The Role of Interpersonal Style, Self Perception and Anger in Sexual Dysfunction[1,2]

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SUMMARY

Purpose: The main purpose of this study was to determine the relationship between interpersonal style, self concept, and anger in the context of sexual dysfunction.

Method: The sample consisted of males and females diagnosed as having sexual dysfunction (N=95) and males and females without a diagnosis of any kind of psychological disorder (N=95). The age range was between 18-53. The participants were given a detailed Demographic Information Questionnaire and the Interpersonal Styles Scale, Brief Symptom Inventory, Multidimensional Anger Scale, Social Comparison Scale and the Golombok-Rust Inventory of Sexual Satisfaction (GRISS).

Results: The results showed that the two groups had significantly different scores on all of the measures, including their sub-scales. The regression analyses of the two groups revealed that for all of the participants, males and females, patients and non-patients, the GRISS scores could be significantly predicted by self-perception, satisfaction with life and relationships. These three variables were the common variables that predicted the GRISS scores regardless of sex. However, the specific predictive variable for the GRISS scores of the female patients, in addition to the three common variables, was vindictive anger reactions. For the non-patient females, these additional variables were belittling and insensitive interpersonal styles. On the other hand, for the male patients, the scores on the GRISS could be significantly predicted by the belittling interpersonal style and aggressive anger reactions, along with the three common variables listed above. For the non-patient males, the additional variable was avoidant interpersonal style.

Conclusion: The above results indicate that sexual dysfunctions can be explained in part by the interpersonal style and anger management deficits of the patients. It is suggested that the addition of anger-management, and interpersonal communication skills training courses into the treatment protocol of sexual dysfunction disorders would be beneficial.

Key words: sexual dysfunction, anger, self perception, interpersonal style

INTRODUCTION

The World Health Organization defines healthy sexuality as "an integration of somatic, affective, cognitive and social dimensions to enhance personality, communication, and love" (Özkan 2001). Sexuality is considerably affected by the interpersonal relationships,, cultural and social context, life circumstances, biological characteristics, and self-perception. On the other hand, when "self" is being formed, a part of it builds upon an individual's perception of sexuality. Therefore sexual dysfunction can effect self-perception negatively, leading to an exacerbation of sexual dysfunction (Tuğrul 1998). A study investigating the importance and frequency of sexual dysfunction (SD) in the general population revealed that,82% of males, 76% of females believe that satisfactory sexuality is important in continuing an intimate relationship and enhancing self esteem (Nicolosi et al. 2004). Other investiga-

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tors reported that sexual effectiveness and performance are two important variables that contribute to male self-esteem (Stimson et al. 1980).

Self-perception, which is an important variable in healthy sexuality, is developed and changed through interpersonal relationships. Interpersonal relationships also play an important role in disorders of sexuality. The past literature states that problems and deficits in interpersonal communication are correlated with the etiology and prognosis and treatment outcome of SD with no known physiological causes (Metz and Epstein 2002, Litzinger and Gordon 2005, Byers 2005). There are also some studies that suggest that certain communication problems are specific to couples with SD, and that in the etiology and prognosis of orgasm disorder, lack of communication and lack of interpersonal trust are important (Heiman and Grafton-Becker 1989).

Additionally, affect regulation is known to be important in interpersonal relations, and in particular anger is one of the intense emotions that should be regulated. Anger can play a role in lowering self-esteem (Deffenbacher 1992), and lowering or hindering libido in intimate relationships (Bozman and Beck 1991). A study conducted by Beck and Bozman (1995), revealed that females are especially affected negatively in terms of their libido when they are anxious or angry. Another study conducted on males with SD, showed that their anger scores are considerably higher than normal, and that their anger type is mostly internalized anger. Additionally, these males were found to have partners with aggressive and externalized anger, compared to males without SD (Rosenheim and Neumann 1981).

In summary, the above findings indicate that there is a correlation between anger, self-perception, interpersonal relations and SD. However, in the related literature, these variables were mostly studied individually in terms of their relationship with SD. The present study aims to consider them as a group. In other words, the relationship between anger, self-perception, interpersonal communication and sexual dysfunctions will be studied in the same sample.

