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Bridging the blind spot in psychotherapy research on personality disorders: a proposal for sexuality-related outcomes as indicators of therapeutic change

Wypełnianie luki w badaniach nad psychoterapią zaburzeń osobowości: propozycja uwzględnienia wskaźników związanych z seksualnością jako mierników zmiany terapeutycznej

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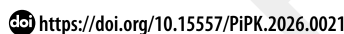

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Abstract

The article examines sexual functioning as a promising domain for identifying outcome indicators in psychotherapy research for personality disorders. Contemporary dimensional models, such as the DSM-5 Alternative Model for Personality Disorders and the ICD-11, consistently identify impairments in emotion regulation, identity, and interpersonal functioning as central features of these disorders. Despite sexuality being profoundly linked to these core areas, both conceptually and clinically, it remains largely neglected in personality disorders psychotherapy research. The article begins with a review of empirical evidence demonstrating associations between personality pathology and various sexual difficulties, including dysfunctions, impulsivity, and relational problems. The degree to which established psychotherapeutic approaches – transference-focused psychotherapy, mentalisation-based treatment, dialectical behaviour therapy, and schema-focused therapy – address sexual functioning, whether explicitly or through their broader mechanisms of change, is then examined. Building on Bancroft's developmental model of sexuality, a structured framework of sexuality-related outcome indicators is proposed for integration into future psychotherapy research. These indicators are aligned with key therapeutic targets in personality disorder treatment, including improvements in self-concept, affect regulation, and interpersonal functioning. It is argued that including sexual functioning as an outcome measure in research on the effectiveness of psychotherapy for personality disorders will allow for a deeper and more comprehensive understanding of its therapeutic potential. The article presents the theoretical and empirical foundations of this proposal and discusses its possible applications in research design.

Keywords: psychotherapy, sexuality, personality disorders, outcome assessment

Streszczenie

Artykuł analizuje funkcjonowanie seksualne jako obiecujący obszar identyfikacji wskaźników efektów terapii w badaniach nad psychoterapią zaburzeń osobowości. Współczesne modele dymensjonalne, takie jak Alternatywny Model Zaburzeń Osobowości w DSM-5 oraz ICD-11, konsekwentnie wskazują na zaburzenia w zakresie regulacji emocji, tożsamości i funkcjonowania interpersonalnego jako centralne cechy tych zaburzeń. Mimo że seksualność pozostaje ściśle powiązana z tymi głównymi obszarami – zarówno na poziomie konceptualnym, jak i klinicznym – wciąż jest w dużej mierze pomijana w badaniach nad psychoterapią zaburzeń osobowości. Analizę rozpoczynamy od przeglądu danych empirycznych wskazujących na związki między patologią

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osobowości a różnorodnymi trudnościami seksualnymi, takimi jak dysfunkcje, impulsywność czy problemy w relacjach. Następnie analizujemy, w jakim stopniu uznane podejścia psychoterapeutyczne stosowane w leczeniu zaburzeń osobowości – psychoterapia skoncentrowana na przeniesieniu, terapia oparta na mentalizacji, terapia dialektyczno-behawioralna oraz terapia schematów – odnoszą się do obszaru seksualności, zarówno bezpośrednio, jak i poprzez bardziej ogólne mechanizmy zmiany. Opierając się na rozwojowym modelu seksualności Bancrofta, proponujemy uporządkowaną strukturę wskaźników efektów terapii związanych z funkcjonowaniem seksualnym, możliwą do zastosowania w przyszłych projektach badawczych. Wskaźniki te pozostają spójne z głównymi celami terapii zaburzeń osobowości, takimi jak poprawa funkcjonowania w obszarze Ja, regulacji emocji i relacji interpersonalnych. Stoimy na stanowisku, iż uwzględnienie funkcjonowania seksualnego jako wskaźnika w badaniach nad skutecznością psychoterapii zaburzeń osobowości może przyczynić się do bardziej pogłębionego i całościowego zrozumienia jej potencjału terapeutycznego. Artykuł przedstawia teoretyczne i empiryczne podstawy tej propozycji oraz omawia możliwości jej zastosowania w projektach badawczych.

Słowa kluczowe: psychoterapia, seksualność, zaburzenia osobowości, ocena wyników

INTRODUCTION

The present paper aims to explore the potential role of sexual functioning as an indicator of change in research on psychotherapy for personality disorders (PDs). We argue that since sexual functioning is explicitly addressed in the diagnostic criteria of some PDs, its improvement should likewise be regarded as a meaningful indicator of therapeutic change. Our goal is to contribute to the advancement of psychotherapy research by drawing attention to the often-overlooked domain of sexual functioning and examining its relevance as an outcome in clinical studies. While existing research commonly focuses on general functioning, symptom severity, or interpersonal difficulties, sexual functioning is rarely assessed as a direct treatment outcome. We consider this a significant gap, particularly in light of growing evidence linking personality pathology with various forms of sexual impairment.

THE COMPLEX RELATIONSHIP BETWEEN PERSONALITY AND SEXUALITY

Both sexuality and personality are complex, multidimensional constructs shaped by a broad range of interrelated factors. This complexity is clearly reflected in widely accepted definitions of both phenomena. According to the World Health Organization (World Health Organization, 2006, p. 4), sexuality is defined as "a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors". In turn, Cervone and Pervin (2018, p. 4) define personality as "psychological systems that contribute to an individual's enduring and distinctive patterns of experience and behaviour". Both definitions highlight shared features, particularly the multifactorial nature of these constructs, the diversity of their expression across contexts, and their reciprocal influence on one another. This overlap suggests that sexuality and personality are deeply interwoven in human functioning, and that an integrative approach is warranted in both clinical practice and research.

