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Changes in Personality Scores Among Couples Subsequent to Sex Therapy

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Changes in personality scores and self-perception of 92 couples through sex therapy are reported. The sample included 52 couples with female symptoms (orgasmic dysfunction and vaginismus) and 40 couples with male symptoms (erectile dysfunction and premature ejaculation), who all completed therapy. One-year follow-up showed significant changes indicating a general increase of emotional stability and a reduction of neurotic tendencies in both partners.

KEY WORDS: sexual dysfunction; sex therapy; personality traits; personality change.

INTRODUCTION

Masters and Johnson (1966), with their therapy model, caused a boom in sex therapy techniques and sex therapy centers, many of which sought to outdo each other in their promises of success. Success was predominantly measured by the extent to which the functional disturbance was either removed or improved. Little or no attention has been given to changes in general personality variables as an effect of therapy.

Because of empirical evidence that sexual function disturbances affect large areas of personality and emotional stability (Frank *et al.*, 1976; Munjack and Stapler, 1976; *cf.* Tables III and IV), it seems clinically and theoretically important to ask if symptom removal also leads to a stabilization of affected personality areas. Since we regard the symptom as part of a

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Table I. Sample Description

Diagnosis	Couples	Duration of symptom > 5 yr (%)	Success rate[a] (%)
Orgasmic dysfunction	108	59	69
Vaginismus	27	59	78
Erection dysfunction	57	53	80
Premature ejaculation	31	77	84

[a]Criteria of success are discussed in Arentewicz and Schmidt (1980).

couple system, both the carrier of the symptom and the partner were subjects of study.

METHOD

Sample

Of the total of 202 couples treated for sexual function disturbances in our department between 1973 and 1978, we refer only to the 92 couples who completed therapy and for whom the follow-up time of 1 year was completed (Table I). The control groups for the pretherapy data were unselected normal subjects.

Treatment

The couples were treated in three different settings (see Table II). This was done to compare the results of each setting. Since there is no significant difference in the effectiveness of the different settings in the 1-year follow-up (Arentewicz and Schmidt, 1980), we shall summarize the results of the three settings.

Table II. Settings of Partner Therapy

1. Two therapists, long term
   Male and female therapist, two sessions a week, 35 sessions on average
2. One therapist, long term
   Male or female therapist, two sessions a week, 35 sessions on average
3. Two therapists, intensive
   Male and female therapist, daily sessions for 3 weeks, 16 sessions on average

PROCEDURE AND MEASUREMENT

The following psychological tests were used.

1. The Giessen Test (GT): This test is basically psychodynamic in its construction, involving factor analysis, and contains a total of 40 items dealing with six personality dimensions including special emphasis on psychological characteristics. It can be used to describe oneself as well as to describe another person. Each patient completed the questionnaire both for himself or herself and for the respective partner.
2. The Freiburg Personality Inventory (FPI): This test is also factor analytic in structure and covers 12 personality dimensions in 212 items.
3. Sexual Attitude Scale (SAS): This questionnaire was developed in in our department and includes 26 items. It covers general attitudes toward heterosexuality and is used as an instrument of general description of sexual attitudes. It contains three scales which have not yet been factor-analytically validated.

As in this context we were interested only in long-term changes, we compared the data at the commencement of therapy and at 1-year follow-up.

For comparison we used two-tailed t tests for dependent samples, which seemed permissible without a notable increase of the p levels, because the scales of the GT and the FPI are not highly correlated. The maximum interscale covariance is 14% for the GT (Beckmann and Richter, 1975) and 38% for the FPI (Fahrenberg *et al.*, 1973).

RESULTS

Pretherapy Data Compared with Controls

Without entering into a detailed description of each scale, a comparison of the pretherapy data with the average scores of the same age group (Fahrenberg *et al.*, 1973) shows the characteristics listed below (see Tables III and IV).

1. Sexually dysfunctional patients and their partners differ from normal controls in the same directions as are typically found in psychosomatic and psychoneurotic patients. They lack self-confidence and self-assurance, and tend to think that they are unattractive. They are easily irritated and depressed (FPI 6, M; GT 4). They describe

Table III. Personality Characteristics of Couples (FPI) Before Treatment[a]