METHOD

Sample

The "study group" sample was composed of patients diagnosed as having SD, according to the DSM-IV, who were patients at the urology, gynecology, and psychiatry clinics of different hospitals in Ankara. None of the patients had started their respective treatments at the time of data collection. The "comparison group" sample was composed of individuals from the community without any complaints with regards to health problems. There were 95 (43 females and 52 males) patients in the study group between the ages of 18-53. The diagnoses the female patients received were: 12 with libido loss, 1 with sexual arousal problems, 22 with vaginismus, and 8 with inorgasm. The male patients had the following diagnoses: 44 premature ejaculation and 8 erectile dysfunction. There were 95 (47 females, 48 males) individuals in the comparison group also between 18-53 years of age. Data from the comparison group participants, who answered the question, "Did you have any physiological or psychological problems in the last 6 months?" on the Demographic Information Questionnaire as "yes", were not included in the analyses.

Data collection instruments

Demographic Information Form

This questionnaire is composed of 34 items, some of which are open-ended and others that are answered with a 5-point Likert-type scale. The participants were asked to report their perceptions of their current economic, physical, and emotional status, and their life in general on the Likert-type items. The responses to these 4 items were indexed as "dissatisfaction with life". Similarly, the participants were also asked to rate their satisfaction with their family of origin, their relationship with their intimate partner, relationships with friends, level of loneliness, and the number of close friends. The responses to these items, as a total, were computed as a score for "dissatisfaction with interpersonal relationships". Higher scores indicated greater dissatisfaction.

Interpersonal Communication Style Scale (ICSS)

This is a 60-item, 5-point Likert-type scale developed by Şahin et al. (2007), which measures interpersonal communication style. Factor analysis during the scale's development process revealed 6 factors, namely, "dominant style", "avoidant style", "angry style", "insensitive style", "manipulative style" and "belittling style". The scale is reported to yield satisfactory psychometric information (Şahin et al. 2007).

Brief Symptom Inventory

This 53-item, 4-point Likert-type scale was originally developed by Derogatis (1992). It is reported to measure psychological symptoms in both patients and non-patients. The Turkish version of BSI was adapted for use in Turkey following 2 different studies with different populations; adults (Şahin and Durak 1994) and adolescents (Şahin et al. 2002). The Inventory was reported to be composed of 5 factor-based subscales according to Turkish adaptation studies: depression, anxiety, negative self, somatization, and hostility. In the present study only the anxiety and somatization subscales were used for analysis.

Multi-Dimensional Anger Scale

This Likert-type scale was developed by Balkaya and Şahin (2003) and consists of 5 dimensions; "anger symptoms", "an-

ger related situations", "anger-related thoughts", "anger-related behaviors", and "interpersonal anger". In the present study, only the "anger-related behaviors" and "interpersonal anger" dimensions were used. The anger-related behaviors dimension has 3 scales: "aggressive behaviors", "anxious behaviors" and "trying to remain calm". The interpersonal anger dimension has 4 scales: "vindictive reactions", "passive-aggressive reactions", "internalization reactions", and "indifferent reactions". The reliability and validity of the scale are well known.

Social Comparison Scale (SCS)

This 18-item, 6-point Likert-type scale measures how individuals evaluate themselves on 18 dichotomous dimensions, based on a comparison to others. The original version was a 5-item scale developed by Gilbert and Trent (1995). During the Turkish adaptation, 13 items were added and a new version was developed (Şahin and Şahin 1992). High scores indicate positive self-perception. The reliability and validity of this scale are well known.

Golombok-Rust Sexual Satisfaction Inventory (GRSSI)

This is an assessment instrument used to evaluate the quality of sexual relations and sexual dysfunctions. It consists of two different gender-specific forms, with 28 items, each having 7 dimensions. Out of the 7 dimensions, 5 dimensions (avoidance, satisfaction, communication, tactile contact, and frequency of sexual activity) are common for both sexes. In the female form, there are dimensions regarding vaginismus, and orgasm problems, whereas in the male form there are dimensions regarding premature ejaculation and impotence (erectile dysfunction). Rust and Golombok (1986) are the original developers of the instrument, which has been adapted for the Turkish culture by Tuğrul *et al.* (1993).

