

Sexual Attitudes and Activities in Women with Borderline Personality Disorder Involved in Romantic Relationships

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Women with Borderline Personality Disorder (BPD) are prone to have sexual relationship difficulties and dysfunctional attitudes toward sexuality. A sample of 34 heterosexual couples composed of women meeting BPD criteria was compared to a sample of dating or married women from the general population. A short form of the Sexual Activities and Attitudes Questionnaire (SAAQ) was used to measure six types of sexual attitudes. Women diagnosed with BPD did not differ from controls on the frequency of three types of sexual activities in the last year but their subjective sexual experiences differed: they showed stronger negative attitudes, felt sexually pressured by their partners, and expressed ambivalence toward sexuality. Regression analyses suggest that anxious attachment mediates the association between BPD and feeling pressured to engage in sex.

Women with Borderline Personality Disorder (BPD) experience a wide-ranging variety of sexual problems. The DSM-IV (APA, 1994) diagnostic criteria for BPD refer explicitly to sexual impulsivity. In addition, theoretical and clinical analyses frequently underline how women diagnosed with BPD often adopt problematic sexual behaviors and evidence a pattern of intense and unstable love relationships (Neeleman, 2007). Furthermore, in this group of patients, sexuality is often used to avoid chronic feelings of emptiness or

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to soothe abandonment anxiety, and disturbances in sexual identity are common. Thus, sexual symptoms observed in BPD patients are heterogeneous, ranging from persistent promiscuity and perversions to severe inhibitions and ambivalence. This heterogeneity may be explained by unique patterns of variance in attitudes toward sexuality in BPD.

Women with BPD are most likely to develop dysfunctional attitudes toward sexuality for many reasons. First, rates of childhood sexual abuse in this population range from 60 to 80% (Zanarini et al., 2002) and severity of abuse is strongly associated with later severity of BPD symptoms and psychosocial impairment. Childhood sexual abuse increases the risk for sexual distortion as issues of sexuality and intimacy are intertwined in this traumatic experience (Noll, Trickett, & Putnam, 2003). Second, a significant portion of this population exhibit high impulsivity and temperamental disposition toward sensation-seeking (Cloninger, & Svrakic, 2000) which puts them at high risk of erratic and high-risk sexual practices. For example, Hull, Clarkin and Yeomans (1993) found that 46% of their sample of women diagnosed with BPD reported that over the past 5 years they had impulsively entered into at least one sexual relationship with partners they did not know well. Third, there is a growing body of evidence suggesting that insecure attachment is closely associated with sexual motives, strategies, and feelings (see Feeney & Noller, 2004; Gillath & Schachner, 2006). A majority of those with BPD have an insecure attachment style marked by fear of abandonment and distrust of others (see Levy, Meehan, Weber, Reynoso, & Clarkin, 2005). Thus, it is expected that attitudes toward sexuality will be influenced by this anxious attachment style. Typically, people with anxious attachment representations (i.e., preoccupied with abandonment or rejection) tend to have sex to reassure themselves that their partner cares about them and to captivate their partner's attention; they may also go along with a partner's sexual demands in order to avoid being disliked or rejected (e.g., Schachner & Shaver, 2004).

The role of attitude toward sexuality and sexual distortions in explaining sexual behavior of victims of childhood sexual abuse has been studied extensively in diverse populations. Some studies have reported a strong association between childhood sexual abuse and sexual distortion (e.g., Stock, Bell, Boyer, & Connell, 1997; Wyatt, 1991), whereas others have reported no associations or only marginal associations (e.g., Herrenkohl, Herrenkohl, Egolf, & Russo, 1998; Smith, 1996; Widom & Kuhns, 1996). Generally, heightened sexual activity, permissive attitudes, prostitution, early pregnancy, sexual risk-taking behaviors, early coitus, sexual avoidance, sexual dysfunction, and compulsive sexual behavior have been reported (see Noll et al., 2003).

