Borderline Personality Disorder and Sexuality

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From its earliest conception, borderline personality disorder (BPD) has been said to entail problematic issues related to sexuality. It is surprising, then, that relatively little research has been conducted on sexuality among this group of mental health clients, and that such research has been limited with regard to samples and measures of sexuality. In this article, we provide an overview of BPD as well as the existing research on sexuality among these clients. We then provide some possible explanations for these research findings and conclude with considerations for counselors when working with clients who exhibit BPD symptoms.

Keywords: *borderline personality disorder; sexual behavior; sexual orientation; childhood abuse*

To elucidate the possible relationships between borderline personality disorder (BPD) and sexuality, we start with an overview of BPD and its diagnosis. We next review the existing research on the relationship between BPD and adult sexuality. After providing possible explanations for the apparent links between BPD and sexuality, we conclude with considerations for counselors and researchers.

AN OVERVIEW OF BPD

BPD lies within the Cluster B personality disorders group in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision* (*DSM-IV-TR*; American Psychiatric Association, 2000). Cluster B personality disorders are characterized by dramatic, emotional, and erratic behaviors, which adeptly captures many of the clinical symptoms observed in clients with BPD.

In the *DSM-IV-TR* (American Psychiatric Association, 2000), there are nine descriptive or diagnostic features for BPD; five are required for diagnosis. These features are (a) frantic efforts to avoid abandonment; (b) a history of unstable and intense relationships with others; (c) identity disturbance; (d) impulsivity in at least two functional areas such as spending, sex, substance use, eating, or driving; (e) recurrent suicidal threats or behaviors as well as self-mutilation; (f) affective instability with marked reactivity of mood; (g) chronic feelings of emptiness; (h) inappropriate and intense anger or difficulty controlling anger; and (i) transient stress-induced paranoid ideation or severe dissociative symptoms.

According to the *DSM-IV-TR* (American Psychiatric Association, 2000), the prevalence of BPD is approximately 2% in the community, 10% in outpatient settings, and 20% in inpatient settings. However, in some of our own studies, we have found up to a 20% incidence of BPD symptoms and/or disorder in psychiatry outpatient samples (Sansone, Rytwinski, & Gaither, 2003) and up to a 50% incidence in inpatient samples (Sansone, Songer, & Gaither, 2001).

Although the incidence of BPD appears to be higher in women than in men (American Psychiatric Association, 2000), this perception may be due to sampling and diagnostic bias (Skodol & Bender, 2003). Indeed, in at least one community sample (Grant et al., 2008), there was an equal incidence of BPD among men and women. It may be that the incidence of BPD is the same for men and women, but each sex manifests the disorder somewhat differently. Women with BPD typically display histrionic features, self-directed self-harm behavior (e.g., self-cutting), and axis I diagnoses of eating disorders and post-traumatic stress

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disorder whereas men with BPD display antisocial features, externally directed self-harm behavior (e.g., getting into bar fights, recklessly racing vehicles), and axis I diagnoses of substance abuse (Johnson et al., 2003). The male profile lends itself to the diagnosis/misdiagnosis of antisocial personality disorder.

Like many psychiatric disorders, BPD appears to be a multidetermined disorder (Bandelow et al., 2005; Paris, 2005; Trull, 2001). There appears to be a genetic contribution (i.e., 42% of the variance; Distel et al., 2008), although what appears to be inherited is nonspecific (Skodol et al., 2002). That is, although BPD as a disorder is not directly inherited, core biological vulnerabilities may arise from combinations of genes. These vulnerabilities might include affective instability, poor impulse management, and/or dysfunctional cognitive/perceptual styles (Goodman, New, & Siever, 2004).

Parental psychopathology and family dysfunction also appear to contribute to BPD, with themes of neglect and a lack of empathy (Yatsko, 1996); ''biparental failure'' (Zanarini et al., 2000); poor relationships with parents (Gunderson & Lyoo, 1997; Norden, Klein, Donaldson, Pepper, & Klein, 1995); and family interactions that are invalidating, conflictual, negative, or critical (Fruzzetti, Shenk, & Hoffman, 2005). Parents have been described by offspring with BPD in very negative terms such as uncaring and overcontrolling (Parker et al., 1999); unempathic (Guttman & Laporte, 2000); conflictual (Allen et al., 2005); aversive, less nurturing, and less affectionate (Johnson, Cohen, Chen, Kasen, & Brook, 2006); emotionally withholding (Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989); and hostile (Hayashi, Suzuki, & Yamamoto, 1995).