In particular, Cervone and Pervin's (2018) integrative framework offers a valuable lens for understanding individual differences in human sexuality. Related beliefs, emotional states, and behavioural patterns are all influenced by personality. Personality aspects – such as self-image and pattern of relating with others – alongside dynamic processes like emotional regulation, influence sexual aspects of identity, sexual responses, and one's capacity for intimacy in relationships. Moreover, past experiences, current psychological states, and future-oriented expectations jointly determine how sexuality is experienced and expressed.

Notably, the relationship between personality and sexuality is also reflected in shared neurobiological and emotional mechanisms. As highlighted by Fischer et al. (2022) in their scoping review, difficulties in emotion regulation are associated with sexual problems and sexual dissatisfaction. Sexual responses engage the nervous system and activate numerous brain regions, including the insula, temporal cortex, limbic system, nucleus accumbens, basal ganglia, superior parietal cortex, dorsolateral prefrontal cortex, and cerebellum. These processes are accompanied by the release of neurochemicals such as oxytocin, vasopressin, dopamine, and serotonin (McFarlane, 2024). Many of these structures and substances are also involved in emotional processing (Spiering and Everaerd, 2007). Furthermore, research has demonstrated that the functional neuroanatomy of sexual behaviour closely parallels that of other reward-related processes, such as those activated by food or music (Georgiadis and Kringelbach, 2012).

Considering the interdependencies outlined above, it seems natural to assume that disturbances in personality may also manifest in the domain of sexual functioning. Indeed, the diagnostic criteria for several PDs refer to the sexual sphere.

For example, as assessed using the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD) (First et al., 2016), various types of personality disorders include questions addressing difficulties in forming close relationships and aspects of sexual behaviour – for instance, schizoid personality disorder includes a lack of interest in sexual activity, while dependent personality disorder involves urgently seeking new relationships as a source of support following the end of previous ones; paranoid PD involves suspiciousness concerning a partner's fidelity; histrionic PD refers to inappropriate sexually seductive or provocative behaviour in interpersonal interactions; borderline personality disorder (BPD) includes questions addressing impulsive sexual behaviour and instability in sexual identity, while antisocial PD involves items related to violations of social norms, including disregard for the boundaries of others.

SEXUAL FUNCTIONING IN PERSONALITY DISORDERS: AN EMPIRICAL PERSPECTIVE

Despite growing interest in the intersection of sexuality and personality pathology, empirical research on this relationship remains limited. However, existing findings consistently indicate that the presence of PDs features is associated with impaired sexual functioning and quality of sexual life (Collazzoni et al., 2017). Most existing studies are based on categorical diagnostic models, such as DSM-IV, DSM-5 Section II, or ICD-10, with the greatest research focus placed on borderline, antisocial, and narcissistic PDs.

BPD has received the most attention in studies exploring the relationship between personality pathology and sexual health (Collazzoni et al., 2017). BPD is often associated with relational instability, impulsivity, compulsive sexual behaviour, and risky sexual practices (Ballester-Arnal et al., 2020; Bégin et al., 2021). It is also shown that a history of trauma is common among individuals with BPD and contributes significantly to female sexual dysfunction (Schulte-Herbrüggen et al., 2009), as well as heightened risk for unsafe sexual behaviour and sexually transmitted infections (Harned et al., 2011).

In turn, studies involving individuals with narcissistic and antisocial PDs suggest that these individuals are more likely to adopt short-term mating strategies, hold permissive attitudes toward casual sex, and engage in more frequent casual sexual behaviours (Collazzoni et al., 2017). Antisocial PD has been linked to violent sexual behaviour and sexually motivated crimes (Koch et al., 2011). Similarly, narcissistic PD has been associated with sexual dissatisfaction, infidelity, a lack of sexual empathy, and sexually exploitative behaviours (McNulty and Widman, 2013, 2014). However, the nature of narcissism appears crucial: grandiose narcissism may be linked to higher levels of sexual functioning, whereas vulnerable narcissism has been associated with poorer sexual satisfaction and functioning (Pavanello Decaro et al., 2021).

In contrast to the relatively extensive literature on Cluster B disorders, empirical data on sexual functioning in individuals with Cluster A and Cluster C PDs remain limited. Cluster A disorders – particularly schizoid PD – are typically characterised by interpersonal detachment, emotional coldness, and a diminished interest in intimate relationships (Ciocca et al., 2017). Consistent with this, Grauvogl et al. (2018) found that women with sexual problems reported significantly higher levels of Cluster A traits, especially schizoid characteristics, compared to women without such problems. Interestingly, their study also showed that higher levels of schizoid traits and lower levels of Cluster B traits (notably borderline and antisocial) predicted lower sexual functioning. With regard to Cluster C disorders, the findings are mixed. Some evidence suggests that individuals with dependent PD are not markedly impaired in their sexual lives and may be able to maintain emotionally and sexually fulfilling relationships (Natoli et al., 2021). In contrast, avoidant personality traits have been linked to sexual dysfunction in some case studies, particularly when co-occurring with social phobia, which may serve as a mediating factor (Tignol et al., 2001).

Given the limitations of categorical models widely discussed in the literature (Bach and Tracy, 2022), dimensional approaches such as the DSM-5 AMPD offer another perspective on relationship between personality pathology and sexual functioning, although research in this area remains scarce. Engel et al. (2023) found that hypersexual men (assigned to the study group on the basis of criteria formulated by the authors) exhibited significantly elevated levels of maladaptive personality traits across all AMPD domains, reflecting the broader burden of personality pathology, despite these traits not independently distinguishing diagnostic groups. Similarly, Van Fossen (2023) demonstrated that both AMPD traits and personality functioning were significantly associated with sexually aggressive cognitions in men, such as beliefs about sexual entitlement and rape myths. Notably, personality functioning added predictive value beyond maladaptive traits, while Big Five personality traits – particularly openness and agreeableness – further enhanced predictive accuracy, underscoring the complementary roles of dimensional models. Supporting these findings, Deschênes et al. (2024) showed that individuals meeting AMPD criteria for PDs reported greater sexual distress and poorer functioning. Path analyses revealed gender-specific patterns: in women, intimacy avoidance was consistently associated with worse sexual outcomes; in men, separation insecurity and intimacy avoidance predicted lower sexual function, while separation insecurity also related to higher distress. Interestingly, traits such as irresponsibility, rigid perfectionism, and intimacy impairment were linked to greater sexual satisfaction.