Considering the number of empirical studies addressing BPD, the sexual functioning of people suffering from BPD is an understudied topic. In a recent review, Neeleman (2007) reported only six empirical studies addressing the sexual functioning of patients with BPD. His general conclusion suggests that people with BPD generally tend to have significant problems

with regard to intimate and sexual relationships. These problems seem to be related to heightened sexual impulsivity, reduced sexual satisfaction, increased sexual boredom, greater preoccupation with sex, avoidance of sex, and a wide range of sexual complaints (Dulit, Fyer, Miller, Sacks, & Frances, 1993; Hull et al., 1993; Hurlbert, Apt, & White, 1992; Stone, 1985; Zanarini et al., 2003; Zubenko, George, Soloff, & Schultz, 1987). In addition, there is evidence that gender identity disorder and ambivalence about sexual orientation occur more frequently in people with BPD. These findings underline the fact that elements related to BPD have important and understudied negative consequences on relationship and sexual functioning.

The current study explores the association between the sexual attitudes of women with BPD and their sexual activities. The main purpose of this study is to explore the attitudes toward sexuality of a well-defined sample of women with BPD in comparison to a sample of women from the community matched on age and education. Another purpose is to assess whether the women's sexual attitudes are associated with their attachment representations (i.e., intimacy avoidance, anxious attachment), the frequency of sexual intercourse, and their marital or couple satisfaction.

HYPOTHESES

Compared to women from the general population, the hypotheses were as follows. Women with BPD will evidence: 1) more frequent sexual activities in the last year, 2) stronger permissiveness and stronger ambivalence toward sexuality, 3) greater negative attitudes and aversion toward sexuality, 4) attachment representations are expected to mediate the association between meeting versus not meeting diagnostic criteria for BPD and attitudes toward sexuality. Finally, correlations between the six types of sexual distortions and relationship satisfaction of women with BPD and of their romantic partners are reported. These are presented on an exploratory basis and no hypotheses were formulated.

METHOD

Participants

WOMEN WITH BPD

Participants were invited to participate in the study by their psychotherapists and through written invitations or posters that were hung in diverse medical clinics in Québec City, Canada. To be eligible, participants had to be in a heterosexual couple relationship for at least 2 months, have been diagnosed with BPD in the last 2 years, and both partners had to be 18 years old or older. The sample originally consisted of 35 couples. One couple had to be removed from the data due to interjudge diagnostic disagreement.

The final 34 participants were heterosexual women in stable monogamous relationships who were either married ($n = 8$), cohabiting ($n = 21$), or dating ($n = 5$). The mean age was 33.47 years ($SD = 10.39$). The women met the DSM-IV diagnostic threshold for BPD according to both their psychiatrist section and to the BPD section of the SCID-II. Women with BPD had a mean of 1.58 suicide attempts ($SD = 3.65$; range = 0 to 20) and 3.40 parasuicidal behaviors ($SD = 5.94$; range = 0 to 20) in the last 12 months. Mean number of days spent in hospitalization in the last year was 9.48 ($SD = 19.67$; min. = 0, max. = 80). Almost all women with BPD (33 out of 34) were undergoing treatment at the time of the study. The mean duration of the women's couple relationship was 5 years and 11 months ($SD = 8.8$ years; ranging from 2 months to 38 years). Most couples (82.4%) had been living together for an average of 4 years and 11 months ($SD = 7.87$) and they had an average of 1.28 children ($SD = 1.33$; range = 0 to 5). The average annual income was \$13,382 CAN a year ($SD = \$12,760$, min. = \$7,500, max. = \$60,000). In addition, 32.9% of women with BPD completed a college education or more.

CONTROL GROUP

Participants for the control group were recruited through e-mail, local newspapers, and announcements in Laval University classes and were invited to take part in the study. To be eligible, both partners had to be 18 years old or more and they had to be either married or cohabiting for at least 6 months. A total of 154 women living in the province of Quebec, Canada, returned their questionnaires and agreed to participate. Participants were mailed a package containing the questionnaires and a prepaid return envelope. In order to form an equivalent control group, 34 heterosexual women were randomly selected in a stepwise fashion based on their match with women of the clinical group on age and education.

Women in the control group were either dating ($n = 8$), cohabiting ($n = 16$), or married ($n = 10$). They were on average 33.76 years of age ($SD = 11.61$) and were involved in their romantic relationship for an average duration of 10.47 years ($SD = 11.51$). Couples cohabiting were doing so for an average of 11 years ($SD = 11.95$) and 35% of them had at least one child ($M = 0.35$ child, $SD = .49$). Control women had a mean annual income of \$23,437 CAN ($SD = 21,718$). In addition, 35.3% of them completed a college education or more.

