An investigation of aetiological factors in sexual dysfunction

Anne H. Pattie

AN INVESTIGATION OF AETIOLOGICAL FACTORS IN SEXUAL DYSFUNCTION

This study is an attempt to explore objectively factors of possible aetiological significance in the development of psychosexual dysfunction. A group of forty patients at a clinic for psychosexual disorders is compared with a control group who have not experienced sexual difficulties by means of a structured interview, a test of family relationships, a personality test, a repertory grid and a problem check list. The inclusion and content of these techniques is based on evidence from the literature which is reviewed in relation to psychosexual development and psychosexual disorders.

The findings confirm the importance of family relationships, particularly the relationship with the father for both men and women but particularly the women. Sibling rivalry, separation or loss and parental attitudes appear to be less important but the incidence of sexual trauma and menstrual disorders was higher for the patient group of women. The importance of the early sexual learning situation is also suggested with introversion in the patient group of men possibly contributing to some difficulties in this area. Personality factors appear to be of some significance for both sexes and there is marked evidence from the grid technique and problem check list of a general dissatisfaction with most areas of their lives including themselves among the women who form the patient group.

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A N N E H P A T T I E

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II INTRODUCTION

Attitudes to human sexuality have changed considerably during this century and particularly during the last decade. The hostility which met Freud's attempt to explain infantile sexuality has been replaced by a greater tolerance and awareness of sexual needs and problems, and in fact by a general acceptance of his views. Much is owed to Kinsey (1948, 1953) for his objective study of sexuality, showing that direct questioning reveals much knowledge, suggesting the forces of repression and suppression may not be as operative as formerly believed. Others who have contributed to this field are, of course, Masters and Johnson (1970) who have studied and treated many cases of sexual dysfunction. Thorne (1966) who has developed a Sex Inventory to study sexuality in the normal and the deviant and Storr whose book on sexual deviation contains an excellent account of sexual guilt and inferiority as contributory factors to sexual deviation.

Kinsey's (1948 and 1953) studies have been concerned with aspects of normal sexuality rather than abnormal or from the clinical point of view. Masters and Johnson (1970) are more concerned with treatment than causality and Storr (1964) with deviation rather than disorder or maladjustment. All are agreed that much research is needed in the whole area of sexuality. A review of the literature suggests that much of the published work has been concerned with treatment rather than cause, and where causality is studied it seems to be more in relation to homosexuality and to a lesser degree lesbianism rather than any other disorders. Little objective research seems to have been carried out to verify or contradict the widely held assumptions that the pattern of early child/parent relationships affect the adequacy of sexual adjustment.

This study will make an attempt to do this by exploring the family relationships, sexual attitudes and personality characteristics of a group of people referred to a clinic for psychosexual disorders and who could therefore be considered to be sexually dysfunctioning. These will be compared with a group who have not experienced such problems. Although the intention of the clinic staff is to assess all those referred and offer treatment where necessary, this study will deal only with the assessment of the patients and therefore possible causative factors rather than treatment. Much of the work carried out in assessments proved useful in providing guidelines for the type of therapy required as well as

prognostic indications. This is considered to be outside the scope of the present study. The present project will be confined to the sexually maladjusted rather than those generally considered sexually deviant and will therefore not include male or female homosexuality.

III A REVIEW OF THE LITERATURE

(1) PSYCHOSEXUAL DEVELOPMENT

Dr Alex Comfort (1963) commented that in the area of human sexuality "poppycock flourishes in the absence of facts" and that "there is much sheer moonshine in the medical textbooks". In recent years however some of the shame and guilt which society undoubtedly attributed to sexuality has been replaced by serious study and knowledge about sexual adjustment and responsivity. There would appear to be several landmarks in the advance of our knowledge about human sexual functioning, associated particularly with Freud, Kinsey and Masters and Johnson.

Prior to Freud sexuality was not considered to exist until adolescence. Freud felt however that the infant and child behaved in ways which were intrinsically sexual. He postulated the three well-known phases of psychosexual development; oral, anal and genital. He suggested that personality disturbance and neurotic illness stemmed from problems or conflicts experienced during these stages. The oral stage which lasted from birth to 18 months was characterised by pleasure being obtained from sucking and biting. If these needs were not met or conflict experienced the individual resorts to repression and sublimation and this may result in later years in dependency, generosity or depression. Sexually deprivations and frustrations might be reflected in deviant oral practices. The second stage; the anal phase in the developmental sequence, lasts from the age of about 18 months to 4 years. Pleasures and frustrations are centred on elimination and excretion and the areas concerned with these functions are seen as foci of interest and sexual curiosity. It was thought that problems experienced at this stage could result in obsessive, compulsive and controlling tendencies and even in adult anal eroticism, thus linking it with aspects of homosexuality. At about the age of 4, the child moves on to the phallic stage of development; eroticism shifts to the genitals. He/she is thought to experience sexual feelings and attraction to the opposite sex parent. In the classic Oedipus situation the boy child desires a sexual attachment to his mother, fears the wrath and retaliation of his father and hence fears castration. Resolution of this conflict depends on repression of these wishes and adequate identification rather than competition with the father.