Another complementary approach is the Hierarchical Taxonomy of Psychopathology (HiTOP), an empirically based system that conceptualises mental disorders dimensionally by deconstructing traditional diagnoses into fundamental,

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transdiagnostic spectra (Kotov et al., 2022). The model organises psychopathology into internalising, detachment, thought disorder, somatoform, and the overarching externalising super-spectrum, which includes disinhibition and antagonism. The internalising spectrum (anxiety, distress) underlies inhibitory sexual problems, such as decreased libido or difficulty with orgasm (Forbes and Schniering, 2013). Such issues may be connected with an individual's excessive self-inhibition and a fear of negative evaluation (Watson et al., 2022). Conversely, the externalising spectrum is associated with problems of discontrol (DeYoung et al., 2024). The disinhibition (impulsivity, risk-seeking) manifests as risky or compulsive sexual behaviours (Kotov et al., 2022). The antagonism spectrum (callousness, manipulativeness) leads to an instrumental treatment of partners and a lack of sexual empathy (Watson et al., 2022). Other spectra, such as detachment, explain a profound lack of interest in sexual activity due to intimacy avoidance, while the thought disorder spectrum links identity diffusion to a chaotic sexual self-image. This approach explains clinical paradoxes, for instance, in BPD, where inhibitory and impulsive sexual behaviours coexist. HiTOP explains this as a complex profile with high scores across multiple spectra simultaneously: internalising, externalising (disinhibition and antagonism), and thought disorder (DeYoung et al., 2024).
Collectively, these studies underscore the complex interplay between personality pathology and sexuality, pointing to the need for a more comprehensive approach that systematically includes sexual health assessment in the clinical care of individuals with PDs. For example, Collazzoni et al. (2017), in their review, stress the importance of integrating both psychodiagnostic and sexual evaluations into psychiatric practice and research concerning this population.

TOWARD A MORE COMPLETE TREATMENT: ADDRESSING SEXUALITY IN PD-FOCUSED PSYCHOTHERAPIES

The four evidence-based approaches to PDs treatment – transference-focused psychotherapy (TFP), mentalisation-based therapy (MBT), dialectical behaviour therapy (DBT), and schema-focused therapy (SFT) (Oud et al., 2018) – differ in the extent to which they address sexuality. Among them, TFP, rooted in object relations theory, places the strongest emphasis on sexual functioning. In this model, the capacity for love – including sexual passion and satisfaction – is considered an important feature of integrated identity (Kernberg, 1974a, 1974b). According to Kernberg (2011), the quality of sexual functioning reflects the level of personality organisation: the lower the level, the more disorganised, aggressive, and potentially dysfunctional the sexuality. Such impairments are particularly associated with increased risk of sexual dysfunctions and paraphilic patterns (Beisert and Izdebska, 2014; Prunas and Bernorio, 2016; Prunas et al., 2016). The TFP highlights the diagnostic value of examining a patient's experiences in the realms of love and sexual functioning, asserting that an important objective of treatment is to foster improvement in these aspects of the individual's life. The integration of aggression fosters identity cohesion, which in turn enhances the individual's capacity for intimacy and sexual fulfilment (Caligor et al., 2018).
Other psychotherapeutic models do not address sexuality as explicitly. Still, they can yield beneficial outcomes in this area, as they facilitate changes in intrapsychic processes that, directly or indirectly, influence sexual functioning. In MBT, the core therapeutic aim is to enhance mentalisation – the capacity to "perceive and interpret behaviour as explained by intentional mental states" (Bateman and Fonagy, 2016, p. 4). At the same time, recent findings suggest that the ability to mentalise sexual feelings may underlie healthy sexual functioning in adulthood (Gaertner et al., 2025), and thus fostering this capacity may enhance sexual health as well as reduce engagement in risky sexual behaviours.
DBT, in contrast, primarily targets acting-out behaviours, self-harm, and suicidal tendencies – common in individuals with BPD – by strengthening emotional regulation skills. These harmful behaviours often include risky sexual activity (Sansone and Sansone, 2011), which is expected to decrease through DBT interventions (McKay et al., 2019). Given the established link between emotional dysregulation and sexual functioning and satisfaction (Fischer et al., 2022), improvements in emotional regulation may also enhance sexual well-being.
Finally, Young's schema theory posits that early maladaptive schemas formed in childhood and adolescence contribute to the development of mental disorders, including PDs (Young et al., 2003). Early maladaptive schemas are linked to sexual self-schemas – cognitive generalisations about sexual aspects of the self-shaped by past experiences (Alimoradi, 2022). That is why in intimate or sexual contexts, early maladaptive schemas may influence the experience of oneself and others (Derby et al., 2016). This may lead to reduced sexual satisfaction (Hashemian et al., 2015) and sexual dysfunctions (Oliveira and Nobre, 2013). In contrast, early adaptive schemas have been positively associated with sexual satisfaction and functioning in pre- and perimenopausal women (Allen and Tully-Wilson, 2023). SFT has also been found effective in reducing sexual variety seeking in individuals with BPD (Mazloumi et al., 2024).
Further support for the potential of PDs therapies to address sexual functioning comes from adaptations of these approaches specifically targeting sexual problems. For example, DBT has been adapted for individuals who have committed sexual offenses (Kolb, 2024), as has SFT (Oettingen and Rajtar-Zembaty, 2022). SFT has also proven effective in treating sexual aversion and enhancing sexual self-efficacy (Ahmadzadeh et al., 2024). Additionally, the possibility of using DBT techniques to support processes described by Bancroft (2009) as gender and sexual identity development is being explored. In particular, DBT-based strategies that buffer against environmental invalidation and

foster self-validation are considered beneficial for LGBTQ+ individuals facing sexual stigma and minority stress (Camp et al., 2023; Skerven et al., 2019).