Given the potential role of family dysfunction in BPD, it is not surprising that repetitive trauma in childhood appears to be a contributory factor (see Sansone & Sansone, 2000; Zanarini, Dubo, Lewis, & Williams, 1997). Trauma types commonly include repetitive physical, sexual, and emotional abuses as well as, in some cases, the witnessing of violence. Still, even with a background of childhood trauma and conflict, BPD may require a triggering event. Zanarini and Frankenburg (1997) described these events as acute psychosocial stressors that appear to abruptly precipitate the onset of BPD symptomatology, although this phenomenon has received little study.

Permutations of the preceding risk factors appear to vary from individual to individual, and the thresholds for precipitating symptoms remain unknown. Many of the characteristics of the disorder have implications for sexual behavior and functioning.

RESEARCH ON BPD AND ADULT SEXUALITY

The notion that sexuality may be a special area of concern in treating people with BPD was noted more than 30 years ago (e.g., Gunderson & Kolb, 1978; Kroll, 1982). Still, since then, the amount of empirical research on the intersection of BPD and sexuality has been relatively sparse. Frequently, generalization from the relevant research has been hampered by idiosyncratic samples and/or limited measures of sexuality.

Early research in this area often simply included one or two sexuality variables. For example, in a study of 71 female psychiatric inpatients diagnosed with BPD (Hull, Clarkin, & Yeomans, 1993), the focus was the percentage of participants who endorsed the ''promiscuity'' items in the BPD diagnostic measures administered. In that sample, 46% of the women reported having ''entered into sexual relationships'' with partners they did not know well, and 28% reported five or more such relationships. Of course, without a comparison group, it is unknown whether these rates compare to women without a diagnosis of BPD. In addition, because many of these women also qualified for other disorders, it is possible that those disorders were related to the sexual experiences as much or more than BPD. Indeed, the researchers reported that alcohol abuse was positively related to endorsement of the sexual ''promiscuity'' items (Hull et al., 1993).

Because endorsement of having engaged in sexual activity with partners not well known is one of the diagnostic criteria for BPD, one might expect that individuals with BPD would report having had a greater number of sexual partners over their lifetimes. Indeed, in a community sample of HIV-positive individuals, most of whom were African American, scores on a measure of BPD symptoms were predictive of a greater number of vaginal intercourse partners for women (Kalichman & Rompa, 2001). We further examined the potential relationship between BPD symptoms and sexual experience among 76 women seen as outpatients in an internal medicine clinic (Sansone, Barnes, Muennich, & Wiederman, 2008). Contrary to expectations, BPD symptoms were unrelated to the total number of sexual partners. However, BPD symptoms were related to an earlier onset of first sexual intercourse as well as having experienced date rape.

The issue of sexual assault during adulthood may be an important one in understanding sexuality and BPD. In one study, 290 patients diagnosed with BPD and 72 patients diagnosed with other personality disorders were followed at 2-year intervals for a total of 6 years (Zanarini, Frankenburg, Reich, Hennen, & Silk, 2005). Rates of sexual victimization declined over time but were higher in the BPD sample. In addition to being victims, it appears that individuals with BPD may be at increased risk of perpetrating abuse. A relatively increased likelihood of BPD has been found among incarcerated women sexual offenders (Christopher, Lutz-Zois, & Reinhardt, 2007), lesbian women who batter their partners (Fortunata & Kohn, 2003), and incarcerated sex offenders with sadistic personality features (Berger, Berner, Bolterauer, Gutierrez, & Berger, 1999).