Measures

PERSONALITY DISORDER DIAGNOSES

A French version of the Structured Clinical Interview for DSM-IV, Axis II, was used (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin (1997);

adapted for French-Quebecers by Pelletier (2003)). In the present study, about one-third ($n = 12$) of all the 35 SCID-II interviews were randomly selected and recoded by a second independent rater. Raters agreed on the BPD diagnosis in 11 out of the 12 cases. The case on which judges disagreed was removed (which lends a final n of 34). The number of symptoms meeting the clinical threshold for a diagnosis of BPD (i.e., 5 criteria or more) was used as a severity index ($M = 7.23$, $SD = 1.52$; $\text{min.} = 5$, $\text{max.} = 9$). Women from the control group were not interviewed with the SCID-II.

ATTITUDES TOWARD SEXUALITY

A shortened French version of the SAAQ was used (Noll et al., 2003; adapted for adult couples and translated into French by Godbout, Bouchard, & Sabourin, 2005). The SAAQ short form has 17 items measuring four types of attitudes toward sexuality on a six-point scale: sexual permissiveness (5 items), sexual preoccupation (4 items), negative attitudes toward sex (3 items), and pressure to engage in sex (5 items). Two other sexual distortions can be computed from this questionnaire: sexual aversion ($-1 \times \text{permissiveness} + \text{negative attitude}$) and sexual ambivalence ($\text{sexual preoccupation} + \text{sexual aversion}$). A second section of the SAAQ measures sexual activities (frequency of thoughts relating to sex, frequency of masturbation, number of incidents of voluntary sexual intercourse in the last year, and number of sexual partners in a lifetime). The long-form version of the SAAQ showed good predictive validity (i.e., associated with pathological dissociation, adult anxiety, and childhood sexual abuse) and discriminant validity (i.e., discriminates between sexually abused and nonabused women (Noll et al., 2003). The factorial structure of the original SAAQ was well replicated in the shortened French version (Beaudoin, Carbonneau, Godbout, Bouchard, & Sabourin, 2007). The brief version of the SAAQ also showed satisfactory internal consistency and concurrent validity (Beaudoin et al., 2007). Sexual attitudes were positively associated with frequency of sexual activities, dyadic adjustment, and psychological distress (Beaudoin et al., 2007). In the present study, alpha coefficients for the four scales were satisfactory (α ranged from .79 to .90).

ATTACHMENT

Attachment representations were measured using the French-Canadian version of the Experiences in Close Relationships scale (ECR; Brennan, Clark, & Shaver (1998); translated and validated by Lafontaine & Lussier, 2003). Factor analysis indicated the presence of two interrelated dimensions of attachment: anxiety about rejection (18 items) and avoidance of intimacy (18 items; Lafontaine & Lussier, 2003). In the present study, alpha coefficients were high (.90 for anxiety and .87 for avoidance).

PSYCHOLOGICAL DISTRESS

Psychological distress was assessed with the brief version of the Psychiatric Symptom Index (PSI-14; Ilfeld, 1978). Items on the PSI-14 assess four dimensions: depression (5 items; $\alpha = .89$), anxiety (3 items; $\alpha = .79$), aggression (4 items; $\alpha = .91$), and cognitive problems (2 items; $\alpha = .90$). The PSI-14 shows good internal consistency ($\alpha = .92$), construct validity, and criteria validity (Prévaille, Potvin, & Boyer, 1995).

RELATIONSHIP SATISFACTION

An eight-item version of the Dyadic Adjustment Scale [DAS-8; Spanier (1976)]; translated into French by Baillargeon, Dubois, & Marineau (1986) was used to assess the level of relationship quality and satisfaction. Global dyadic adjustment scores range from 0 to 41, with higher scores reflecting a higher level of relationship quality and satisfaction. The brief version showed satisfactory internal consistency (α ranged from .76 to .96), and the predictive validity was supported in a 3-year longitudinal study of couple dissolution (Sabourin, Valois, & Lussier, 2005). In the present sample, alpha was .85.

SEXUAL ABUSE.