Freiburg Personality Inventory scale	Orgasmic dysfunction (N = 103) vs. control	Vaginismus (N = 27) vs. control	Erection dysfunction (N = 51) vs. control	Premature ejeculation (N = 29) vs. control	Orgasmic dysfunction vs. control	Vaginismus vs. control	Erection dysfunction vs. control	Premature ejaculation vs. control
1. Nervousness	–	–	(+)0.10	–	–	–	–	–
2. Aggressivity	–	(–)0.10	–	–	–	–	–	–
3. Depression	(+)0.10	–	–	–	–	–	–	–
4. Arousability	–	–	–	–	(–)0.10	–	–	–
5. Sociability	–	–	–	–	–	–	–	(+)0.05
6. Calmness, Relaxation	(–)0.001	(–)0.001	–	(–)0.10	(–)0.05	–	(–)0.05	–
7. Dominance	(–)0.01	(–)0.01	(–)0.01	(–)0.05	(–)0.001	(–)0.05	(–)0.01	(–)0.001
8. Social Inhibition	(+)0.05	(+)0.05	–	–	–	–	–	–
9. Openness	–	–	–	–	–	–	–	–
E. Extraversion	–	–	(–)0.10	–	–	–	–	–
N. Emotional Lability	(+)0.05	–	–	–	–	–	–	–
M. Masculinity	(–)0.05	(–)0.01	(–)0.01	(–)0.10	(–)0.001	(–)0.05	–	–

[a]Levels of significance for differences between the sample means and the control group (Freiburg Personality Inventory). For different age groups (15-30, 31-50) these are separate means and SDs for the normal control group (male 15-30 years, N = 112; males 31-50 years, N = 105; females 15-30 years, N = 109; females 31-50 years, N = 101). Our sample ranged from 18 to 52. As best estimation for the variance we took the variance of the population with the mean which demonstrated the smallest difference from our sample. Differences between the respective norm group and the sample mean were tested by t tests.

Table IV. Personality Characteristics of Couples (GI) Before Treatment[a]

Giessen Test scale	Patients: Orgasmic dysfunction ($N = 101$) vs. control	Patients: Vaginismus ($N = 25$) vs. control	Patients: Erection dysfunction ($N = 51$) vs. control	Patients: Premature ejaculation ($N = 29$) vs. control	Partners: Orgasmic dysfunction ($N = 101$) vs. control	Partners: Vaginismus ($N = 25$) vs. control	Partners: Erection dysfunction ($N = 51$) vs. control	Partners: Premature ejaculation ($N = 29$) vs. control
1. Social Resonance	(–)0.001	(–)0.001	(–)0.001	(–)0.01	(–)0.01	(–)0.05	(–)0.01	(–)0.05
2. Submissivity	(–)0.001	(–)0.05	–	(–)0.05	–	–	(–)0.05	(–)0.10
3. Control	–	(–)0.05	–	–	–	–	–	(–)0.10
4. Depression	(+)0.001	(+)0.001	(+)0.001	(+)0.01	(+)0.01	(+)0.05	(+)0.001	(+)0.001
5. Reservedness	(+)0.01	(+)0.05	–	–	–	(+)0.10	–	–
6. Intimidation	–	(+)0.10	–	–	–	–	–	–

[a]Levels of significance for differences between the sample means and the control group (Giessen test). Ages ranged from 18 to 34. T test were calculated to test significant differences between the sample and normal control means. In the normal population there are no separate means and SDs for groups of different age. Therefore, the variance of the complete control group was taken as best estimation for the variance of the population (males, $N = 107$; females, $N = 128$). The table presents the levels of significance for the minimal differences of means. +, Significantly higher mean than control; –, significantly lower mean than control.

themselves as obstinate and not cooperative (GT 2), and as reactive-aggressive (FPI 7).

2. The female patients in addition describe themselves as inhibited, shy, and timid (FPI 8). This corresponds to their tendency to turn in in on themselves, be distrustful, and hide their feelings (GT 5).
3. There are very few differences between patients and their partners. This seems to be an additional argument and empirical justification for a therapeutic approach which estimates the sexual dysfunction as a dysfunction of partnership. In this respect it is of no importance whether the neurotic tendencies of the partners have contributed to the sexual dysfunction or are an effect thereof.

One-Year Follow-up Compared with Pretherapy

Tables V and VI indicate the changes in personality scores at the time of the 1-year follow-up.

1. Women who were treated for orgasmic dysfunction or vaginismus view themselves as less nervous, have fewer psychosomatic complaints, are less depressive (FPI 1, 3), and are less irritable (GT 4). They view themselves as more relaxed and self-confident (FPI 6). Their attitudes toward sexuality are more permissive, realistic, and less sex-role stereotyped (SAS 1,2,3).
2. In males who were treated for erection disturbances or for premature ejaculation, we find changes similar to those among the females. The men view themselves as less depressive, less aggressive, and less inhibited (FPI 3,5,8). In addition, the men describe themselves as less sex-role stereotyped (FPI M, SAS 2). Generally the changes in males are less striking compared with those in females.
3. Tables V and VI indicate some of the data gathered on the female partners of males with erection disturbances or premature ejaculation and of the male partners of women with orgasmic dysfunction or vaginismus. Interestingly, the partners go through almost the same positive changes as the carriers of the symptom. The male partners of functionally disturbed women view themselves as less nervous, with fewer psychosomatic reactions, less depressed, less inhibited (FPI 1,3,8, E), less restrictive (SAS 1), less extraverted, and with better social resonance (GT 1).
4. Female partners of functionally disturbed males describe themselves subsequent to therapy as less nervous, having fewer psychosomatic reactions, less depression, less inhibited, and being more open and emotionally stable (FPI 1,3,8,9, N).