As noted previously, very little research on sexuality and BPD has consisted of extensive measures of sexuality. One

exception is a study involving women who had attended a series of marital workshops held for active military personnel and their spouses (Hurlbert, Apt, & White, 1992). After initial screening based on self-report measures, a structured interview was blindly administered to confirm diagnoses. The final sample consisted of 32 women who were diagnosed with BPD and 32 women who did not meet diagnostic criteria for any personality disorder. Compared to the control group, the women with BPD reported an earlier age at first sexual intercourse as well as greater incidence of orgasmic dysfunction and relationship problems related to sexual activity. When asked "Do you find your current sexual relationship to be boring?" Forty-one percent of the women with BPD answered "yes," compared to only 3% of the women without BPD. Similarly, when asked "Would you have a sexual affair with someone you are attracted to if you knew you would never be caught?" Forty-four percent of women with BPD indicated they would, compared to only 3% of the women without BPD. On previously published scales, the women with BPD scored relatively higher on measures of sexual assertiveness, erotophilia, sexual self-esteem, sexual preoccupation, and sexual dissatisfaction. So, compared to women without personality disorders, the women with BPD reported feeling more comfortable with sexual stimuli and expressing their sexual feelings, thinking about sex more, and viewing themselves as desirable sex partners. However, these women also reported experiencing more sexual problems and feeling less sexually satisfied.

The theme of sexual difficulties was mirrored in a 6-year longitudinal study of nearly 300 patients diagnosed with BPD (Zanarini et al., 2003). The comparison group consisted of 72 patients diagnosed with one or more other personality disorders but not BPD. Because the sexuality measure was part of an instrument focused on experiences of sexual abuse, the sexuality variables consisted only of "avoidance of sex" and "sexual relationship difficulties." At some point during the study, 61% of respondents with BPD compared to 19% without BPD reported having had some form of sexual relationship difficulty. Similarly, respondents with BPD were substantially more likely than the comparison group to have avoided sexual activity at some point during the study period. The incidence of sexual difficulties and avoidance was more common among females respondents with BPD compared to male respondents with BPD.

Complicating the relationship between BPD and sexuality is the issue of sexual orientation. More than 20 years ago, researchers noted a relatively high rate of homosexuality among patients with BPD. In a small sample of inpatients diagnosed with BPD, 10 of 19 men and 7 of 61 women were deemed homosexual based on their recent sexual behavior and attractions (Zubenko, George, Soloff, & Schulz, 1987). More recent longitudinal research with a sample of nearly 300 inpatients has confirmed an apparent association between BPD and nonheterosexuality (Reich & Zanarini, 2008). At some point over the 10-year study period, approximately one third of both men and women reported having engaged in homosexual relationships.

In summary, the existing research points to several generalizations about the relationships between BPD and adult sexuality. Relative to non-BPD samples, individuals with BPD appear to start engaging in sexual intercourse at an earlier age, be more likely to engage in homosexual activity and be more likely to engage in sexual activity with casual partners, all of which may or may not result in a greater total number of sex partners (perhaps depending on the sample). Reflecting their relatively increased likelihood of having experienced childhood sexual and physical abuse, individuals with BPD appear to have increased vulnerability to sexual and physical assault as adults, and perhaps an increased likelihood of perpetrating such abuse on others. With regard to sexual functioning within relationships, individuals with BPD appear to have a relatively increased likelihood of sexual problems, sexual dissatisfaction, and avoidance of sexual activity.

EXPLAINING LINKS BETWEEN BPD AND SEXUALITY

There are several aspects of BPD that may help explain the existing research findings on the ways in which individuals with BPD differ in their sexuality from those without this disorder. Perhaps foremost is the relatively high rate of childhood abuse, especially sexual and physical abuse, among individuals with BPD. These damaging early experiences may set the stage for subsequent difficulties engaging in physical intimacy with a partner, perhaps through creating a negative attachment style. In support of this impression, in one study, outpatients diagnosed with BPD were more likely than a healthy control group to demonstrate an anxious/fearful attachment style or an avoidant attachment style rather than a secure attachment style (Minzenberg, Poole, & Vinogradov, 2006; also see Alexander et al., 1998). For some individuals with BPD and a history of victimization, engaging in sexual activity may trigger post-traumatic anxiety, and these individuals could be expected to avoid sexual activity. In other cases, individuals with histories of childhood abuse may find themselves re-enacting the abusive relationship dynamic (Trippany, Helm, & Simpson, 2006), which may explain the apparent link between BPD and both sexual and physical victimization and perpetration during adulthood.

