization of BPD and homosexuality hence follows a similar trajectory—stigma, secrecy, overpathologization and difficulties in accessing peer support and adequate healthcare are common to both phenomena.

4.3 A focus on sexual behavior and impulsivity

Both BPD [104] and homosexuality [141] are associated with a variety of impulsive behaviors, including sexual impulsivity and sensation seeking. As both BPD patients and homosexual men tend to report high-risk sexual activities, STDs, date rape, and multiple sexual partners, clinicians may tend to focus on STDs when it comes to studying BPD in the context of gay and bisexual men.

Two case studies analyzed in the current review discussed men diagnosed with HIV and BPD at the same time [95]. The authors curtly noted that people with BPD are more likely to engage in risky sexual activities and attributed the HIV infections among the two men to BPD symptoms. The English abstract made pointed references to a gay patient disregarding the rules and regulations of the hospital, forcing the investigators to set limitations on him. The authors concluded their abstract by declaring that as HIV was rapidly rising in Japan during the 1990s, they expected BPD to be more prevalent among HIV-infected men as well. This is a crucial example of stigma against BPD-diagnosed gay or bisexual men. For instance, while BPD is known to cause turmoil among those who suffer from it, people also associate it with problematic sexuality such as sexual risk behaviors [142] and promiscuity. Gay and bisexual men are similarly perceived to be promiscuous [143], at a greater risk of being diagnosed with HIV and other STDs [144], and to be sexually impulsive [145]. Provider bias and prejudice still persist, and this may affect gay and bisexual men's access to PreP. These biases may be further crystallized by gay and bisexual men's recreational drug use [146].

Other authors evaluated in the current review, such as Hansen *et al.* [100], Ellis *et al.* [93], and Sansone *et al.* [103], also focused on HIV while studying BPD among gay and bisexual men. Sansone *et al.* [103] noted that sexual impulsivity seems to be a hallmark of BPD and that the descriptors of the time missed the undertone of sexual victimization among BPD patients. The authors advised primary care professionals and healthcare providers to urge BPD patients to seek contraception and prophylaxis against sexually transmitted diseases [102].

It's important to remember that normative structures inform healthcare providers regarding behaviors that are deemed to be acceptable or unacceptable. These structures enable and perpetuate structural stigma [147]. For instance, healthcare professionals feel overwhelmed when treating BPD patients due to the disorder's complexity and propensity for unsafe behaviors. As gay and bisexual men are perceived to engage in unsafe behaviors as well [148], healthcare providers may further perpetuate stigmatizing attitudes toward gay and bisexual men [149], including suspecting their behaviors to be linked to BPD [150].

4.4 Recognition of prejudices and biases

Studies show that people diagnosed with BPD experience more bias than people with mental health issues in general [19], akin to homosexual men [41]. BPD-diagnosed individuals face discrimination and stigma from both medical professionals and people in general [19]. They are often aware of the stigma their diagnosis carries and tend to withhold information from clinicians [151]. Exposure to bias, prejudice and stigma may heighten expectations of selfishness, malevolence and disloyalty (mistrust) among people with BPD [152]. These phenomena resemble gay and bisexual men's expectations of discrimination from society and family members and stigma awareness, all of which are now considered "sexual minority stressors". These phenomena may also result in inflexible social interpretations [153] and a reduced ability to detect verbal irony, necessitating transparent and harmonious communication with individuals with BPD [154]. It's worth noting that BPD is characterized by reduced social connectedness [155]. This is particularly important in the context of carers, who report frustration when encountering stigmatizing language [156]. Some of these issues are experienced by gay and bisexual men and their families as well.

In this review, Silverstein noted that gay people were overrepresented in the BPD population and tried to explain it from a psychoanalytic perspective. Using various cultural variables, he presented BPD as a metaphor for the confusion and complexities of modern life [91]. Stone had similarly questioned Zubenko *et al.* [87] regarding inflated figures of BPD among gay and bisexual men. Seidler *et al.* [91] seemed to identify homosexual activities as a predictor of BPD,

which might be early proof of clinician bias. Silverstein also acknowledged that BPD was a controversial diagnosis back in 1988 [91]. More recently, Rodriguez-Seijas *et al.* [41] specifically sought to explore if there was any bias in the diagnosis of BPD among gay, bisexual and lesbian clients and also raised the question of trans-diagnostic factor differences between gay and heterosexual men [105].