Table V. Changes in Personality Scores (Freiburg Personality Inventory) After Therapy[a]

Freiburg Personality Inventory scale	Patients		Partners	
	Female dysfunction ($N = 48$)	Male dysfunction ($N = 37$)	Female dysfunction ($N = 50$)	Male dysfunction ($N = 35$)
1. Nervousness	(−)0.05	n.s.	(−)0.05	(−)0.10
2. Aggressivity	n.s.	n.s.	n.s.	n.s.
3. Depression	(−)0.001	(−)0.05	(−)0.001	(−)0.01
4. Arousability	n.s.	n.s.	n.s.	n.s.
5. Sociability	n.s.	n.s.	(−)0.05	n.s.
6. Calmness, Relaxation	(+)0.05	(−)0.05	n.s.	n.s.
7. Dominance	n.s.	(−)0.05	n.s.	n.s.
8. Social Inhibition	(−)0.10	(−)0.10	(−)0.01	(−)0.05
9. Openness	n.s.	n.s.	n.s.	(+)0.10
E. Extraversion	n.s.	(−)0.10	(−)0.01	n.s.
N. Emotional Lability	(−)0.05	n.s.	n.s.	(−)0.05
M. Masculinity	n.s.	(−)0.05	n.s.	n.s.

[a] Significance relates to differences of means (t test) before therapy and at the time of 1-year follow-up. Mean at 1-year follow-up compared to pretherapy: +, significantly higher; −, significantly lower.

Table VI. *Changes in Personality Scores (Giessen Test, Sexual Attitude Scale) After Therapy*[a]

	Patients		Partners	
	Female dysfunction	Male dysfunction	Female dysfunction	Male dysfunction
Giessen Test	(N = 50)	(N = 40)	(N = 52)	(N = 36)
1. Social Resonance	n.s.	n.s.	(+)0.05	n.s.
2. Submissivity	n.s.	n.s.	n.s.	n.s.
3. Control	n.s.	n.s.	n.s.	n.s.
4. Depression	(–)0.01	n.s.	(–)0.10	(–)0.05
5. Reservedness	(–)0.01	n.s.	n.s.	n.s.
6. Intimidation	n.s.	n.s.	n.s.	n.s.
Sexual Attitude Scale	(N = 50)	(N = 38)	(N = 52)	(N = 35)
1. Restrictivity	(–)0.05	n.s.	(–)0.10	(–)0.01
2. Sex-role stereotype	(–)0.01	(–)0.10	n.s.	(–)0.05
3. Romanticism	(–)0.01	(–)0.01	n.s.	(–)0.01

[a]Significance relates to differences of means (t test) before therapy and at the time of 1-year follow-up. Mean at the time of 1-year follow-up compared to pretherapy: +, significantly higher; –, significantly lower.

5. These changes run parallel to a high symptom removal rate between 69% for orgasmic dysfunctions and 84% for premature ejaculation (Table I).

DISCUSSION

Summarizing, we found:

1. Symptom-specific therapy of sexual function disturbances runs parallel to statistically significant changes in positive self-perception. It is not clear whether these are unspecific effects of therapy or whether, as one would suspect, symptom removal caused the change in positive self-perception.
2. The most important changes involve a reduction of neuroticism. This can be observed among both male and female patients and their partners.
3. The carrier of the symptom tends to profit more from therapy and goes through greater changes. The changes in the partner are, however, unexpectedly apparent and go in the same direction.
4. In addition to the reduction of neuroticism observed among both female and male patients, there are differing tendencies between the sexes: female patients reveal increasingly permissive, egalitarian, and realistic attitudes toward sexuality; male patients change in the direction of less reactive-aggressive, masculine-stereotyped behavior and less extraversion.
5. The partners of female patients change their sexual attitudes the least.
6. The reduction of neuroticism in men suffering from sexual dysfunctions in connection with the reduction of extraversion would tend to indicate a reduction of "hysterical" tendencies. The decrease of their sex-role stereotyped attitude would appear as if they could more easily relinquish their "chauvinist" position after regaining or gaining their sexual function.

The data give empirical evidence for a general change in nonsexual areas of self-perception that runs parallel to symptom removal. Even if we have no untreated control group retested to ensure that all changes are beyond the retest effect which tends toward average, the magnitude of the changes makes a pure statistical artifact unlikely. For the treatment of sexual dysfunctions our results show that the general emotional lability connected with the sexual symptom can be reduced during therapy. More generally, we think that further research should continue focusing clinically and theoretically on the relation between sexual and nonsexual areas.

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