Given the long-standing clinical use of these therapeutic models and the evidence supporting their effectiveness – particularly in the treatment of BPD – it appears justified to include sexuality-related indicators in studies evaluating treatment outcomes. However, the current literature reveals a notable gap in this area.

SEXUAL FUNCTIONING INDICATORS OF CHANGE: CURRENT PRACTICES, OMISSIONS, AND OPPORTUNITIES

Sexuality in research on effectiveness of psychotherapy for personality disorders: current state of art

Despite the well-documented association between PDs and sexuality in both theoretical and empirical literature (e.g. Ciocca et al., 2023; Frías et al., 2016), this relationship is underrepresented in clinical studies on psychotherapy. This is particularly surprising given that intimacy and sexual functioning are explicitly included in the diagnostic framework for PDs in the DSM-5 and in the SCID-5-PD (First et al., 2016).

A review of randomised controlled trials (RCTs) drawn from high-quality medical evidence databases, such as the Cochrane Library, reveals a striking absence of outcomes directly assessing sexual functioning in studies evaluating psychotherapeutic interventions for PDs. This trend is observable not only in research reports but also in broader systematic reviews (e.g. Stoffers-Winterling et al., 2022). Interestingly, many RCTs do assess factors related to interpersonal functioning alongside PDs symptomatology – factors that may, at least partially, overlap with aspects of sexual functioning. This pattern is evident in the Cochrane systematic review comparing various psychological and psychotherapeutic interventions for BPD (Storebø et al., 2020), in which none of the included RCTs explicitly evaluated sexuality functioning as an outcome. In contrast, nearly all studies included measures of psychosocial functioning or interpersonal problems.

Closer inspection of the outcome measures used in these studies suggests that elements of sexual functioning may be marginally represented within broader constructs. Psychosocial functioning, for instance, is frequently assessed using instruments such as the Global Assessment of Functioning (GAF) scale (American Psychiatric Association, 1987) or the Social Functioning Questionnaire (SFQ) (Tyrer, 2005). These tools include general items on relational impairments (e.g. "Serious impairment in relationships with friends", or "Frequent fights with family"), but do not isolate sexual functioning as a distinct domain. In the case of the SFQ, sexual functioning is addressed in a single item ("I have problems in my sex life"), rated on a scale from 0 (*no problems*) to 3 (*severe problems*), which is not analysed independently or incorporated into a specific subscale.

Similarly, interpersonal problems are commonly assessed using instruments such as the Inventory of Interpersonal Problems (IIP) (Horowitz, 1988), or selected subscales and items from broader psychopathology measures – such as the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) (Zanarini, 2003) or the Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1994). These instruments contain single items that reference sexual concerns (e.g. "Loss of sexual interest or pleasure", or "Feeling shy or uneasy with the opposite sex"), but such items are typically embedded within broader constructs – such as "Interpersonal Sensitivity" – and are not examined as separate outcomes. Collectively, these findings highlight a systematic omission of direct sexual functioning measurement in RCTs evaluating psychotherapeutic interventions for PDs.

A broader perspective on the issue emerges when studies not included in the Cochrane database are considered. In this context, beyond the assessment of social functioning, some studies also include measuring attachment (e.g. Diamond et al., 2023; Levy et al., 2006). In both cases, attachment was assessed using the Adult Attachment Interview (AAI) (George et al., 1985), a semi-structured clinical interview designed to evaluate adults' internal working models of attachment. Although attachment is not a measure of sexual performance, it is a construct that falls within the broader domain of sexuality (Bancroft, 2009), as it concerns an individual's functioning in intimate relationships. In this sense, attachment may represent a notable exception within the general neglect of sexuality – including intimacy – in PDs research.

At the same time, the lack of inclusion of sexual functioning in research is further reflected in current research guidelines and outcome sets for PDs studies. These guidelines recommend the evaluation of factors grouped under categories such as mental health (e.g. identity disturbance, emotional distress, emotional dysregulation, suicidal ideation), behaviour (e.g. impulsivity, aggression, self-harm), functioning (e.g. global functioning, social functioning, interpersonal functioning, self-care), and recovery (e.g. health-related quality of life, sense of belonging, PD severity) (Prevolnik Rupel et al., 2021). While these standardised domains are designed to facilitate improved outcome monitoring and international benchmarking in mental health care, sexual functioning is notably absent from the list of core recommended outcome measures.

Although we did not identify studies directly addressing the reasons for the omission of sexuality in psychotherapy research on PDs, we believe this gap reflects a broader, systemic neglect of the topic – one that is also present in clinical practice. In the clinical context, this neglect may arise from therapists' fears of boundary violations, perceived threats to the therapeutic alliance, uncertainty about appropriate language, and discomfort in confronting their own values (Horvath et al., 2001; Vesentini et al., 2024).

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In a study by Lans et al. (2025), 46% of therapists perceived erotic transference as threatening, which often led to avoidance, defensive reactions, and the dismissal of clinically valuable material. Similar dynamics are observed in supervision, where sexuality is frequently met with "supervisory silence", hindering the development of professional competence (Yan, 2022). This avoidance is especially concerning given that supervisory experience is a strong predictor of a therapist's readiness to address sexuality in clinical work (Moore, 2018). It is also plausible that clinical anxieties and methodological avoidance in research mutually reinforce one another, contributing to a self-perpetuating cycle of omission.