The Childhood Sexual Experiences Questionnaire [QASE, Godbout, Lefebvre, & Sabourin, (2002)] was used to assess a variety of sexually abusive experiences. Participants were first asked "prior to age 18, were you ever sexually abused?" If the answer was YES, participants were asked to specify: the age of the first and last abuse, the frequency of abuse, the relation with the perpetrator(s) (e.g., father, teacher, stranger, etc.), the act(s) perpetrated (e.g., complete penetration, oral sex, touching, etc.), and the level of violence used.

RESULTS

Convergent and Construct Validity

In order to determine the construct validity of the SAAQ in the clinical sample, correlations between attitudes toward sexuality and sexual activities were examined in women with BPD (see Table 1). These associations are presented since Beaudoin et al. (2007) originally validated the French version of the SAAQ in a community sample. The associations between the six types of attitudes toward sexuality and the sexual activities suggest that the SAAQ brief form possesses good convergent and construct validity in a psychiatric sample of BPD patients. All types of attitudes toward sexuality were associated as hypothesized with specific sexual activities. For example, frequency of masturbation was positively associated significantly with sexual preoccupation and negatively to negative attitude toward sexuality. Sexual

TABLE 1. Associations Between Attitudes Toward Sexuality and Sexual Activities in Women With BPD

| | Sexual permissiveness | Sexual preoccupation | Negative attitude | Pressure to engage in sex | Sexual aversion | Sexual ambivalence |
|---|-----------------------|----------------------|-------------------|---------------------------|-----------------|--------------------|
| Frequency of sexual thoughts | .57** | .40* | -.52** | -.00 | -.60** | -.45** |
| Frequency of masturbation | .29 | .47** | -.36* | -.10 | -.32 | -.12 |
| Number of voluntary sexual intercourse (12 month) | .68** | .39* | -.65** | -.17 | -.73** | -.64** |
| Number of sexual partners (life) | .44** | .45** | -.49** | -.30 | -.50** | -.27 |

Note. Spearman's rho correlations; $n = 34$.

* $p \leq .05$, ** $p \leq .01$.

ambivalence was not associated significantly with frequency of masturbation and was negatively and significantly associated with lifetime number of sexual partners.

Descriptive Statistics

The prevalence of childhood sexual abuse in the present sample was higher in women suffering from BPD (76%) in comparison to women from the control group (21%, $\chi^2(1, N = 68) = 21.25, p < .001$). We tested for significant group differences on socio-demographic variables (age, number of children, annual income, and education) with nonparametric Mann Whitney tests and chi-square tests. Women diagnosed with BPD reported a lower annual income ($z = -2.29, p = .02$) and fewer children ($z = -2.73, p < .006$) than women from the control group.

Group Comparisons

Transformations were used in order to reduce data skewness and improve normality and linearity of data distribution. Square root transformations were performed on permissiveness, negative attitudes, aversion, avoidant attachment, psychological distress, and couple adjustment. With the use of a $p < .001$ criterion for Mahalanobis distance, no outliers among the cases were found.

DIFFERENCES IN SEXUAL ACTIVITIES

Group differences in sexual activities were assessed using a multivariate analysis of variance (MANOVA) performed on four dependent variables (frequency of thoughts related to sex, frequency of masturbation, number of incidences of voluntary sexual intercourse in the last year, and number of sexual partners). The multivariate test was significant, $F(4, 62) = 10.69, p < .001, \eta^2 = .41$. As reported in Table 2, only one main effect was observed. Specifically, BPD women reported more sexual partners than women from the control group. For example, whereas only 5.9% of the control women ($n = 2$) have had more than 30 sexual partners in their lifetime, 50% of the women with BPD did ($n = 19$).

DIFFERENCES IN SEXUAL ATTITUDES

Group differences in sexual attitudes were assessed using a MANOVA performed on six dependent variables (permissiveness, preoccupation, negative attitudes, pressure to engage in sex, aversion, and ambivalence). The multivariate test was significant $F(6, 61) = 5.42, p < .001, \eta^2 = .35$. As reported in Table 2, the BPD group reported more negative attitudes toward sex, feeling more pressured to engage in sex, and a higher level of sexual ambivalence in comparison to the control group.