Procedure

The participants were given the assessment forms and the informed consent form in an envelope. After they filled out the questionnaires and signed the informed consent form, the forms were returned to the researchers in the sealed envelope. Patients who visited the urology and gynecology clinics were evaluated by their clinic doctors for any physical problems before they were sent to the psychiatry clinic, where they were evaluated for any associated psychiatric problems, by the clinic psychiatrist. The data were evaluated to ensure that the data were accurately entered and normally distributed prior to analyses.

RESULTS

I. Analyses regarding sociodemogaphic variables

The sample was divided into two groups in terms of age (18-30 and 31 and higher) and into three groups in terms of education (primary school, secondary school, and university). A 2 (group) by 2 (age) by 3 (education) ANOVA was conducted for the males and females, and the GRSSI scores were used as the dependent variable. The results showed that, as expected, the variable "group" had a main effect on the scores of both females ($F_{(1, 78)}$ =101.73; p<.001), and males ($F_{(1, 88)}$ =51.62; p<.001). Female patients with SD had significantly greater GRSSI scores (x=60.38, sd=16.83), compared to females without such disorders (x=26.15, sd=9.64). Similarly, males with SD had significantly greater scores (x=40.91, sd=10.46) compared to males without these disorders (x=22.11, sd=8.35). No main effects of age or education were found on the scores of both genders. The finding regarding the "group" variable main effect was interpreted as the comparability of the patient and non-patient groups according to the study variables.

II. Comparison of the groups with and without SD in terms of the study variables

An independent samples t-test was conducted to investigate the difference between the groups. The results are given in Table 1 after the Bonferroni correction.

Table I. Comparison patients with and without sexual dysfunction disorders, in terms of the research variables

	Study Group		Comparison Group		
	N= 95		N= 95		
Variables	x	ss	x	ss	t
ANGER (Total score)	199.66	31.20	191.55	30.68	1.81
Interpersonal anger (Total score)	125.84	24.90	121.10	25.44	1.30
Vindictive reactions	55.79	18.39	53.57	17.12	.86
Passive-aggressive reactions	30.68	6.43	31.55	7.10	.88
Internalised anger reactions	32.81	5.50	29.30	6.09	4.17***
Indifferent reactions	6.56	2.72	6.68	3.20	.29
Anger-related behaviors (Total score)	73.81	9.37	70.45	9.26	2.49*
Aggressive behaviors	26.53	7.87	24.73	6.79	1.69
Trying to stay calm	33.88	5.54	32.89	6.51	1.13
Anxious behaviors	13.41	3.21	12.83	3.14	1.25
INTERPERSONAL STYLE (Total score)	132.48	32.96	117.24	27.71	3.45***
Dominant style	25.60	9.33	23.68	7.72	1.54
Avoidant style	24.57	6.80	20.88	5.74	4.04***
Angry style	23.58	7.64	19.96	5.86	3.66***
Insensitive style	24.91	6.56	21.93	6.64	3.12**
Manipulative style	24.50	6.42	21.65	6.20	3.12**
Belittling style	9.32	3.64	9.13	3.43	.36
SELF PERCEPTION	81.34	14.55	89.45	11.43	4.27***
BSI (Total score)	47.00	32.44	28.49	19.34	4.77***
Anxiety	9.60	8.33	5.90	4.87	3.73***
Depression	13.57	9.66	7.96	5.85	4.84***
Negative self	10.51	8.59	6.06	4.96	4.37***
Somatization	6.32	6.11	3.60	3.60	3.73***
Hostility	6.98	4.48	4.97	3.93	3.28***
Dissatisfaction with life	14.91	3.39	12.53	2.64	5.40***
Dissatisfaction with interpersonal relations	11.87	2.50	10.72	2.28	3.34***

* p <.05 ** p <.01 *** p ≤.001

As the table shows, the "internalized anger" scores of the group with SD, are significantly greater than the group with-

out SD. There is a similar pattern seen with internalized anger and anger-related behavior scores. When comparing the scores of the two groups on the Interpersonal Styles Scale, it is seen that the group with SD received a significantly greater score on all of the sub-scales except "dominant style" and "belittling style". The group with SD also received significantly higher scores on all of the sub-scales of the BSI and on the index scores of dissatisfaction with life and dissatisfaction with interpersonal relationships. The self perception of the same group was significantly more negative.