Similarly the girl child may experience feelings of attraction to the

father and hence fear the hostility of the mother. She also has to cope with alleged feelings of inadequacy as she discovers anatomical differences between herself and little boys and/or father. She experiences penis envy, perhaps even believing she had one and lost it. As children develop through this phase they begin to accept the reality of the situation, the boy abandons competing with father and identifies with him, allowing himself to see the mother again as a loved and cherished person - girls realising they cannot gratify the desire for father turn back to mother, incorporating her in their own self-concept. During the next few years Freud sees the sexual instincts entering a latency period at which time other aspects of personality development are happening and later, a re-awakening of sexual interest at adolescence.

Critics of Freud say he based too much of his theorising on the patients he saw in his clinics, which may not be appropriate to other cultures and times. Kaplan (1975) points out that Freud did not observe children; he assumed what they experienced through the hindsight of adults. She feels that sexual pleasure seen in children is basically genital from early on in life, and there is no evidence of this shift in sexual or erotic pleasure through oral and anal phases though pleasure and interest is undoubtedly experienced in these areas. Schachtel (1959) pointed out that observation of sexual behaviour in children was the result of adults interpreting their behaviour in terms of adult sexual behaviour and did not necessarily reflect the motivation or experience of the child. A child touching his genitals may not necessarily be experiencing sexual pleasure in the same way as an adult and they are not really able enough, intellectually, to give any information about what they do experience. Freud is also criticised for having a 'masculine' view of sexuality because of his view of the supremacy of the penis and the consequent inferred inferiority of the penis-less feminine sex.

Despite the many and varied criticisms of what is generally seen now as over-emphasis on the explicitly sexual nature of the infant and child it is also generally recognised that knowledge advanced considerably from Freud's thinking. He managed to combine biology, socialisation and family dynamics into an integrated whole which provided insights which changed the direction of our thinking and led to a much wider more dynamic study of psychosexual development.

Although Freud's suggestion that children could and did experience erotic feelings and fantasy caused a considerable uproar at the time it is now accepted that sexuality begins early in life and attitudes to behaviour which is seen as related to sexuality such as touching the genital areas or asking questions about sex are of prime importance in shaping the child's developing personality. An integral aspect of this personality are his attitudes to himself in his gender role and to his sexuality.

These attitudes are influenced not only by parental responses but by society's attitudes. Cauthery and Cole (1971) say that "the child's ability to love, its confidence in itself as a member of its own sex, its possible fears of sex and the opposite sex, and its ability to adapt happily to the role appropriate to its own sex in adult life can be and are affected by childhood environment". Much of the recent work in the field of sexuality focuses on sexual or gender identity with reference particularly to biological and environmental aspects of homosexuality and it is refreshing to see the concept of 'confidence in itself as a member of its own sex' seen as an integral part of many aspects of sexual adjustment.

Kaplan (1975) outlines sexual behaviour in developmental terms. The young boy child has erections from birth onwards - handling the genitals or infantile masturbation is seen as a normal part of development. Girls also show sexual pleasure and enjoy sex play from an early age. Whereas the psycho-analysts saw the repression of oedipal desires leading to the latency period Kaplan and others feel that it is the social pressures and prohibitions which produce an apparent loss of interest in sexual behaviour during the middle years of childhood. At times it seems that society has equated sex and sin; parents tend to condemn sexual activity both in infancy and childhood. Parents are usually ashamed and secretive about their own masturbation and become anxious when they see it occur in their children. Cauthery thinks this may happen more with girls because masturbation is seen as more common and acceptable in boys. Whether unconsciously or openly, pleasantly or with hostility parents are quick to inhibit any display of sexual behaviour in their children. This inevitably leads to anxiety and guilt on the part of the children and obviously to the attitudes that sexual activity is wrong or bad. If sexual interest is seen as

incompatible with the love of parents the individual may not be able later in life to incorporate sexual and love relationships.

Storr (1964) points out that even if adults do not deal punitively with sexual activity they never positively reinforce it. This in itself may make the child see it as bad and guilt-invoking. Attitudes to toilet training may generalise feelings of avoidance for sexual contact because of the physiological nearness of the genitals. No matter how enlightened the parents, sexuality cannot be openly satisfied within the family and Storr feels some guilt is inevitable. The young child is loved for his whole self as is the adolescent or adult in a heterosexual relationship - it is in the years of middle childhood that he is loved minus his sexuality.

Kaplan suggests that although sexual interest and sex play in boys and girls differs it is at adolescence that the gender differences in psychosexual development appear most. Physical changes occur in both but the boy with his very high androgen level is at the peak of sexual activity at the age of 17-20. His orgasmic experience is usually at its highest and occurs in masturbation, nocturnal emissions or sexual intercourse. Girls on the other hand although sexually mature are less concerned with orgasmic experience, may not masturbate and appear more interested in falling in love and attracting boys than in sex per se. Although frequency of intercourse may reach a peak in the 20's women appear to show greater responsiveness in their 30's. This may be due to a variety of factors, greater security in the sexual relationship and hence a decrease in inhibition; being less tied up and tired that when very occupied with young children; or to change in social attitudes. These have changed rapidly in the last few decades allowing women greater freedom to respond. Another likely explanation is that the young man's sexuality is less demanding - in his 30's he becomes more romantic and concerned with love play. This may allow the wife more opportunity to respond and become orgasmic.