Addressing the blind spot: toward the inclusion of indicators of sexuality in PDS psychotherapy outcomes

In response to the marked gap in the exploration of sexuality within studies evaluating the effectiveness of psychotherapeutic interventions for PDs, we have developed a proposal for outcome indicators that specifically target this domain. We hope that this initiative will serve as a step toward addressing this overlooked area and advancing more comprehensive research in the field. As a conceptual foundation for this initiative, we adopted Bancroft's (2009) eclectic interactional model of sexual development. Although the model primarily focuses on the developmental aspects of sexuality, it offers a comprehensive perspective that reflects the multidimensional nature of the construct. Bancroft identifies three strands of sexuality that unfold across distinct life stages, beginning in the prenatal period and continuing into adulthood. These three strands are: (1) sexual differentiation and the development of gender identity; (2) sexual responsiveness; and (3) capacity for close, dyadic relationships. They develop concurrently, initially functioning independently and in parallel during the prenatal and early childhood phases. Beginning in adolescence, these strands begin to interact and become increasingly integrated, ultimately shaping the complexity and individuality of each person's sexual identity and patterns of sexual functioning. In the present work, Bancroft's model serves as a conceptual foundation for identifying specific domains of sexuality and, furthermore, for evaluating their relevance as outcomes in research on psychotherapy for PDs. While these domains cannot be directly translated into one-to-one measurable psychotherapy outcome indicators, the authors reflectively discuss the utility of the model's developmental strands and their applicability in studies on psychotherapy for PDs. The discussion includes a critical examination of which aspects of sexuality, as proposed in Bancroft's model, may be less suitable or feasible for empirical investigation. The decision to draw on Bancroft's framework in this context is informed by several of its key features.

First, the model's eclectic nature – integrating biological, psychological, and socio-cultural dimensions – provides a valuable framework for critically considering both the potential and the limitations of various forms of influence on human sexuality. Some components, being strongly biologically determined, are not subject to change through psychotherapy. In contrast, other aspects (psychological) may be amenable to modification through psychotherapeutic or psychoeducational approaches. Within the spectrum of available interventions, this raises an important question about the plasticity of human sexuality in the context of treatment for PDs.

Second, the strands of sexuality described by Bancroft align closely with key aspects of PDs emphasised in contemporary frameworks. Specifically, they correspond to the domains of interpersonal functioning and self-identity, as described in both the DSM-5 AMPD and the ICD-11 classification. Given this conceptual overlap, Bancroft's model appears particularly well-suited for incorporating sexuality-related outcomes into psychotherapy research on PDs. Building on this convergence, it is reasonable to assume that people with PDs will also experience sexual functioning problems in the self and interpersonal areas. Both clinical experience and the studies cited above indicate that this is indeed the case. In other words, maladaptive personality functioning is likely to manifest in the domain of sexuality, just as it does in other areas of life.

Third, Bancroft's model provides a structural framework for analysing sexuality, which can be translated into a corresponding hierarchy of indicators. This structural framework is based on the distinction of three major developmental strands, which subsequently give rise to a new quality – namely, an individually specific sexual identity and associated patterns of sexual functioning that characterise adult sexuality. In our view, this structure offers a valuable foundation for analysing the complexity of individual sexuality, including the identification of specific trajectories of change within the psychotherapeutic process.

Finally, Bancroft's developmental perspective offers potential for evaluating both treatment and research outcomes not only in adult populations but also in younger age groups. There is currently extensive research into the prevalence and diagnosis of PDs, particularly BPD, in adolescents (Cierpiałkowska and Grzegorzewska, 2023). More and more early interventions are available to treat PDs in this age group (Jørgensen et al., 2021). There are also approaches, e.g. adaptation of transference-focused psychotherapy for adolescents (TFP-A), that explicitly address sexual functioning as a relevant domain for both assessment and potential intervention in this age group (Normandin et al., 2021). The authors of this approach emphasise that the differential diagnosis of PDs in adolescence should consider normative developmental processes, including the identity crisis commonly associated with the emergence of sexual identity. This is particularly important for minority youth, where the development of a minority sexual identity may be complicated by minority stress, potentially intensifying psychological difficulties. Furthermore, issues related to

relationship capacity – including romantic relationships – and the integration of sexuality into the self and interpersonal functioning are included in the diagnostic evaluation. We believe that it is necessary to systematise knowledge on the sexual functioning of adolescents with PDs, and that Bancroft's model could support research on age-appropriate indicators of therapeutic change in the context of adolescent sexuality.

Below, we present the elaboration of potential sexuality-related outcomes in PDs psychotherapy research corresponding to the three main domains of sexuality identified in Bancroft's model. Additionally, we developed a list of indicators for a fourth domain – sexual identity and patterns of sexual expression – which, according to Bancroft (2009), emerges from the integration of the preceding three. Each section begins with a definition of the respective domain, followed by a proposed list of its relevant indicators. These indicators – accompanied by brief descriptions – are presented in Tab. 1 through 4. Subsequently, we analyse the potential utility of these indicators as outcome measures in psychotherapy research, considering two key aspects: (1) their potential to change in response to psychotherapy for PDs; and (2) the feasibility of using them as outcome measures in empirical studies focused on the treatment of PDs.

This compilation results from extensive discussions informed by a review of theoretical and clinical literature on Bancroft's model of sexuality (Bancroft, 2009; Bancroft et al., 2009; Janssen and Bancroft, 2023; Szymańska-Pytlińska and Beisert, 2016), as well as our clinical experience in diagnosing and treating individuals with sexual disorders and PDs. We do not present the proposed set of indicators as exhaustive or definitive. Rather, we consider it a preliminary step toward addressing what we believe is an overlooked dimension in PDs psychotherapy research – sexuality as a domain of therapeutic change.

Indicators related to sexual differentiation and gender identity

The first strand concerns sexual differentiation, which contributes to the development of gender identity (Tab. 1).

Biological processes occurring during the prenatal stage of life that shape sexuality are not subject to change through psychotherapy. The process of sex differentiation can occur in a less typical manner, leading to the development of diverse sex characteristics in an individual's body at the chromosomal, gonadal, and other levels. A lack of congruence in sex characteristics is understood as an expression of human sexual diversity, and the absence of efforts to achieve bodily conformity should not be regarded as an indicator of a PD (De Sutter, 2020; Krege et al., 2019).