The differences in terms of the Golombok-Rust Sexual Satisfaction scores are shown in Table II.

Table II. Comparison between males and females who have sexual dysfunction disorders, in terms of the Golombok Rust Sexual Satisfaction Invenory scores

	Study Group		Comparison Group		
	n= 43		n= 47		
Females	x	ss	x	ss	t
GRSSI Total score.	60.38	16.83	26.15	9.64	11.97***
Frequency	5.18	2.13	3.28	1.52	4.91***
Communication	4.40	2.22	2.76	1.75	3.91***
Satisfaction	8.85	3.47	3.51	1.99	9.05***
Avoidance	7.51	4.41	2.88	2.02	6.49***
Touch	6.79	4.28	2.27	1.89	6.58***
Vajinismus	8.39	5.44	3.15	2.45	5.98***
Anorgasmi	10.14	3.76	4.32	2.07	9.20***
	Study Group		Comparison Group		
	n= 52		n= 48		
Males	x	ss	x	ss	t
GRSSI Total score	40.91	10.46	22.11	8.35	9.88***
Frequency	4.04	2.20	2.44	1.32	4.34***
Communication	3.21	2.35	1.99	1.58	3.02**
Satisfaction	7.26	3.37	3.92	2.20	5.83***
Avoidance	2.58	2.12	1.24	1.47	3.65***
Touch	2.30	2.71	1.75	1.93	1.16
Premature ejaculation	9.45	3.62	3.25	3.02	9.26***
Impotance	6.90	4.06	2.28	2.06	7.10***

* p <.05 ** p <.01 *** p <.001

As shown above, the GRCD scores of the females with SD were significantly higher than controls. A similar finding was true for the males with SD. The males with SD received significantly higher scores on all of the sub-scales of GRCD, except the sub-scale "touching".

III. Variables predicting Sexual Dysfunction and Sexual Satisfaction

The Golombok-Rust Sexual Satisfaction Scale is an assessment instrument which aims to measure SD intensity in patients with SD as well as the quality of sexual life in those without a diagnosis. Therefore, a four-step hierarchical regression analysis was conducted to investigate the predictive variables for sexual dysfunction in males and females, both in the the patient group and in the comparison group. The first step independent variables were the demographic variables of age, education, income, and length of marriage. In the second step, the subscales of the MDAS, vindictive reactions, passive-aggressive reactions, internalized reactions, indifferent reactions, aggressive behaviors, anxious behaviors and trying to stay calm were entered. In the third step, the sub-scales of the Interpersonal Styles Scale (dominant, avoidant, angry, insensitive, manipulative, and belittling styles) were entered. The fourth step consisted of self perception scores, the fifth step of dissatisfaction with life, the sixth step of dissatisfaction with relationships, and in the last step, symptom scores measured by the sub-scales of the BSI were entered in the analyses. The results are given in Table III.

The table illustrates that, "self-perception", "dissatisfaction with life" and "dissatisfaction with relationships" were found to be the common variables predicting sexual dysfunction scores. On the other hand, for female SD patients, the "vindictive anger reaction" scores were also entered into the equation, and raised the predictive power to 20%. For the male patients with SD, the other predictive variables were, "aggressive behaviors" and "belittling interpersonal style", which together explained 45% of the total variance in the sexual dysfunction scores.

For the females in the comparison group, less serious sexual dysfunction scores were found to be predicted by "belittling interpersonal style" and "insensitive interpersonal style", along with the common predicting variables of "negative self-perception", "dissatisfaction with life" and "dissatisfaction with relationships", all together explaining 41% of the total variance in the sexual dysfunction scores. On the other hand, for the males in the comparison group, less serious sexual dysfunction scores were found to be predicted by "avoidant interpersonal style", along with "negative self-perception", "dissatisfaction with life" and "dissatisfaction with interpersonal relationships", predicting 27% of the total variance.