With increasing age the man's sexual desires wane more than the wife's. Despite more marked physical ageing in the woman's sexual physiology the sexual urge may remain strong within the woman and many women masturbate more as they grow older than in their teens. This may be due partly to social pressures on women which prevent their seeking out new partners for sexual activity as they

grow older and are still single, widowed or separated. Kaplan (1975) suggests that psychic aspects of sexuality increase as women grow older and that learning is an important determinant of female sexuality - sex may become more satisfactory in middle age if responding has been regularly reinforced by pleasurable experience.

Sex for the older couple may continue to be satisfactory if they both adjust to the change in pattern of sexual response. The man takes longer to achieve an erection for what appear to be physiological reasons and if the wife understands this and the couple cope within a loving relationship positive sexual experience is likely to occur. Decreasing interest and even impotence need not reflect the physical effects of age so much as the anxiety and hurt associated with the inability to perform as well as previously.

Just as guilt and anxiety become negative contingencies of much early sexual expression they may continue to pose problems for adequate sexual adjustment in adulthood. If the stress of early experiences and attitudes to sexuality are severe the individual may not be able to function sexually as an adult. Fortunately most people appear able to integrate mild trauma and parental or social repression and develop adequately as sexually functioning adults. In some cases the individual may not be aware of the pressures which have produced the conflict and Freud's recognition of unconscious motivation enabled people to understand more of what might be interfering with sexual adjustment.

Recent work on sex and identity has extended Freud's concept of identification with the parents in terms of further study of the individual's need and ability to identify with the masculine or feminine gender role. This has been particularly relevant to homosexuality and disorders such as transexualism and transvestism but adequate identification with one's own sex is obviously necessary for subsequent mature sexual adjustment. Rosenburg and Sutton-Smith (1972) have queried whether it is possible to prepare for adult sexual roles while they appear to be changing so rapidly but there is still considerable confusion over the different contributions from biology and learning in determining sexual identity. Hampson and Hampson (1961) feel that the biological aspects are undifferentiated and that experience and social learning shapes the behaviour patterns. Diamond (1965) argues for the interaction of learning and genetics

however saying 'sexual predisposition is only a potentiality setting limits to a pattern that is generally modifiable by ontegenetic experiences'. The general conclusions on this topic seem to agree with this view to a greater or lesser extent with most feeling that the biological or sexual aspects are not entirely neutral. If learning experiences shape sexual identity or psychological sex then clearly they influence sexual identity in the normal as well as the abnormal and will be reflected not only in one's self-image but in one's acceptance of the self, particularly the physical self.

The second landmark in our understanding of human sexuality came with Kinsey (1948 and 1953). The main change in approach at this stage was that normal sexuality was investigated and that this was done by direct questioning about sexual behaviour and attitudes. The goal of the Kinsey reports was to increase knowledge and factual information. This increased understanding and in many cases provided reassurance. Information about masturbatory activity, orgasmic experience etc showed that much previous knowledge had been based on insufficient investigations. Understanding the slower responsivity in women, the lack of need for simultaneous orgasm etc, made it possible to identify sources of sexual anxiety. Kinsey investigated sources of sex education, class differences etc and brought a new direct approach to the whole area. It may be that some of his data is out of date but his contribution in terms of changed approach and factual data has been immensely valuable in clearing a way for new sources of knowledge. Brecher (1970) thinks that the Kinsey reports are still the fullest and most reliable sampling of human sexual behaviour. Generally speaking any further studies have confined his findings. These studies were of course American but British counterparts have followed.

Schofield (1965) investigated the sexual behaviour of young people in Great Britain. He used the Kinsey approach of direct questioning about sexual behaviour. He said he found it impossible to say if attitudes and behaviour were changing because there was no reliable data for other generations. He quotes Carstairs in the 1962 Reith lectures saying 'If we turn to consider young people's sexual behaviour today we encounter many vehement opinions but little reliable data'. Schofield used sampling techniques and standardised interviews to seek information on dating and leisure activities as well as frequency of genital stimulation, intercourse etc. 1873 interviews were carried

out, making the survey one of the most thorough studies into sexual behaviour ever done in Great Britain. One of the main areas of this research was sex education. Like Kinsey he related the results to social class and other differences. He found for example that 84% of girls as opposed to 45% of boys received some sex education in school and that the working class boys were least likely to have had sex education either at home or at school. He found no relationship however between sex education and the amount of sexual experience which they had had. 67% of the boys and 29% of the girls said they had never had advice from parents. Again there seemed to be no close relationship to sexual activity in the teens. He found some evidence to suggest that extraversion may be associated with early sex experience in boys and that the quality of parent-child relationship may be related to the level of sexual behaviour in adolescents.

Schofield (1973) followed up a large proportion of his sample about seven years after the first investigation. Some of the areas which he investigated were directly comparable to his first study and to the present research project. He found that total sexual outlet was similar for both sexes; the boys on the whole starting earlier but often less frequently than the girls. His second survey showed attitudes to pre-marital sex had changed considerably. 71% of the group had had intercourse prior to their marriage; 80% of men and 61% of women, making, says Schofield pre-marital intercourse the normal pattern. 40% of them however either had no experience or with one partner only, the one they subsequently married. Pre-marital interccurse seemed to be linked to higher classes and higher paid groups and was less likely to occur among churchgoers.