In addition, there seem to be sex-related differences in the manifestation of BPD. While there is a pattern of impulsivity and intense and inappropriate anger among men with BPD, female BPD patients tend to report chronic feelings of emptiness, suicidality, and affective instability [157]. According to another study, BPD-associated behaviors among women elicited pity from others, whereas the same behaviors elicited anger, fear and a sense of perceived dangerousness towards men, highlighting the differences between how the two sexes are perceived [158]. This is in line with how homosexual men elicit fear, anger, disgust, contempt, and a perceived sense of danger in others—emotions typically associated with homophobia. Moreover, men diagnosed with depression tend to exhibit cluster B personality traits such as externalizing behaviors, substance use, emotional suppression, and risk-seeking tendencies [159]. There also seems to be an implicit bias that encourages licensed clinical psychologists to diagnose women with BPD and men with antisocial personality disorder [160]. This phenomenon may problematize masculinity and male sexuality in general.

In line with these findings, Eubanks-Carter *et al.* [82] demonstrated that gay and bisexual men were more likely to receive a BPD diagnosis. There have also been attempts to reframe BPD to legitimize individual experiences and acknowledge each individual as an expert of his own life [161]. As with homosexuality, there is also a need to destigmatize BPD [162] by using psychoeducation as a tool. There is also a need to reassess existing training programs for clinicians, which tend to crystallize preexisting biases against BPD-diagnosed individuals [163]. Some studies estimate that approximately half of those diagnosed with BPD do not respond to evidence-based approaches and that there is a need for novel and tailored intervention programs for the treatment of non-responsive individuals [164]. Finally, akin to internalized homophobia, which gay and bisexual men experience, people with BPD experience self-stigma. Self-stigma is associated with various BPD-related emotions such as anger, shame, guilt, resentment, suicidal urges and interpersonal issues [165].

4.5 Child sexual abuse (CSA) and bullying

Both adverse and positive childhood experiences (ACEs and PCEs) shape human brain development across one's life span. ACEs include being sexually, physically, or emotionally abused, being exposed to household mental illness, domestic violence, or substance use, and experiencing parental divorce or separation [166]. Being exposed to ACEs predicts suicidality [167] and poor mental health during adulthood [168]. Over half of the adults may have been exposed to at least one adverse childhood experience [169]. Those who reported exposure to four or more ACEs had dramatically higher rates of mental illness, risk of suicide, and different health conditions such as heart disease, cancer, liver disease, *etc.*, making a cut-off score of four or more clinically significant [169]. Positive childhood experiences (PCEs) consist of recollections of specific positive experiences during childhood, such as having felt safe and protected and a sense of belonging at school and among peers. A safe and stable environment and nurturing relationships during childhood help in optimal development [170].

Studies show that non-heterosexuals report ACEs more frequently than heterosexuals [171]. Being non-heterosexual may also be a risk factor for being sexually abused as a child [172]. Previous studies suggest gay and bisexual men [173] may have increased exposure to multiple development risks and instances of emotional, sexual and physical abuse [174]. Gay and bisexual individuals may recall significantly higher ACEs than heterosexual individuals [166, 174–176]. In the current review, Beitchman *et al.* [92] suggested that male victims of CSA develop disturbed adult sexual functioning. Penetrative abuse perpetrated by a father or stepfather was associated with more significant long-term harm [92]. A systematic review found that childhood sexual trauma was associated with BPD, and those with BPD displayed higher rates of homosexual relationships [104]. Ivanov described the case of a man who displayed borderline personality traits and had been abused as a child and adolescent by his mother, grandmother, and, as a young adult, by his male friend [97]. The Spanish study in this review linked childhood sexual trauma with BPD and BPD with same-sex activity in adulthood [96].

In addition to adverse childhood experiences, anti-gay bullying causes substantial distress and is associated with negative and dysfunctional thoughts among gay and bisexual men [177]. Stephens *et al.* [178] identified being gay or bisexual as one of the many risk factors for being bullied during teenage years. In the current review, Lin *et al.* [109] found that experiencing homophobic bullying during childhood was directly related to BPD symptoms during adulthood. However, this association weakened in the presence of family support [109].