Symptoms of BPD include impulsivity and poor judgment, although the root causes of these deficits remains unclear. Recent research, however, suggests that attachment concerns may play an important role. Compared to a control group, a sample of outpatients diagnosed with BPD performed nearly one standard deviation below a control group on measures of short-term memory recall, executive

function (e.g., judgment, inhibition of impulses), and intelligence (Minzenberg, Poole, & Vinogradov, 2008). Interestingly, impaired memory recall was related to an anxious attachment style, whereas impairment of executive functioning was related to an avoidant attachment style. Adding substance abuse to the mix, a common comorbid condition with BPD, would conceivably further impair judgment and impulse control, perhaps leading to poor choices of sexual partners.

Still other factors may contribute to sexual activity with partners barely known to the individual with BPD. One primary symptom of BPD is identity disturbance, perhaps most commonly in the form of subjectively feeling a lack of coherence in one's identity (Wilkinson-Ryan & Westen, 2000). A relatively unstable sense of a coherent identity, especially when combined with feelings of abandonment or boredom, may result in increased likelihood of indiscriminant sexual partnering. This dynamic might be most evident among heterosexual women and gay men, as these two groups would have a relatively easier time finding male partners interested in casual sex. The combination of impulsivity and a relatively unstable sense of personal identity may also help explain the elevated rates of homosexual behavior among individuals with BPD.

There are numerous ways that unstable mood, anger, paranoia, and other common characteristics of BPD may impair ongoing sexual relationships. Much more research is needed on these topics and many others as they pertain to BPD and sexuality. Most of the research to date has focused on women, using relatively limited measures of sexuality and entailing samples drawn from psychiatric inpatient settings or idiosyncratic sources. Gathering accurate self-report data may be especially difficult, given the histrionic self-presentation style common among individuals with BPD. Such tendencies toward the dramatic may explain seemingly contradictory findings, such as relatively higher scores on measures of sexual self-esteem and measures of sexual dissatisfaction among women with BPD (Hurlbert et al., 1992). That is, respondents with BPD may be more likely than other respondents to simply describe themselves using the extreme end of any continuum provided by the researcher.

IMPLICATIONS FOR COUNSELORS

There is always a certain tension between clinical research and practice. Research is focused on trying to uncover characteristics of a group that distinguishes that group from others—in this case, ways in which individuals with BPD differ sexually from those without BPD. The hope is that such generalizations will facilitate understanding and treatment of the individuals with the disorder. The tension arises, however, because counselors do not treat groups of people with a particular disorder; they treat individuals. Any particular individual may or may not match the presentation of clients with the same diagnosis upon which research generalizations were based.

Perhaps the safest advice is a reminder to thoroughly assess and address specific sexuality issues in clients with BPD. Rather than making assumptions about a client's sexuality based on that individual's diagnosis with BPD, the diagnosis can serve as a reminder to consider sexuality issues in much greater detail than might be the case with most other clients. The relatively high rate of childhood trauma among such clients provides a ready-made bridge to addressing sexuality as experienced currently by the client. Similarly, problems in interpersonal relationships are common with BPD, providing an entryway for counselors to address sexuality through the ways in which it might be problematic for the individual client. All of this is not to say that clients with BPD will always take ownership of sexual problems. In the Hurlbert et al. (1992) study of married women with BPD, 25% indicated the belief that it was the husband who had problems with sexuality.

Trippany et al. (2006) emphasized the importance of considering that many of the symptoms of BPD may be explained as post-traumatic reactions to prior abuse. They note that by thinking of a client as someone who has BPD, and who also happens to have a history of abuse, the counselor may then construe many of the client's problems as characterological in nature, rather than response to trauma. Implicit assumptions about the treatability of particular symptoms or problems may not only influence how the counselor approaches work with the client but also may be subtly communicated to the client him- or herself. The client may then come to view his or her problems as inherent in his or her personality, making it more difficult and less likely that change will occur.