With respect to gender identity, psychotherapy may support the process of its emergence and consolidation, but it cannot be aimed at its change. Although people with PDs may experience a lack of sexual identity integration resulting in its high lability or even failure to emerge, it happens regardless of gender identity. The latter means that gender identity itself does not reflect personality pathology, regardless of whether someone identifies as cisgender, transgender, or nonbinary (Müldner-Nieckowski et al., 2020). Pursuing changes in gender identity as a psychotherapeutic goal would be unethical and is more appropriately classified as a form of conversion practice. It stands in clear opposition to the current recommendations of supporting the affirmation of sexual diversity (Coleman et al., 2022; Müldner-Nieckowski et al., 2020) and the recognition of gender incongruence of adolescence and adulthood as a condition related to sexual health in ICD-11 (World Health Organization, 2022). Gender role identification may or may not be consistent with one's gender identity. It includes patterns of behaviour, roles, attributes, and other traits that are typically assigned to men or women within a specific cultural context (Polderman et al., 2018).

While the content of gender identity may be largely influenced by biological or relatively stable factors, its formal qualities, including continuity, internal coherence, and consistency with other aspects of the self, may be shaped through psychotherapeutic intervention. Given that identity disturbances are a core feature of PDs and a key target of therapeutic work (American Psychiatric Association, 2013; Gad et al., 2019), psychotherapy for PDs may support the development of a more stable, integrated, and coherent gendered self-concept, even if it does not affect the biological foundations of that identity or its content itself.

Indicators related to sexual responsiveness

Sexual responsiveness involves an individual's physical and emotional reactions to sexual stimuli, encompassing physiological arousal, desire, and satisfaction. It is shaped by a combination of psychological, hormonal, and social factors. According to Bancroft's Dual Control Model (DCM), an adequate sexual response hinges on the balance between sexual excitation, which promotes arousal, and sexual inhibition,

Indicator	Description
Biological markers resulting from the process of sex differentiation	Pertains to biological differentiation, which begins prenatally and includes the development of sex-specific structures – from gonadal differentiation and internal/external genitalia to hormone-driven brain differentiation (Hines, 2020; Ristori et al., 2020).
Gender identity	Refers to one's internal, intrinsic sense of gender (e.g. woman, man, non-binary), regardless of assigned sex at birth (Coleman et al., 2022).
Gender role	A way of expressing and communicating one's gender identity through behaviour, clothing, make-up or mannerisms intended to reflect it (Pliczko and Mijas, 2020).

Tab. 1. Description of the sexual differentiation and gender identity strand

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Indicator	Description
Level of sexual desire	The subjective motivational state driving individuals toward sexual behaviour and the experience of sexual pleasure (Bancroft, 2009; van Tuijl, 2022)
Capacity for physiological sexual response	The ability to initiate and sustain both genital responses (e.g. lubrication, erection) and broader neuroendocrine-based responses (e.g. elevated heart rate, blood pressure, or respiratory rate) (Janssen et al., 2007)
Capacity to experience sexual pleasure	The ability to experience "physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism" (GAB, 2016). More recent literature defines it as a multifaceted concept encompassing several state-like and trait-like domains. State sexual pleasure is the "experience of positive affect ('feeling good') during sexual activities", while trait-like sexual pleasure refers to the "tendency to enjoy sexual activities" (Werner et al., 2023, p. 314)
Presence of sexual dysfunctions	The inability, due to various reasons, to participate in and enjoy sexual activities (see also sexual dysfunctions in: World Health Organization, 2022; American Psychiatric Association, 2013)
Presence of sexual pain or other physical discomfort	The experience of pain or uncomfortable sensations associated with sexual activity (see also sexual pain disorders in: World Health Organization, 2022; genito-pelvic pain/penetration disorder in: American Psychiatric Association, 2013)
Awareness of sexual arousal	The affective-cognitive evaluation of one's own sexual arousal, encompassing sensations and/or the perception of the sexual response (Álvarez-Muelas et al., 2022; Sierra et al., 2017; see also Leavitt, 2024 for the Sexual Mindfulness concept)
Level of sexual activity	The frequency of various types of sexual activity, both solitary and with others
Capacity to regulate sexual excitement	The ability to establish a balance between sexual excitation and inhibition processes, which determines whether sexual excitement translates into behaviour (Bancroft, 2009; Bancroft et al., 2009). Impairment in this regulation can lead to either compulsive, impulsive, risky sexual behaviours or inhibited sexuality (Bancroft, 2009; Bancroft et al., 2009)

Tab. 2. Description of the sexual responsiveness strand

which suppresses it. An imbalance between these processes is associated with a higher likelihood of experiencing sexual impairments (for proposed detailed indicators related to sexual responsiveness see Tab. 2). (Bancroft, 2009; Bancroft et al., 2009; Janssen and Bancroft, 2023).

Integrating the DCM with other models enhances the comprehensive understanding of sexual response. For example, Basson's (2001) model contributes by emphasising the crucial role of emotional intimacy and relational context. More integrative frameworks, such as those by Toates (2009) and Janssen et al. (2000), posit that arousal results from a complex interaction between automatic (biological) and controlled (cognitive, contextual) processes, which are shaped by individual learning and motivation. These models underscore the complexity of sexual response, a fact corroborated by empirical research demonstrating significant individual variability (e.g. Hidalgo and Dewitte, 2021; McCool-Myers et al., 2018). This multifaceted nature is also reflected in the ICD-11, where diagnoses of sexual dysfunctions and sexual pain disorders allow for the specification of contributing etiological factors (World Health Organization, 2022).