TABLE 2. Mean, Standard Deviation, and Group Comparisons Between BPD and non-BPD Women on their Sexual Activities, Sexual Attitudes, and Psychosocial Adjustment

| | BPD | Non-BPD | F | η^2 |
|------------------------|----------------|---------------|-------|----------|
| Sexual activities | | | | |
| thoughts | 4.36 (1.56) | 4.74 (.83) | 1.50 | .02 |
| masturbation | 3.15 (1.75) | 2.94 (1.25) | .32 | .01 |
| number intercourse | 3.82 (1.51) | 4.25 (.99) | 2.06 | .03 |
| number partners | 32.34 (28.42) | 6.02 (7.54) | 27.28 | .30*** |
| Sexual attitudes | | | | |
| permissiveness | 19.64 (8.01) | 22.29 (4.67) | 1.24 | .02 |
| preoccupation | 12.63 (5.69) | 11.29 (3.43) | 1.38 | .02 |
| negative attitude | 7.47 (4.81) | 5.41 (4.21) | 4.20 | .06* |
| pressure | 15.41 (7.19) | 10.76 (5.42) | 8.93 | .12** |
| aversion | -12.18 (11.52) | -16.88 (5.83) | 1.34 | .02 |
| ambivalence | .46 (10.97) | -5.59 (6.32) | 7.74 | .11** |
| Psychosocial variables | | | | |
| anxiety | 4.98 (1.04) | 3.27 (1.25) | 44.60 | .41*** |
| avoidance | 3.12 (1.13) | 1.79 (.65) | 39.01 | .38*** |
| psychological distress | 38.88 (9.86) | 24.0 (5.43) | 61.41 | .49*** |
| couple adjustment | 26.44 (7.30) | 33.18 (4.28) | 19.87 | .23*** |

SD appear in parentheses beside means.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

DIFFERENCES IN PSYCHOSOCIAL ADJUSTMENT

Group differences in psychosocial adjustment were assessed using a MANOVA performed on four dependent variables (anxious attachment, avoidant attachment, psychological distress, and couple adjustment). The multivariate test was significant, $F(4, 621) = 23.93, p < .001, \eta^2 = .61$. As presented in Table 2, the BPD group reported more insecure attachment, more psychological distress, and a lower level of couple adjustment than the non-BPD group.

CONTROLLING FOR THE EFFECT OF CHILDHOOD SEXUAL ABUSE (CSA)

Subsequent MANOVAs were performed to investigate the unique contribution of BPD on the dependent variables. Before entering the variables in the analyses, the variance associated with child sexual abuse was removed in all variables. First, the group difference in sexual activities remained significant after controlling for CSA: BPD women reported more sexual partners than non-BPD women, $F(4, 65) = 11.79, p < .001, \eta^2 = .15$. Second, only one group difference in sexual attitudes remained significant after controlling for CSA: BPD women reported feeling more pressured to engage in sex than non-BPD women, $F(1, 66) = 4.62, p < .03, \eta^2 = .07$. Third, all group differences in psychosocial adjustment remained significant: BPD women reported more insecure attachment [anxiety: $F(1, 65) = 16.46, p < .001,$

$\eta^2 = .20$; avoidance: $F(1, 65) = 14.27, p < .001, \eta^2 = .18$], higher levels of psychological distress, $F(1, 65) = 18.90, p < .001, \eta^2 = .23$, and lower levels of couple adjustment, $F(1, 65) = 9.27, p = .003, \eta^2 = .13$ compared to non-BPD women.