Less than half of the group found their first experience pleasurable. This did not seem to put them off further attempts however. At the time of the second survey the vast majority were fairly content with at least the frequency of their sexual contact though about 20% felt they were not getting enough and a very small minority too much. When offered a list of frequently experienced problems 57% said they had had at least one of them. 18% said they experienced anxiety about their sexual activities and 16% of the men and 9% of women also reported some guilt. Most of these did not seem to be extreme problems and Schofield concluded that waning interest was most likely to worry the married and feelings of guilt the unmarried. 24% of the group had a problem they had not discussed with anyone; 33% had disoussed their difficulties and most found

this helpful though there was some evidence to suggest they got more help from friends and relatives than from professionals such as doctors and clergymen. It is interesting to note that among the total possible marital problems 19% mentioned financial anxiety, 10% housing, 8% relationship problems and only 6% specifically sexual anxieties. In most cases the sexual problem occurred early in the marriage and was often associated with lack of satisfaction or contraception. The inexperienced seemed slightly more likely to have sexual problems and although inconclusive Schofield feels the figures suggest there is no foundation for the theory that abstinence from sexual relationships prior to marriage contributes to later sexual adjustment.

In addition to ongoing research in recent years on factual data such as Schofield's follow-up study the greatest innovation in our knowledge of sexual matters has been through the work of Masters & Johnson followed by a great awakening of interest in sexual problems because of the new therapies developing from their studies. In 1966 Masters & Johnson published their book, 'Human Sexual Response'. This was an account of their work in trying to understand the physiology of the sexual response as it was felt that lack of knowledge limited the amount of successful treatment which could be offered to people with sexual problems. They therefore studied in considerable detail by observation of ongoing sexual behaviour in the laboratory, the physiological responses of about 600 men and women with a wide age range during a series of sexual responses.

Masters & Johnson divided the sexual response of men and women into four stages - excitement, plateau, orgasm and resolution. They were able to give an account of physiological changes occurring during these successive stages, and suggested the response for both sexes was biphasic which basically divided the responses into arousal and orgasmic experiences. This has physiological corollaries in the nervous system and has implications for treatment. While the physiological aspects of sexual response as such are outside the scope of the present study the importance of the work done by Masters & Johnson must be acknowledged - as intended, their work did lead on to a great increase in understanding of the normal response and hence, in the treatment situation, of psychosexual disorders. It is felt that the physiological component is more important in the male, particularly when he is young, and the psychic or cultural

components more relevant to the female (Kaplan 1974). Masters & Johnson's second book in 1970 gave an account of sexual inadequacy which will be considered in the next section.

Others have contributed to our understanding of normal sexual functioning, particularly in the female. Fisher & Osofsky (1967) asked 42 women seen on five separate occasions to rate their sexual responsiveness, orgasm consistency and intercourse frequency and concluded that as these variables were only moderately correlated one could not regard sexual responsiveness as a simple undimensional variable. They investigated by several measures the relationship between sexual responsiveness and variables such as early dating behaviour, hostility, personality and value judgements. They found that early adult but not adolescent dating behaviour was related to subsequent sexual responsiveness and their most prominent finding they felt was "the possibility that the ability to obtain sexual gratification is but a single aspect of a more manifold capacity to feel positively toward objects and persons and to secure body satisfaction from them". This finding was based on the link between sexual satisfaction and pleasure from other physical activities and interest in food and oral satisfaction. Personality variables did not appear to be particularly relevant.

In his book 'Understanding the female orgasm', Fisher (1973) undertook a study of the responses of nearly 300 women to questions about sexuality, personality and history of childhood experience and relationships. In this investigation attention focussed on orgasmic experience with most of the results being related to subjects with high and low orgasmic experience. The findings of this larger survey supported those of his earlier paper that sexual responsiveness and orgasm capacity cannot be equated and that therefore orgasmic outlet is not necessarily related to the enjoyment of, or frequency of, intercourse. Fisher admits that, although sexual satisfaction and orgasm are not synonymous, orgasmic experience must be considered to be a central point of discussion on sexuality. His findings are therefore relevant to the present investigation, though this study is concerned with people complaining of sexual dissatisfaction which may or may not include complaints about orgasmic experience - in fact there were more frequently related to difficulty in obtaining arousal.

Again the main theme of Fisher's book is of a lack of scientific evidence for many of the accepted theories and reputed 'facts'. Briefly they found no

evidence of an association between femininity, early dating (though they did not include pre-marital intercourse), menstrual disorders or any relationship to mental health, in terms of anxiety, emotional expressiveness or hostility. Attitudes to sexual freedom sex education and early parental attitudes also seemed to be unrelated to frequency of orgasm. Despite his distinction between orgasmic consistency and sexual satisfaction Fisher tends periodically to equate them e.g. he says that the finding of no relationship between orgasmic consistency and parental attitudes dims the importance of parental repressions to sexual dysfunction to their children. Despite this slight confusion many of Fisher's points are of interest and relevance to this paper. He found the low orgasmic woman to show more concern with the loss of love, though not necessarily associated with actual loss or separation, and that the relationship with the father was particularly important. Endurance or persistence seem to be associated with high orgasm and insecurity with low orgasm frequency. The insecurity about loss is not seen in greater dependence or independence, greater friendliness or greater anxiety - Fisher sees it as independent in its personality adjustment. Surprisingly greater anxiety was seen in the group of women who preferred vaginal to clitoral stimulation, which seems in some way to be the opposite result of what one might expect in relation to vaginal satisfaction often being associated, apparently erroneously, with increased maturity and psychological well-being.