DISCUSSION

In this study, the most interesting finding is related to the common variables, which predicted the sexual dysfunction scores of both high and low intensity. These common variables were "negative self-perception", "dissatisfaction with life" and "dissatisfaction with interpersonal relationships." These three variables have been previously found to be predictive of anxiety (Şahin et al. 2011a), depression (Şahin et al. 2011b), and stress symptoms (Batıgün et al. 2011) of high and low intensity. When examined from this perspective, it can be stated that these three variables are predictive of several types of disorders of different intensities. In other words, these variables are not specific to sexual dysfunctions. On the other hand, some variables were identified that seemed to be specific to sexual dysfunctions only. These variables were not found to be predic-

Table III. Variables predicting the scores on the GRSSI for males and females with and without sexual dysfunction disorders

		Variable(According to the order odf inclusion in the analyses)	R	R^2	R^2 Değişim	Beta	t	F
FEMALES	SD Present	Vindictive anger reactions	.305	.093	.093	.242	1.55	4.22*
		Self-perception	.408	.167	.074	-.235	-1.32	4.01*
		Dissatisfaction with life	.452	.204	.037	.208	1.32	3.34*
		Dissatisfaction with interpersonal relations	.452	.204	.000	-.015	-.08	2.44
	SD Not present	Belittling style	.359	.129	.129	.268	2.01*	6.64**
		Avoidant style	.498	.248	.120	-.195	-1.34	7.27**
		Self-perception	.533	.284	.035	-.116	-.93	5.68**
		Dissatisfaction with life	.587	.345	.061	.288	1.97*	5.52***
		Dissatisfaction with interpersonal relations	.588	.346	.001	.033	.24	4.33**
		Somatization	.641	.411	.066	-.303	-2.12*	4.661***
MALES	SD Present	Aggressive behaviors	.558	.312	.312	.402	3.35**	22.66***
		Belittling style	.604	.364	.053	.207	1.66	14.04***
		Self-perception	.658	.433	.069	-.210	-1.51	12.22***
		Dissatisfaction with life	.659	.434	.001	-.011	-.08	9.00***
		Dissatisfaction with interpersonal relations	.670	.449	.015	.149	1.13	7.50***
	SD Not present	Avoidant style	.342	.117	.117	.142	.94	6.09*
		Self-perception	.416	.173	.056	-.209	-1.25	4.72*
		Dissatisfaction with life	.423	.179	.006	-.005	-.03	3.20*
		Dissatisfaction with interpersonal relations	.425	.180	.002	-.003	-.02	2.37
		Negative self	.518	.268	.087	.338	2.24*	3.07*

*p<.05; **p<.01; ***p<.001

tive of other symptoms, such as anxiety, depression, and stress, mentioned in the above studies. For example, the more serious sexual dysfunction symptoms of the females could be predicted by "vindictive anger reactions", whereas the more serious symptoms of the males with SD could be predicted by a "belittling interpersonal style", along with the three other common variables (Please see Table III). It is interesting that these variables did not enter the regression equations of patients with anxiety, depression and psychosomatic disorders (Please see the above mentioned studies).*

When we interpret these finding from this perspective we can state that, for females, a vindicative expression of their anger can have detrimental effects on their sexual lives, as well as on the sexual performance of their partners. Even though this study did not investigate partners, since sexuality is a dyadic process, it would make logical sense that the reactions of one partner toward the other can affect the sexuality of both individuals. Similarly, if a male partner approaches his female partner aggressively or belittles her either due to his own sexual dysfunction (premature ejaculation or erectile problems) or due to his general interpersonal style, there may be negative effects on both his and his partner's sexuality. The t-test comparison between those with a diagnosis of sexual dysfunction and those without showed that there are problems in the interpersonal styles of the SD patients (Please see Table I). When we look at the item content of the Interpersonal Style Scale sub-scales, the intensity of anger in their styles differentiates between the groups ("When I am angry I say things I regret afterwards", "When I am angry, I shout", etc.). It can be stated that such styles can cause the partner to be more defensive, resistant, rigid, and to experience feelings of intense anger.

On the other hand, it can be also be stated that when anger is too intense and cannot be controlled, interpersonal communication suffers to a great degree. When we look at the common variables that predict both the high and low intensity sexual dysfunction scores, it can be stated that for both males and females, "anger" is an important variable (Please see Table III).