Mentalization-based treatments and attempts to reinforce PCEs during the therapeutic process may help BPD-diagnosed men regardless of their sexual orientation. Mentalization, or the ability to reflect on affective mental states [179], could be impaired when exposed to adverse childhood experiences (ACEs) [180]. Poor mentalization skills are associated with BPD traits [73], as is being exposed to ACEs [181]. Mentalizing helps people understand themselves and others at a deeper level [73]. The inability to mentalize effectively causes symptoms associated with BPD [73]. Similarly, encouraging men to recollect PCEs during psychotherapy sessions may facilitate positive outcomes. PCEs have a cumulative effect of lowering the risks of loneliness, anxiety and depression. They may improve self-rated life satisfaction, meaning in life, and health, even after accounting for adverse childhood experiences [182]. PCEs are essential in reducing shame and enhancing self-regulation [183]. Self-regulation is a crucial protective factor against substance abuse, anxiety and depression, which are prevalent among gay and bisexual men at higher levels [110]. PCEs may also have a protective role against affective lability, a symptom of BPD [184].

4.6 Therapeutic relationship and sexual minority stressors

In the current review, Gabbard *et al.* [89] observed that establishing and maintaining a therapeutic alliance with BPD clients is challenging. The authors suggested minimizing a confrontational approach and validating the BPD client's homosexual experiences. Neeleman recognized the prevalence of gender identity issues and homosexuality among BPD patients. The author suggested integrating love and sexuality with a suitable partner as part of assisting borderline patients, which was a tacit admission of barriers to stable same-sex relationships [99]. This may be difficult among gay and bisexual men, whose same-sex relationships are often viewed with contempt or are not officially recognized. They also tend to make extensive use of dating applications [185] such as Grindr, Scruff, Jack'd and Tinder [186] to meet multiple sexual partners, resulting in relationship instability.

Gay-affirming care has received a lot of impetus in the last few decades. Goldhammer *et al.* [81] noted that there was a need to understand whether, when and how to diagnose and treat BPD among "gender minority" clients. The authors also noted that stigma-related stressors could produce behaviors and symptoms that mimicked BPD. The importance of adopting an affirming framework to treat BPD symptoms when dealing with "gender-diverse" clients was emphasized. In addition to an affirming approach, the authors also stressed the importance of using traditional and evidence-based treatments such as DBT, psychiatric management, mentalization-based therapy [187], and transference-based psychotherapy [81]. Unfortunately, a similar study has not been conducted on gay or bisexual men or even on lesbian and bisexual women, highlighting the lacunae that exist in BPD research in the context of sexual orientation. However, issues identified by Gonsoriek in 1982, such as gay affirmative therapists hesitating to diagnose gay men with mental illnesses to avoid further stigmatization, may resemble the current discomfort with labeling individuals with BPD despite obvious psychological distress. Similar to biased clinicians who overpathologize benign coping mechanisms of gay and bisexual men, "affirmative therapists" may undermine gay and bisexual men's well-being by hesitating to label or diagnose genuine psychological distress and by "affirming" unstable identities.

BPD is a challenging condition to treat and is characterized by invalidating childhood experiences [188], perceived emotional invalidation throughout adulthood [189], self-stigma [165], and emotional dysregulation [190] in response to different psychological processes and external triggers. Similarly, gay and bisexual men may experience dysregulated emotions and other symptoms associated with BPD as a result of individual circumstances related to their sexual orientation [191]. Structural stigma [192], or the various social, legal and political hurdles and difficulties, may cause gay and bisexual men to experience learned helplessness and hopelessness [193]. Learned helplessness and hopelessness are consequences of being unable to change one's situation despite one's best attempts [194]. These states are associated with both depressive affect and anxiety [195]. Enacted stigma in the form of bullying, being exposed to violence and discrimination, *etc.*, can cause hypervigilance [196], PTSD-like symptoms, anger, disgust, resentment toward perpetrators, and other emotions that are characteristic of BPD [197]. Expectations of discrimination by family members, healthcare providers [198], and society, in general, may result in gay and bisexual men feeling invalidated [199], which is associated with BPD. Sexual orientation concealment [108] and stigma awareness are both associated with BPD as well. Internalized homophobia is a form of self-stigma that gay and bisexual men experience at varying degrees [200].

As with BPD-diagnosed patients [201], encouraging gay and bisexual men to seek advice and support [202] while establishing meaningful connections can help reduce their interpersonal difficulties and sense of alienation [203]. A trusting and validating therapeutic relationship may help men seek treatment for BPD regardless of their sexual orientation [204].