Given these frameworks, therapy for PDs – which targets cognition, emotional regulation, and interpersonal patterns – could impact sexual response by influencing the underlying excitation and inhibition processes. Potential outcomes could include: a more balanced level of sexual desire (neither persistently hypoactive nor hyperactive), a reduction in sexual dysfunctions and pain, an increased capacity for sexual pleasure, an enhanced ability to consciously recognise and regulate sexual tension, as well as a decrease in compulsive, impulsive, or high-risk sexual behaviours.

However, the utility of sexual responsiveness-related research outcomes is limited by their multifactorial nature. Improvement in PDs does not guarantee a corresponding change in sexual function due to numerous other variables. These include biological factors (general health, anatomical conditions, medical issues (e.g. diabetes, neurological diseases), and side effects of treatments or medications), experiential factors (a history of sexual abuse) (Schulte-Herbrüggen et al., 2009), habitual gratification patterns (Imieliński, 1990), insufficient knowledge, unrealistic expectations, or poor sexual technique (Halvaiepour et al., 2022; McCool-Myers et al., 2018) and situational factors, e.g. natural fluctuations in desire related to age or life circumstances which all can complicate the interpretation of short-term changes. An interesting example of the interplay of various factors comes from a study by Schulte-Herbrüggen et al. (2009), which found that sexual inactivity in female patients with BPD was primarily linked to co-occurring major depression or selective serotonin reuptake inhibitors (SSRI) medication use, not the BPD itself. Therefore, when interpreting the results of a study, it may not be entirely clear to what extent an observed improvement in sexual functioning following BPD therapy is attributable to core personality changes, and to what extent it may result from other factors, such as a reduction in SSRI use.

This does not mean that studying sexual responsiveness in PDs treatment research is unfounded. Rather, it is a valuable area of investigation that demands methodological rigor. In particular, we believe that research should: (1) measure and control for non-personality factors that influence sexual response; in cases where conducting a comprehensive assessment is not feasible, an alternative may be to focus on indicators where personality factors appear to be most salient; for example, an enhanced ability to regulate sexual tension, a reduction in high-risk sexual behaviours, or changes in trait-like sexual pleasure may be less confounded by medical or situational variables than indicators like the presence of sexual dysfunctions, sexual pain, or state-like

sexual pleasure; (2) assess sexual functioning over extended periods in order to reduce the impact of temporary situational influences. While the proposed approach would increase the complexity of research designs, it would ultimately yield more meaningful and clinically relevant insights.

Indicators related to capacity for close, dyadic relationships

The capacity for close, dyadic relationships refers to an individual's ability to form and sustain emotionally intimate, mutually satisfying partnerships that can encompass a sexual component. As Szymańska-Pytlińska and Beisert (2016) highlight, this capacity holds threefold significance for adult sexuality: (1) it provides the foundation for engaging in non-solitary sexual activities; (2) it enables the fulfilment of sexual functions beyond mere pleasure, such as biological, social, and bonding; and (3) within a stable relationship, it ensures the long-term satisfaction of an individual's sexual needs by providing consistent partner availability. Ultimately, the capacity for close relationships enables individuals to express their sexuality within a trusting, reciprocal partnership.

The capacity for dyadic intimate relationships has been a subject of extensive research, reflected in numerous assessment tools such as the Perceived Relationship Quality Components Inventory (PRC) (Fletcher et al., 2000), Dyadic Adjustment Scale (DAS) (Busby et al., 1995; Spanier, 1976), Couples Satisfaction Index (CSI) (Funk and Rogge, 2007), Capacity to Love Inventory (CTL-I) (Kapusta et al., 2018) or the Triangular Love Scale (TLS) (Sternberg, 1997). Our own reflection, informed by these sources, underpins the indicators we have distinguished for the capacity for close dyadic relationships. We have consciously omitted "sexual passion" – an element often described in the context of dyadic relations (e.g. CTL-I, TLS) – as we believe it more accurately represents the integration of Bancroft's three model strands, discussed later. Our selected indicators are summarised in Tab. 3.

Among the three strands of Bancroft's model, the capacity for close dyadic relationships appears to hold particular therapeutic potential in the treatment of PDs and, consequently, for sexuality-related research outcomes in PDs psychotherapy studies. This domain is especially relevant in PD populations, where interpersonal dysfunction constitutes a core diagnostic feature (American Psychiatric Association, 2013; Hopwood et al., 2013). It also aligns closely with various personality models that link the capacity for enduring and satisfying dyadic relationships to underlying developmental processes (e.g. Caligor et al., 2018; Fonagy and Luyten, 2009). In PDs psychotherapy, many of these are directly addressed, allowing for the emergence of a previously impaired capacity for deep connection with others. For instance, aggression becomes more integrated with libido, resulting in a more coherent identity (TFP). Similarly, the ability to understand one's own and others' mental states (thoughts, feelings, intentions) improves (MBT). Early maladaptive schemas of thinking, feeling, and behaving undergo modification (SFT), and the capacity for emotion regulation and distress tolerance develops (DBT). All these therapeutic gains may translate into better, deeper, and more fulfilling close relationships, into which sexuality can simultaneously be integrated.