Orgasm consistency was unrelated to frequency of intercourse, which can be taken as at least a measure of satisfaction in the sexual situation particularly since few women admitted to having intercourse for reasons other than pleasure. Frequency was related to pleasure from enhancing the appearance, grooming and experience of pleasure and satisfaction with social situation and life generally. When asked what contributed to their sexual responsiveness many aspects had to do with perceiving the world positively and pleasurably. Parental attitudes and critical or traumatic experiences did not appear to be related to this measure i.e. frequency of intercourse. There was no correlation between menstrual problems and sexuality for this sample though Fisher admits this does not preclude a relationship where there are special sexual or personality attributes. Fisher also concludes that women do not feel less secure sexually or have feelings of

physiological inferiority. His main conclusions seem to be that the early sexual learning situation is not necessarily related to orgasmic consistency but the relationship with the father is possibly more important than ever suspected. It is interesting that Fisher makes no reference to his previous findings in conjunction with Osofsky and in this survey does not find the same relationship between eating and other bodily satisfactions and sexual satisfaction.

There has not been as much emphasis in the literature on male responsiveness. Since male orgasm is virtually always associated with sexual arousal and erection, studies on male sexual inadequacy have tended to centre on impotence which is equivalent to frigidity rather than orgasmic dysfunction. Emphasis has been placed too on heterosexuality v homosexuality in the male rather than on quality of response.

Before leaving the question of psychosexual development and hence sexual adjustment it is essential to look at least briefly at some of the work which has been carried out in the field of marital relationships. Cauthery and Cole (1971) emphasise the importance of good sexual adjustment particularly within the marital relationship because of the need for people to be "happy beings producing an environment within which our young can flourish physically and mentally". They see sex as a "form of deep interpersonal communication" and problems arising within the sexual relationship having far reaching effects in society in terms of divorce, offences, V.D. and unwanted pregnancies. There is the possibly less directly causal relationship with a great deal of mental ill-health. Dicks (1967) queried whether divorce was in fact a substitute mental illness and emphasised the 'virtual social epidemic' of divorce noted by the Royal Commission in 1956, an incidence which has undoubtedly increased since. While it must be recognised that divorce and marital difficulty cannot be equated with sexual maladjustment there is undoubted overlap in terms of cause and effect.

Wallis (1970) feels that cases can sometimes be a variable of the searcher - he or she may find what is being looked for but he feels that if a client describes a problem then basically a problem exists for him or her. He thinks that people have so many defences about sexual matters that their denial of having such a problem where one thinks it exists may just as easily mean they are unwilling to discuss it. Both Wallis and Dicks think that it is rare for sexual dysharmony

to exist in an otherwise stabel relationship but the former agrees 'the sexual aspect of marriage is often the most sensitive area in which emotional changes show themselves inadvertently since it is so emotionally rich and complex'. It is not distinct from every other factor of the marriage - 'it mirrors the way the partners feel toward each other'. He emphasises therefore the emotional aspects of marriage and feels that sex can be over-emphasised - a wife may resent the husband's need for achievement in pleasing her or getting the 'correct' responses. Sex can be an end in itself to men within the marriage, whereas women see it as one aspect of being valued, wanted and admired. Wallis feels that people must trust their own sexuality to be without fear or distrust of the sexuality of their partner. Similarly a couple must have the confidence obtained by feeling acceptable to each other. Couples who accept their own bodies and bodily functions seem to be able to have the ability to see themselves as acceptable and lovable to their partner.

Dicks and other writers, comment as Masters and Johnson do later that the relationship between a couple is a dyadic relationship having its own crucial identity and being more than 'the sum of two parts'. The Tavistock clinic research showed that despite enormous individual variation all people have a concept of their ideal in pre-marital and marital behaviour but that sex does not appear to rank particularly highly within this ideal. Dicks too says that sex can be over-rated within the marriage - in some cases couples have been able to cope successfully in other areas without a sexual relationship. Parson and Bales (1955) felt that the role of the man is power and instrumentality whereas the wife's role is power and expressiveness. The stronger force of the husband means the wife can surrender some of her own instrumentality; a suggestion which probably fits in with the finding of Cattell et al (1968) that too much dominance in both partners may lead to instability in a marriage. Successful marriage seems to be associated with a sharing of power rather than a power struggle, which may or may not involve sexual behaviour. Hence it seems that sex within a marriage is one particular and obviously important aspect of the relationship but there is some doubt as to whether problems in the sexual relationship are always a reflection of problems in the relationship generally. The different findings by authors such as Schofield, Masters and Johnson and Dicks suggests that

perhaps again this is a variable of the researcher - the difficulties which they recognise as sexual problems varying among them.

In conclusion, the early work of Freud emphasising developmental aspects of sexuality has been followed by others who have outlined the development of sexual behaviour and identity in behavioural and factual terms, all leading to study of attitudes to sexuality within the child, adolescent and adult in his family and in society. Other studies have concentrated on more objective and survey data adding a complementary dimension to the previous work. Recent years have seen the detailed study of the neurophysiological aspects of human sexuality which have led to greater understanding and application of therapeutic techniques for intervention when some problem during psychosexual development or adjustment leads to an individual experiencing a psychosexual disorder.