The risk of implicit assumptions also applies to the issue of sexual orientation when working with clients with BPD. The previous research indicates an increased likelihood of having engaged in homosexual behavior. However, this may not translate into self-labeling as gay, lesbian, or bisexual. In the Reich and Zanarini (2008) study, in which nearly 300 patients with BPD were followed for 10 years, many respondents during that period switched between having sex with one gender versus the other, yet few changed self-labeled sexual orientation. The association between BPD and homosexual behavior may bias counselors toward labeling such clients as gay. Eubanks-Carter and Goldfried (2006) presented 141 psychologists with a scenario in which a hypothetical client was described. The hypothetical client was described as male or female and as having problems that resembled BPD symptoms but were also consistent with a sexual identity crisis. Interestingly, when psychologists perceived a male client as gay they were more likely to diagnose the client as having BPD, whereas perceived sexual orientation of female clients did not lead to a BPD diagnosis. Psychologists were also more confident and willing to work with female clients and gave females a better prognosis.

The intersection of BPD and sexuality within the context of couples' counseling may prompt several different types of problems. The individual with BPD may be the more sexually experienced member of the couple with regard to number of past sexual partners and perhaps homosexual experience. However, the individual with BPD also may be more prone to problematic emotional reactions to the sexual aspect of his or her current relationship. A high threshold for stimulation may result in sexual boredom. An unstable sense of identity may result in periodic desires for validation from potential sex partners outside the primary relationship. A traumatic sexual past may result in sexual avoidance in the current relationship, and a vulnerability to interpersonal dependency and/or abuse may result in resentment over behaving sexually in ways the individual with BPD does not desire.

Regardless of the form of sexual difficulty experienced by the couple in which one or both members have BPD, it is likely that those issues will need to be addressed. Rather than use the BPD as the framework in which clients can conceptualize and "make sense" of the problematic sexual issues, perhaps it is advisable to focus on the "functions" the sexual problem is serving. In other words, by tying the sexual problem to the client's unique history, both members of the couple can work toward understanding the problem in the context of how that sexual problem "works" in the client's (or the couple's) life. Does sexual indifference or avoidance serve to distance the client from traumatic memories or disturbing emotional reactions? Do behaviors or impulses directed toward people outside of the primary relationship serve to validate the client's sense of self or distract the client from distressing issues?

Just as sexual acting out may constitute a distraction from other problematic issues in the client's life, addressing sexual issues within a couple may be counterproductive if mishandled. For example, the individual with BPD may disclose in couple's counseling issues sure to elicit a strong reaction from the individual's relationship partner, such as infidelity or previously unexpressed sexual dissatisfactions with the relationship partner. Sharing these "secrets" in counseling may fall under the guise of therapeutic honesty and hard work. The concern with individuals with BPD is whether such disclosures reap secondary gain, perhaps through eliciting strong emotions from the relationship partner, thereby indicating that the partner cares for the individual with BPD. Dealing with the emotional aftermath of such disclosures may also serve to derail counseling from addressing underlying issues that may be more therapeutically beneficial, but also more painful and/or anxiety producing for the client with BPD.

Individuals with BPD may share provocative disclosures only with the counselor, and attempt to swear the therapist to secrecy. On the surface, such secrecy may seem warranted if the disclosure involved infidelity that occurred in the distant past, or the client seems especially remorseful, or such disclosure to the primary relationship partner would simply be hurtful with little apparent benefit. The concern, however, is whether the individual with BPD may be gaining a sense of connection with the therapist through their shared collusion or whether the client may be testing the therapist's allegiance. Although there are no black-and-white rules regarding how to handle a client's attempts to keep particular disclosures secret from his or her romantic relationship partner, because fear of abandonment is a primary feature of BPD, the function of such secretive disclosures always should be a consideration. How might the client benefit from creating a triangle involving him- or herself, the therapist, and the client's romantic relationship partner?

In conclusion, despite sparse research, many clients with BPD may have histories of impulsive sexual behaviors. This may be explained in a variety of ways that relate to the BPD diagnosis itself, apart from any specific sexual difficulties. In working with clients with BPD, it is important for the clinician to explore, not necessarily assume, the individual's sexual history, in an effort to develop a well-rounded treatment plan. Special issues may arise, involving disclosure and secrets, especially in the context of couple's counseling. Clearly, additional research in this area is needed to fully understand the intersection of BPD and sexuality, both for the individual and within the couple.

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