In females with considerably lower sexual dysfunction scores, expression of anger through belittling and insensitive styles were found to be predictive, while expression of anger through more intense indirect ways such as vindictive reactions were found to be related, to more serious sexual dysfunction symptoms. Similarly, in males, lower sexual dysfunction scores, were found to be related to avoidant interpersonal styles and the more intense SD symptoms were found to be related to belittling interpersonal styles and aggressive anger behaviors. When we consider the general finding related to the more indirect ways of anger expression in females (Lerner 1996), the predictive role of vindictive behaviors for sexual dysfunction scores of female patients is understandable. The aggressive anger behaviors found in the male SD patients is also supported by the related literature. Roseinheim and Neuman (1981)

*The specific variable predicting depression scores in patients with a diagnosis of depression were found to be "internalized anger" (Şahin et al. 2011b), whereas the specific variable predicting the anxiety scores of patients with anxiety disorders was found to be "trying to stay calm when angry"(Şahin et al. 2011a). The stress symptoms of the patients with psychosomatic disorders was found to be "aggressive behaviors" (Batıgün et al. 2011).

stated that, males with SD seem to exhibit greater interpersonal anxiety and anger. Additionally, the predictive power of more aggressive anger in male patients may be explained by considering the finding that males seem to prefer more direct ways of anger expression (Aydın and Gülçat 2004).

The predictive power of self-perception on the sexual dysfunction scores found in the current study is also a finding in other studies. Stimson *et al.* (1980) have reported that inefficient sexual performance in males is the most important variable related to self-esteem. Similarly, in the Turkish culture, problems related to sexual function are perceived as a failure on their part (Aydın and Gülçat 2004).

The finding related to the predictive power of an insensitive interpersonal style in considerably lower sexual dysfunction problems seems to be associated with the findings of Kelley *et al.* (2006), regarding the relationship between sexual dysfunctions and communication styles. In other words, while the problems in sexual life might lead to interpersonal problems, the interpersonal style problems might also lead to problems in sexual life, intensifying them or causing them to persist.

Cushman and Cahn (1985) have mentioned the role of self-perception in the regulation of communication skills. Considering that sexuality is an important dimension of self-organization in males (Stimson *et al.* 1980), and that it is equated with "success" in our culture (Aydın and Gülçat 2004), we can state that sexuality is a determining variable of the concept of "self" for males. Consequently, as it is reported in the related literature (Fugl-Meyer and et al. 1997), this immersion of "self" in sexuality for males, might be related to the negative emotions and psychosomatic symptoms females develop in response to problems in their sexual lives. This finding parallels the reports of Stimson *et al.* (1980) and Aydın and Gülçat (2004), regarding the importance of sexuality in the organization of self concept. They have proposed that the problems experienced in sexuality are generalized to the entire self and evaluation of life.

When we consider the findings of the present study as a whole, it can be stated that whether a patient presents with mild or serious SD problems, there is a relationship with satisfaction with one's self, one's life, one's interpersonal relations, and problems in one's interpersonal style. If in addition to these, if an indvidual has problems with anger management (males, expressing their anger through aggressive behaviors; females, expressing anger through vindictive reactions), sexual functioning seem to be effected more seriously.

Nevertheless, it should be kept in mind that these are two-way relationships. In order to be able to say more about the nature of this relationship, these variables should be investigated within a model. More could be said if a study was conducted to evaluate the effect of anger management and communication skills training programs on SD when added to the treatment protocols of patients with SD. Hawton *et al.* (1992) have conducted such a study, which revealed that the addition of communication skills training to the regular treatment program was beneficial in alleviating the symptoms of patients with sexual problems. It is also reported that the gender differences should also be taken into consideration in order to choose the appropriate interventions.

The present study also has some other limitations. For example, couples were not the focus of this study. However, sexuality is a shared experience and problems one partner experiences sooner or later affects the other. Therefore, in order to get a better idea of the effects of interpersonal communication on sexuality, future studies should include couples. Larger samples would also yield more detailed findings, as well as open a possibility for comparing different categories of sexual dysfunction disorders. In the present study, the female patient sample was biased toward vaginismus, and the male patient sample was biased toward premature ejaculation, therefore the reader should be cautious when generalizing these findings to the large spectrum of sexual dysfunction disorders.

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