(2) PSYCHOSEXUAL DISORDERS

Although some people seek help for psychosexual problems it is thought that the vast majority do not. The demand for pornography, sex aids and literature on sexual matters suggests an enormous unadmitted need. Despite this, medical education has not until recently given sexual adjustment much importance - psychiatric and gynaecological textbooks did not give much emphasis if any to the significance of psychological factors in sexual adjustment in the normal person.

In his book on Sexual Deviation (1964) Storr points out that it is difficult to say what is normal and what is deviant because of differences in acceptance of different behaviours in different times and in different cultures. He suggests that there is general unanimity on the concept of maturity, though it can scarcely be easily defined and is rarely if ever achieved. He says that 'in the sexual sphere, maturity may be defined as the ability to form a stable relationship with the opposite sex which is both physically and emotionally satisfying, and in which sexual intercourse forms the main, though not the only, mode of expression of love'. It will be clear that although his book is concerned with sexual deviation this definition of sexual maturity, if it can be so called, is of relevance to the sexual disorders in the present study. Indeed it could be postulated that sexual maladjustment is a lesser form of sexual deviation in that the individual has not managed to achieve sexual maturity but is still attempting to do so rather than resorting to deviant methods of obtaining sexual satisfaction. Storr sees the latter as forms of immaturity and the persistence of childhood feelings of guilt and inferiority. It seems therefore that some of what he says about the origins of sexual deviation will apply also to the lesser disorders.

Storr feels that if the child is not loved and accepted by his parents he will not learn to be loved and to love and hence will not be able to achieve 'happy love relationships'. The importance of childhood relationships appears repeatedly in the literature. In most cases this is tied to the relationships and attitudes over sexual matters as was outlined in the last section. If guilt and shame are attached to sexuality then feelings of inferiority often follow. These feelings are likely to inhibit the development of healthy sexual attitudes

and may prevent the individual falling in love and making happy mature sexual relationships. A child who is unloved may feel unlovable and hence have no self-confidence in his sexual role. It has been said that self-confidence is more necessary for men because of the need for the man to adopt an active role by maintaining an erection and because women can produce children as evidence of success as a female which has no real equivalent for the male.

A review of the literature shows that psychological conflict as an aetiological factor has had most attention in the past. It is probably true to say that male homosexuality and orgasmic dysfunction have been the two topics in human sexuality attracting most scientific attention, followed by impotence in the male. It will be necessary in this section to review what is known in general and specific terms of these psychological conflicts and other causes of sexual maladjustment and of course to discuss the disorders themselves.

The influence of family and social and cultural factors on the individuals psychosexual development have been discussed in the previous section. Further evidence of the importance of warmth in childhood handling is available from animal psychology e.g. Harlow (1963) in his work with monkeys demonstrated that without physical contact and peer contact at critical times the monkeys were often unable to function sexually as adults. In the clinical setting the evidence of faulty relationships in childhood contributing to marital and sexual problems abounds but Dicks (1967) suggests that this is not so well validated as the increased likelihood of positive adjustment where childhood relationships have been good, i.e. it is not necessarily true that bad parental and family relationships invariably lead to marital (sexual) dysfunction. Much of our knowledge in this area remains at a clinical or subjective level based on the knowledge of experienced workers in the field of treatment but not necessarily validated against other groups and often not based on factual objectively obtained data.

Such studies have tended to be focussed on parental relationships in homosexuality; there are considerably fewer validated studies on the aetiological factors in psychosexual disorders. The work of Eva Bene (1965) actually promoted some of the ideas for the present project and although it is a study into homosexuality it is so similar in design and concept to part of this study that it seems worth reviewing.

Bene investigated the recollected childhood relations of homosexual and married men using the Bene-Anthony Family Relations test (which is used in the present study and described in Section IV) and a short questionnaire. This study which she describes as 'an attempt at clarifying the role of the parents' was based on 83 self-confessed homosexuals, who were not psychiatric patients and 84 married men, and was followed by a study of 37 lesbians compared with 80 married women. Bene comments that most of the literature on female homosexuality particularly is based on work carried out with emotionally disturbed patients, but her studies avoid this possible additional distortion of psychiatric illness. She excluded 15 of her initial 52 lesbian women because they were illegitimate or came from broken homes - this proportion would seem in itself to have aetiological significance.

Bene's finding were that homosexual men had poor relationships with their fathers. There was no support for the frequently mentioned view that homosexual men had more over-indulgent and over-protective mothers or for the dominance of the mother in role-identification. Homosexual women similarly had poor relationships with fathers, and saw them more frequently as weak and ineffectual as parents. Bene feels that the relationships with the mothers, usually found most relevant in psycho-analytical studies, may be of more importance with psychiatric patients than the otherwise normal homosexuals for whom the most striking finding was the importance of the often neglected relationship between father and child for both sexes.