Notably, the limited empirical studies that have explored any aspects of sexuality within the context of PDs psychotherapy have focused on the domain of intimate relations, in particular examining changes in attachment. However, we believe there is greater potential for developing outcomes based on this strand for research into the effectiveness of PDs therapy. First and foremost, a primary indicator could refer to whether an individual has ever engaged in an intimate relationship during their lifetime, as well as the number of such relationships across the lifespan. A related indicator is relationship duration – a time-based measure reflecting how long partners remain together. Furthermore, valuable indicators for consideration might include a lower level of various relationship-related anxieties (e.g. fear of rejection, separation anxiety, fear of fusion), increased emotional intimacy

Indicator	Description
Capacity for commitment	The ability to dedicate oneself to maintaining a long-term, loving relationship (Sternberg, 1986)
Level of attachment anxiety	The level of anxiety experienced in the context of close relationships, such as a fear of intimacy or fear of rejection (Pepping and MacDonald, 2019)
Interest in the partner's life	Engagement with one's partner's life and well-being, e.g. sharing and knowing life plans, and celebrating the partner's successes and growth (Kapusta et al., 2018)
Capacity for empathy	The ability to actively understand how one's partner feels (Ulloa et al., 2017)
Capacity for non-violent expression of aggression	The ability to express feelings of hurt or respond to conflict in a constructive, self-regulated manner, rather than resorting to physically/verbally aggressive behaviours
Disposition towards gratitude	The capacity for a positive emotional response to benefits received from a partner, particularly when these benefits are perceived as intentionally given and responsive to one's own needs (Algoe et al., 2010)
Ability to trust	The capacity for a fundamental belief in a partner's empathy and support, which enables one to openly express feelings and needs, and to feel safe and comfortable in the relationship (Kapusta et al., 2018)
Acceptance of mourning	The ability to tolerate loss and bear the associated psychological pain and depressive feelings that arise from relationship ruptures or disappointments (Kapusta et al., 2018)

Tab. 3. Description of the capacity for close, dyadic relationships strand

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Indicator	Description
Sexual identity (including type of preferred sexual objects and activities)	A self-narrative provided by the participant in answer to the question: "What kind of sexual person am I?" that relates to preferences for particular sexual partners or activities that are incorporated into sexual scripts (Bancroft, 2009)
Sexual self-esteem	It refers to a person's overall positive evaluation of their sexual self, including emotional responses to their sexual behaviours and the value they assign to their sexual identity and acceptability (Firoozi et al., 2016; Khamseh and Nodargahfard, 2020). It may include various domains, such as perceived sexual attractiveness, competence, or control, depending on the specific measurement tool used
Direction of sexual desires	Preference of the solitary versus parter-oriented sexual behaviours in terms of sexual motivation (Cooper et al., 1998)
Sexual fidelity	Sexual exclusivity in an intimate relationship (Bukenya et al., 2022)
Relationship satisfaction	Evaluation of a sexual relationship in terms of sexual satisfaction stemming from a predominance of sexual rewards over costs (Freihart et al., 2020)
Sexual quality of life	Sexual quality of life refers to an individual's subjective evaluation of both positive and negative elements of their sexual life, along with personal interpretation and reaction to this evaluation. It is closely linked to overall life satisfaction and general quality of life (Bagherinia et al., 2024)

Tab. 4. Sexual identity and patterns of sexual functioning

and trust, enhanced capacity for forgiveness, the ability to tolerate mourning and jealousy as integral parts of a loving relationship, improved communication, reduction in acts of aggression towards a partner. For example, an individual who previously oscillated between intense, unstable sexual relationships and avoidant withdrawal might, following treatment, establish a more consistent and emotionally attuned partnership characterised by mutual affection and gratitude.

Sexual identity and patterns of sexual functioning: integration in Bancroft's model

Bancroft (2009) not only identified three core developmental components of human sexuality, but also emphasised that adult sexuality is the effect of their integration. These developmental strands converge into a coherent sexual self-concept and relatively stable patterns of sexual functioning within intimate adult relationships. Since this integration represents the emergence of a new psychosexual quality, we argue that it requires the identification of distinct indicators that are specific to this configuration (see Tab. 4).

We believe that these indicators may be highly translatable into measurable variables suitable for use in research on the effectiveness of psychotherapy for PDs. In particular, psychotherapy for PDs, by supporting the development of an integrated self, may facilitate the emergence of a clearer and more positive sexual identity. For instance, an individual who previously experienced confusion, shame, or avoidance around their sexuality may, through therapy, develop the capacity to more consciously articulate and embrace this aspect of self. Gaining clarity in "who I am, sexually", is one facet of resolving PDs characteristic identity confusion. Ultimately, improvements across the aforementioned domains are likely to enhance an individual's overall sexual quality of life, as well as increase the degree to which sexual functioning contribute positively to general life satisfaction. It is also worth highlighting the potential variability in how the psychotherapy of PDs may lead to these more general improvements, resulting from the integration of shifts across various strands of sexuality. One example could involve the gender-specific determinants of overall sexual satisfaction (Nomejko and Dolińska-Zygmunt, 2019) – particularly the greater role of relational factors in women (Basson, 2000) – it may be hypothesised that improvements in the capacity for close relationships during psychotherapy would contribute more significantly to increases in overall sexual satisfaction in women than in men, given comparable improvements. In this way, Bancroft's framework opens the door to compelling research hypotheses concerning the differential impact of specific psychotherapeutic modalities on overall sexual well-being, depending on the extent to which they influence particular strands of sexuality.

CONCLUSION

Beyond highlighting the potential clinical relevance of sexual functioning in the treatment of PDs, we also aimed to articulate our own line of thinking regarding its role as a possible indicator of psychotherapeutic change. Nevertheless, the considerations outlined above, should be regarded as a starting point for further empirical inquiry, as they reflect an early-stage conceptual exploration of the theme that has thus far been largely neglected in literature. By making our conceptual framework and reasoning explicit, we hope that our work will inspire future research and contribute to addressing an important yet underexplored area in the study of psychotherapy outcomes – namely, the role of sexual functioning in the psychological recovery of individuals with PDs. In doing so, we aspire to contribute to a gradual broadening of outcome assessment in clinical research – one that increasingly reflects the complexity and richness of human psychological recovery.

Conflict of interest

The authors do not report any financial or personal connections with other persons or organisations which might negatively affect the content of this publication and/or claim authorship rights to this publication.

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Author contribution

Original concept of study; collection, recording and/or compilation of data; analysis and interpretation of data; writing of manuscript: AI, MESP, JB, MMS, JAF, MOJ. Critical review of manuscript: AI, MESP, JB, MOJ. Final approval of manuscript: AI, MESP, JB.

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