Sexual Attitudes and Role of Attachment Representations

REGRESSION ANALYSIS AND MEDIATION

Regression analyses were performed to observe the role of attachment behaviors as a mediator in the relationship between group affiliation (BPD versus non-BPD) and feeling pressured toward sex. According to Baron and Kenny (1986) (see also Holmbeck, 1997), a number of conditions must be met in order for a variable to be considered a mediator. First, the predictor (i.e., group affiliation) must be significantly associated with the hypothesized mediator (i.e., anxious and avoidant attachment): both anxiety ($\beta = .60, p = .001$) and avoidance ($\beta = .59, p = .001$) were associated with group affiliation. Second, the predictor (i.e., group affiliation) must be significantly associated with the dependent variable (i.e., feeling pressured toward sex): group affiliation was associated with feeling pressured toward sex ($\beta = .34, p = .004$). Third, the mediator (i.e., anxious and avoidant attachment) must be significantly associated with the dependent measure (i.e., feeling pressured toward sex): results showed a significant relationship between anxious attachment and feeling pressured toward sex ($\beta = .43, p = .001$). However, we did not find a significant association between avoidant attachment and feeling pressured toward sex. Finally, to demonstrate mediation, the association between the predictor and outcome variable must be reduced or rendered null after controlling for the impact of the mediator on the outcome: multiple regression showed that anxious attachment ($\beta = .66, p = .02$) fully mediated the relationship between group affiliation and feeling pressured toward sex (group affiliation was no longer significant when entered simultaneously with anxious attachment). Thus, we found partial support for our hypothesis that attachment representations mediate sexual attitudes in our sample of women diagnosed with BPD (i.e., only for the dimension of anxious attachment).

Associations Between Relationship Satisfaction and Attitudes Toward Sexuality

Relationship satisfaction of women with BPD was positively associated with sexual permissiveness (Spearman's $\rho = .39, p < .05$) and aversion (Spearman's $\rho = -.31, p < .057, n. s.$). Relationship satisfaction of the romantic partners of women with BPD did not correlate with any of the attitudes toward sexuality of their romantic partners (i.e., women with BPD).

DISCUSSION

The main purpose of this study was to explore the association between sexual attitudes and activities in women suffering from BPD. Four general conclusions can be drawn from our results.

First, the differences in the frequency of sexual behaviors between the two groups partly confirm our hypothesis that women with BPD would have more frequent sexual activities in the last year. Compared to women from the control group, the percentage of women with BPD (19 versus 2 in the control group) who have had more than 30 sexual partners across their lifetime was close to 10 times higher for women with BPD. This result gives support to clinical observations reporting high frequency of sexual partners in this population. On the other hand, once in a relationship with their current partner, women with BPD did not report excessive sexual activities and promiscuity in the last year. More specifically, women with BPD did not differ from those of the control group on the number of sexual thoughts, the frequency of masturbation, and the number of voluntary sexual contacts in the last year. These results suggest that women with BPD who are in a stable romantic relationship could present different sexual behaviors compared to those who are sexually active but not in a serious relationship. The results also suggest that the frequency of sexual behavior in women with BPD may vary over time. Perhaps women with BPD initially tend to engage in more frequent casual sex and have a strong propensity to use sex as a means to secure physical proximity with a partner and to increase feelings of emotional closeness. But once the union manages to bring about a sense of relative security or durability, it appears that women with BPD do not engage in sexual activities to a greater extent than other women from the community. Future research should assess variations in levels of sexual activity in the larger context of attachment processes across the lifespan.

Second, the differences in attitudes toward sexuality generally confirm our hypothesis. Although frequency of sexual behaviors did not differ significantly, the subjective experience of women with BPD seems to be different from the experiences reported by women from the control group. Being diagnosed with BPD seems to contribute to variations in attitudes toward sexuality. Results show that negative attitudes toward sexuality, sexual ambivalence, and feelings of being pressured toward sex were more elevated in the BPD group than in women from the control group. The hypothesis that women suffering from BPD would evidence more ambivalence toward sexuality is supported and is consistent with previous observations in a sample that also examined childhood sexual abuse (Noll et al., 2003). Although childhood sexual abuse was strongly associated to sexual distortions in both groups, the feeling of being pressured by the partner was uniquely associated with meeting criteria for BPD after controlling for the effect of sexual abuse. Since four of the five items for this factor seem to tap preoccupations

about gaining love and respect from one's partner and since people with BPD are known to have anxious attachment representations, this result is in line with what was expected. To our knowledge, our study is the first to demonstrate the specific effect of being diagnosed with BPD, over and above the effect of childhood sexual abuse, on attitudes toward sexuality.