4.7 Bias of omission in BPD research

Of the five questions that the present authors initially asked during the review stage, only one was satisfactorily answered—there does seem to be clinician bias and general assumptions while making a BPD diagnosis among gay and bisexual men. The reviewers could not find any published studies or reviews on PubMed that adequately answered the rest of the questions. This review did not satisfactorily answer why gay and bisexual men are overrepresented among those diagnosed with BPD. It also did not identify with clarity the lifestyle factors that may lead to gay and bisexual men being diagnosed with BPD. In addition, no study or review described the implications of BPD diagnosis or the treatment strategies that could be adopted among gay and bisexual men.

Between 2014 and June 2024, only one article specifically focused on gay and bisexual men in BPD research [109]. Recent articles place more focus on gender identity disorder or on gender dysphoria as it is known now, while placing it under the umbrella of lesbian, gay, bisexual and transgender (LGBT) research. This increases the risk of psychological research related to male homosexuality and masculinity being sidelined [205] by emerging queer and gender theories. "Queer theory" originated in literature and critical theory departments and may not have conclusive biological or psychological evidence [206].

Most of the studies did not differentiate between gay and bisexual men in BPD research and instead clubbed them under the following groups: men who have sex with men (MSM), lesbian, gay, bisexual and transgender (LGBT), and sexual minorities/non-heterosexuals. Gay and bisexual men differ in several aspects, including internalized homophobia, sexual orientation concealment [207], exposure to discriminating events, and socio-legal hurdles [208]. In addition, both gay and bisexual men express bi-directional stigma toward each other, with gay men engaging in biphobia while bisexual men participating in homophobia [209]. Hence, studying them as a single group may lead to false conclusions. Moreover, "sexual minority" is an all-encompassing term that includes people and groups with conflicting interests and issues. For instance, "LGBT" also includes female homosexuals (lesbians), female bisexuals, and transgender individuals (those with gender dys-

phoria). These disparate terminologies can be confusing to researchers in mental health and medical sciences, who may confound and conflate sexual orientation with gender ideology, while discounting the differences that exist among different sexual orientations [210].

Identity issues play a central role in how BPD manifests [211], and gender identity issues (now known as gender dysphoria) could be a result of sex role confusion [212] and internalized homophobia [213]. Attempts at identifying with the opposite sex could be a consequence of internalized homophobia and a desire to mimic heterosexual relationships and identities. Internalized homophobia may also cause problems with self-image, self-identity, and self-concept. Hence, internalized homophobia could be studied as part of BPD research, which may also have the benefit of resolving gender identity issues and reducing instances of transitioning and subsequent detransitioning [213].

While gay and bisexual men may be overrepresented in BPD epidemiological studies, heterosexual men are underrepresented. As heterosexual men experience substance abuse disorders [214], are victims [215] and perpetrators [216] of intimate partner violence, and have high rates of suicide [217] and mental health issues [218], BPD needs to be considered in this population as well. Although heterosexual men do not figure prominently in BPD research, there is a genuine possibility of a silent epidemic of cluster B personality disorders among heterosexual men. This could be due to societal expectations, which necessitate men to internalize their emotions and not seek help when they are vulnerable [219].

5. Reflections and insights

BPD and homosexuality follow a similar trajectory. Both have been stigmatized and deemed problematic and challenging since the outset of psychological research. Initial understanding of the prevalence of BPD among gay and bisexual men was rooted in the stigmatization and exoticization of male homosexuality [90]. Gonsiorek observed that there was no connection between homosexuality and psychopathology and that therapists should be adequately trained to treat this population fairly [85]. Jacob *et al.* [107] suggested that although sexual orientation was associated with psychotic experiences, underlying mechanisms such as stressful life events, loneliness and BPD traits play an essential role in maintaining psychopathology. Ellis *et al.* [93] noted that gay men who were diagnosed with HIV tended to engage in high-risk behaviors and used substances at a higher level. Chang *et al.* [108] ascertained that "being out" resulted in both acceptance and stigma, depending on the context. Other studies have found that therapists are more likely to diagnose gay and bisexual men with BPD than the rest of the population. Therapists were also more willing to work with women than with gay and bisexual men, highlighting professional discrimination [82]. Frías *et al.* [104] observed that therapists' discomfort with sexuality in general could contribute to misdiagnoses and poor outcomes among gay and bisexual men. Rodriguez-Seijas *et al.* [41] proposed there is a strong clinician bias when it comes to sexual minority patients and that they are at a higher risk of being diagnosed with BPD due to their sexual orientation.