Other work has stressed the cognitive aspects of acquiring sexual identity - Poole (1972) investigating the aetiology of lesbianism, hypothesised that the lesbian had been orientated by her socialising or learning experience away from heterosexual role performance. Using a questionnaire to ascertain socialisation experience he found that a lesbian group of women had significantly fewer childhood experiences which could channel their erotic potential towards the heterosexual role. They tended to have females as a source of emotional and/or sexual satisfaction. He found that the parents of the lesbian group lacked affection and understanding, disapproved of the subject of sex and the mothers were unhappy with the maternal role. This was in contrast to the sexually adjusted 'who had a positive childhood exposure to female heterosexual role learning games, an

influential mother happy in her role and both parents manifesting affectionate understanding while being without disapproval of sex'. It is this last positive finding, supported, Poole says, by a large number of interviews during his project, which is of possible relevance and significance to the present study. Although the role learning games are not considered here, the relationships of parents and attitudes to sex will be investigated for those with sexual problems.

Rabach and Supara (1961) also laid stress on the importance of an emotionally stable family background on a comparative study of 600 patients with sexual disorders and 600 complaining of sterility. 22% of the former group considered their parents marriage 'disharmonic' compared with 9% of the others. They had also experienced more frequent loss of parents through separation and divorce. They also found position in family relevant, the only and eldest children in the family being more likely to have sexual disorders. This large scale survey does not seem to have been replicated elsewhere.

Dicks (1967) said his pilot study on marital tension found grossly disturbed or unhappy family background very frequent. He feels that the importance of happy parental family background for marital success is much better validated than the contrary, i.e. that family unhappiness necessarily leads to marital problems. Michel-Wolfromm (1953) found some of her vaginismus patients were 'infantile', i.e. not detached enough from their families whereas others tended to be aggressive and independent. Litman and Swearingen (1972) in a study on bondage and suicide found more disturbance in family core relationships, though no constant pattern of family interaction was found.

Masters and Johnson (1972) found some relationship between vaginismus and the inhibiting effects of a severe early upbringing particularly associated with religious views. They found, however, other points also of relevance, e.g. sexual dysfunction in the male partners of these women, early trauma and early homosexual leanings prior to attempts at heterosexual contacts. They also suggest that maternal dominance is frequently found in cases of impotence - the young male growing up with no strong figure to identify with and hence little confidence in his masculine role. In some cases the parental roles have been reversed and the fathers too dominant for the child's healthy independence to develop. It seems that both types of cases reflect an imbalance in the parental relationship which

may lead to psychosexual disorders. Again however it must be pointed out that despite the apparent significance of this frequently found conflict or maladjustment in the parental relationship the lack of a similar review of cases without sexual disorders makes it difficult to assess the significance of these factors. Sex education and trauma are mentioned also by Masters and Johnson but other studies e.g. Schofield's suggest this may not be as important as one expects. As in the days of Freud, extrapolation from clinical data is still liable to distort the significance of certain factors. Despite these reservations it is obvious that the social and emotional background of the child and adolescent contributes considerably to the sexual attitudes of the young adult and hence family background emerges from the literature as of prime importance.

Masters and Johnson said that they considered that 'sociocultural deprivation and ignorance of sexual physiology contributed more to the likelihood of sexual dysfunction than did psychological or medical illness' but others such as Belliveau and Richter (1970) feel the public and helping professions still view seriously psychological factors, and tend to treat these with psychotherapy and psychoanalysis. This view may already be out of date as a result of the success of behavioural treatments.

Kaplan (1975) thinks that biological factors may be important in as many as 10% of cases which came to the attention of the medical profession. She suggests this may be an over-estimate of overall incidence because a higher proportion of non-organic cases may not seek professional help. Conditions such as early diabetes, multiple sclerosis, abuse of alcohol or drugs, neurological and psychiatric disorders may all contribute to sexual difficulties. Particularly in the case of impotence it is felt that possible organic factors should be excluded before attempting psychological treatment in all cases where there does not seem to be a situational cause. They are perhaps less likely in women's disorders though muscle tone may be impaired in cases of orgasmic dysfunction and fluctuating hormonal states during the menstrual cycle, and loss of libido associated with the use of the contraceptive pill may be relevant to a variety of disorders. Where an organic cause can be found and alleviated then the associated psychological problem should improve - when this does not happen it is usually because of secondary anxiety i.e. reactive performance anxiety has resulted.

Physical and psychological factors are so interrelated in sexual functioning that secondary anxiety is a frequent cause of continuing difficulty.

Performance anxiety is prevalent in two of the other main determinants of sexual disorder - the dyadic and learned causes. It was discussed in the section on marital relationships that the relationship was unique to the two individuals involved and so problems can arise within a marriage which are uniquely the result of that relationship. Unrealistic expectations of each other, naivety, technique problems, power struggles or conflict arising from child/parent relationships may affect the interaction of the couple both psychologically and sexually. It seems likely that communication difficulties contribute to and perpetuate problems which may arise. In working through or ignoring problems a couple may be creating tension for themselves and each other. They can lower the self-esteem of the partner by criticism of their performance or bodies; they may act or dress unattractively in an attempt to repulse the partner's attentions.

All difficulties and causes will be aggravated by learning or experiential factors in the specifically sexual situation. Early traumatic experiences or first experiences may create anxiety or guilt which affects subsequent relationships. A negative experience will produce a cycle of escalating anxiety, fear of failure, actual failure and despair. Couples who communicate easily may overcome early problems but some will start to avoid sexual situations and what could have been a temporary set-back becomes a chronic sexual dysfunction.