Third, our results did not confirm the hypothesis stating that women with BPD would exhibit stronger interest in sexuality: no differences were found for permissiveness and preoccupation between the two groups. The attitudes of permissiveness and preoccupation toward sexuality represent approach motivations toward sex. The absence of a difference between women with BPD and the control group is intriguing. Despite the high prevalence of childhood sexual abuse in our clinical sample, attitudes toward permissiveness and preoccupation with sex did not appear to be affected. Having been forced to engage in sexual contact with an adult while a child generally fosters aversion toward sexuality (see Noll et al., 2003) it does not significantly affect attitudes associated with approach motivations in the present sample of women engaged in stable romantic relationships. Given that avoidance and approach motivations toward sex are relatively independent and can co-occur, the current findings suggest that interventions should aim more at modifying negative attitudes toward sex rather than increasing positive attitudes toward sexuality in this particular population.

Fourth, the findings revealed that anxious attachment representations play a mediational role in the association between the presence of BPD and feelings of being pressured to engage in sexual activities. In practical terms, abandonment anxiety seems to interfere not only with general interpersonal functioning but also in the more intimate area of subjective sexual experience. This finding is consistent with other studies suggesting that attachment dimensions have a significant influence on sexual experiences and feelings of sexual pressure in romantic relationships (e.g., Brassard, Shaver, & Lussier, 2007). For women with BPD, it seems that the function of sexuality in a couple is entangled with their attachment system particularities, especially with a desperate need for closeness unfortunately paired with a fear of rejection. One explanation could be that these women may feel they have to engage in sex with their partner (i.e., feeling pressured) because they have the inner need to calm the fear that their partner would reject them or worse if they were to refuse to engage in sex with them (i.e., anxious attachment).

During the interviews pertaining to this study, a number of the romantic partners of the women with BPD acknowledged to the first author that they often have been accused by their female partner of pressuring her to have sex. Although some men may actually exert sexual pressure on their female partner, the anxiety associated with the women's feelings of being coerced may also increase the sensitivity of the women toward feeling pressured even if the male partner is unaware of it or is making efforts to be respectful. Based

on the results on this study, one crucial task of sex therapy with these clients could be helping the patient to recognize the influence of her inner world on her intimate relationship and educating the male partner about those feelings and possible causes of her concerns about their sexual relationship. These results also give support to the idea that clinicians should try to integrate attachment theory into current thoughts on the etiology and treatment of sexual difficulties in women with BPD. In order to help these clients have a clearer grasp of what drives them to behave in certain problematic ways in the realm of sexuality, clinicians should help them to explore the attachment motives behind some of their attitudes toward sexuality.

The findings of the current study are a preliminary effort to examine the sexual attitudes of women with BPD and some limitations should be mentioned. The small size of this sample, composed of women with BPD recruited in a treatment setting, limits the generalizability of the findings. Replication of the findings in other treatment settings with larger samples of couples is necessary. Further research is also needed to address the heterogeneity and process of attitude variations in women with BPD for three main reasons. First, BPD diagnosis is known to be heterogeneous and subtypes of BPD probably exist (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983; Widiger & Sanderson, 1995). Second, heterogeneity in the sexual behaviors of people suffering from BPD has been reported (Hurlbert et al., 1992). Third, people suffering from BPD may exhibit great variations in sexual adjustment as a function of the stage of their relationship (e.g., early in courtship versus later stages of committed relationships). Finally, another potential limitation of this study is the fact that the presence of BPD was not screened out in the control group. So a possibility remains that some differences which were reported nonsignificant could in fact be statistically significant given the additional discriminating power that this procedure could have granted.

In conclusion, more research on the sexual functioning of couples where one member suffers from BPD is clearly needed. Longitudinal studies are essential in order to look at the hypothesis that hypersexuality may be present at the time of courtship and in the early stages of a relationship, and that sexual inhibition, in some cases, can gradually appear as the relationship provides increasing security and stability. Also, the contribution of attitudes and personality characteristics of the romantic partner of people suffering from BPD represents an understudied and promising topic. Many authors (e.g., Fruzzetti, 2006; Hoffman, Buteau, Hooley, Fruzzetti, & Bruce 2003; Maltz, 1988) believe that the only effective approach to the treatment of women with BPD is a couple approach, as the spouse is often viewed as a vicarious victim of the psychopathology and an underestimated ally to the treatment process. Clinicians and researchers should be more aware of this neglected dimension. We hope that by further studying this complex and fascinating topic, promising treatment for these couples will continue to emerge and that more couples will benefit from them.

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