To address these issues, some have suggested replacing or modifying terminologies related to BPD [106]. However, changing terminologies to suit societal expectations poses problems. In addition, disregarding the importance of classifications can result in misunderstandings. While challenging BPD as a diagnosis [106] creates problems for those who do experience this cluster of symptoms, replacing and/or subsuming homosexuality with gender ideology and queer theory-influenced terms and ever-expanding acronyms confuse both researchers and clinicians [220]. It must be noted that "queer" is perceived to be a derogatory and traumatizing term by many older homosexual men [221], although certain activist groups claim to have reclaimed it [222]. "Queer" may also be an inappropriate term to use in therapeutic settings unless the patient identifies so and insists on using it. A conservative and respectful usage of terminologies is more helpful in both clinical and research settings while working with individuals with an unstable self-image.

As BPD is also an interpersonal issue, intimacy issues within relationships, parental and familial acceptance, intimate partner violence, and the choice of sex of the romantic partner play an important role in the maintenance, manifestation, and treatment of BPD. It is urged to conduct BPD research among men regardless of their sexual orientation, but recognize that gay, bisexual and heterosexual men have different psychosocial realities that may affect the development, manifestation, and prognosis of BPD. Further research into the genesis and maintenance of BPD and possible treatment options for the same will help men regardless of their sexual orientation.

6. Limitations

This review had several limitations. There were very few original research articles that explored BPD among gay and bisexual men. Due to a lack of original research, the authors also included letters to editors, case studies, review articles, and original research articles. Most reports mentioned BPD only fleetingly in the context of sexually transmitted diseases, risky sexual behavior, and certain psychiatric conditions. The choice of PubMed as the only database also presented a limitation. Conducting a more extensive systematic review by incorporating other databases such as Scopus, Web of Science, Google Scholar, and PsychINFO is necessary. Finally, the review process was narrative, which may have contributed to bias. With minimal quantitative data on this topic, researchers may have to wait for future research studies to conduct a scoping or extensive systematic review.

7. Conclusions

Important themes that this review paper identified were clinician bias, a high prevalence of same-sex activity among BPD and psychiatric patients, the impact of adverse childhood experiences, recognition of sexual minority stressors having an impact on BPD, and a growing lack of focus on men regardless of sexual orientation in BPD research in recent years. There is a risk of authentic research related to male homosexuality being shrouded by emerging and contradictory terminologies proposed by LGBT and queer theorists [205]. It is important to

note that gender ideology and queer theory are influenced by Marxist [223], Foucauldian [224] and intersectional theories [225], which cast doubt on the sexual binary but promulgate an oppressor-oppressed binary [205]. An objective, clinically relevant, and scientific approach necessitates sifting through theories, terminologies, and ideologies that do not adhere to the principle of falsifiability [226]. This is especially pertinent in the context of BPD, a multi-factorial classification that has been questioned, too [106]. Most importantly, BPD is characterized by an unstable self-identity, and the proximity of multiple terminologies and identities may further confuse vulnerable men at different stages of self-acceptance. Not being prudent during the diagnostic process also does a disservice to male borderline patients, regardless of their sexual orientation [227].

There is a dire need to understand the reasons for the overrepresentation of gay and bisexual men [104] among those diagnosed with BPD and heterosexual men's underrepresentation [228]. Lifestyle factors among gay and bisexual men, such as meeting strangers for sex through dating applications, using substances recreationally, inability to find stable partners or sustain relationships, unstable self-image, and loneliness, can all be misconstrued by clinicians as signs and symptoms of BPD. On the other hand, heterosexual men may go under the radar when it comes to BPD screening and diagnosis despite obvious signs such as anger issues, domestic violence, interpersonal problems, suicidality, self-harm, impulsive behaviors, and substance abuse. The authors of this review recommend being judicious when diagnosing gay and bisexual men with BPD while not discounting it among heterosexual men. The authors also suggest exploring the roles of childhood experiences and sexual minority stressors such as internalized homophobia, structural stigma, expectations of discrimination and sexual orientation concealment on BPD.

AVAILABILITY OF DATA AND MATERIALS

Not applicable.

AUTHOR CONTRIBUTIONS

JC, DCS, LH—designed the research study. JC—performed the research; wrote the manuscript. DCS—provided help and advice on identification of themes. LH—verified the identified themes. DCS, LH—provided inputs. All authors contributed to editorial changes in the manuscript. All authors read and approved the final manuscript.

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The authors declare no conflict of interest.

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found, in the online version, at https://oss.jomh.org/files/article/1851503196182069248/attachment/Supplementary%20material.docx.

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