As has already been stated the possibility of underlying homosexual orientation interfering with heterosexual adjustment has been noted clinically. Masters and Johnson feel that sexual adjustment need not be a problem to those who commit themselves to heterosexual or homosexual patterns of behaviour but the people who switch from one to the other or who try to commit themselves despite feelings of insecurity in the role are liable to become sexually dysfunctioning. In fact many cases are seen where marriage has been seen as a solution to homosexual desires and hence it seems likely that problems may arise. It is impossible to obtain figures about the incidence of doubts about homosexuality from the existing literature. The incidence of occasional homosexual contact of one type or another appears to be high and may be seen as almost a normal aspect of growing up which in no way seems to influence future heterosexual adjustment. It seems likely that a number of people will experience stronger feelings of

attraction to homosexuality and yet make a satisfactory later adjustment. Clinical experience suggests that in some cases the individuals who present with fears of homosexual orientation are people who have relationship problems generally throughout childhood and adolescence. Where they have to include not only friendship but opposite sex relationships among their repertoire of social behaviour they experience considerable stress. Fear and unfamiliarity of opposite sex relationships leave some people with the feeling that, since not overtly heterosexual, they may be homosexual. It would appear therefore that homosexual feelings may at times be a sign of immaturity rather than difference in sexual orientation but investigation of this topic would need much greater review than is possible in the present investigation.

Research into the importance of personality factors in sexual dysfunction again seems to have focussed on homosexuality. On the whole there seems to be little evidence to suggest aspects of personality contributes to sexual adjustment. Cattell's (1970) work is discussed briefly under the section on the 16 P.F. but is not directly relevant to sexual problems within marriage. Eysenck (1971) found sexual pathology to be associated with high neuroticism and introversion in a group of 800 students. There appear to have been very few studies if any with cases of psychosexual disorders, where recent interest has been very much in terms of treatment. Storr discusses guilt and fear contributing to problems and there is much discussion about inhibitions, dominance and insecurity and one might conclude from the literature, albeit subjectively, that anxiety will frequently be present in cases of sexual dysfunction.

Since the days of Freud there has been emphasis on sexual problems occurring in a setting of psychological disturbance. Certainly there may be an increased anxiety about sexuality in mental illness and loss of libido, for example, is seen as a symptom of depression but clinical experience over the last few years has suggested that sexual problems can exist in what appears to be stable or certainly not mentally ill patients. It is with this group that specific treatments seem to be most successful and with whom the present paper is concerned.

At this stage it is necessary to consider the problems which are usually seen as evidence of sexual dysfunctioning.

a) MALE DISORDERS

Premature Ejaculation:

Masters and Johnson (1970) define this as an inability 'to control the ejaculation process for a sufficient length of time during intravaginal containment to satisfy his partner in at least 50% of their coital connections'. They felt this definition avoided the problem of giving an expected duration of actual intercourse prior to the male's reaching a climax. If the wife was found to be non-orgasmic for other reasons this definition is not valid, but it seems to be a more satisfactory explanation than a time-based one. Too rapid an ejaculation is less frequently complained of by the young, the lower social classes or by couples where the wife is disinterested in sex and therefore anxious for rapid conclusion of intercourse. The lack of satisfaction experienced by the wife who hopes for her own sexual expression is the factor which usually initiates the couples' seeking help. It is impossible to say how frequently premature ejaculation occurs in early sexual experience in couples who later cope adequately. Many couples may not seek help although their sexual relationship is not really satisfactory because of too early an ejaculation by the husband.

It is thought that premature ejaculation was the result in the older age group of early experiences with prostitutes where the man was encouraged to perform as rapidly as possible. Similarly in the younger age groups rapidity of performance during illicit sexual intercourse, whether in the parental home or back of a motor car, lessens the risk of being caught. Sexual contact at the end of a petting session to give the boy relief, birth control by coitus interruptus and other hurried early experiences are seen by Masters and Johnson as setting a pattern of premature ejaculation. They see it accepted with tolerance and understanding in many cases for months or years, but leading inevitably to frustration and distress, reduction in frequency of intercourse and frequently to secondary impotence. All are associated with a loss of confidence in their sexuality by both partners. The dysfunction or disorder seems particularly to be the result of early sexual experience rather than family background, religious doctrine or to any aspect of masturbatory experience. Despite the frequently expressed view of the wife in such a partnership that is the responsibility of the husband to 'sort it out' it is clearly a partnership problem, both, to a certain extent, in cause, and certainly in terms of therapeutic need.

Ejaculatory Incompetence:

This term describes the inability of a man to ejaculate in the vagina of his partner or a particular partner. This may be with anybody or only with a particular partner. It is frequently associated with what appears to be a resultant secondary impotence, because of the anxiety and fear of failure engendered by such difficulties. They may be associated with childish or adolescent fears of forbidden areas of the female body of contamination, or with a fear of total commitment to the partner. Some men are repulsed by their wives responding sexuality and are unable to complete the sexual act, but this is probably less common. Masters and Johnson comment that this can occur after a specifically traumatic event such as the discovery of infidelity.

In both premature ejaculation and ejaculatory incompetence the male is able to achieve an erection without difficulty, but one is over-reactive or 'too quick' and the other under or non-reactive. Both will cause anxiety and feelings of inadequacy in the marital unit and hence may be followed by impotence.

Impotence:

The inability for a man to achieve an erection, is often seen as one of the most frustrating and humiliating medical conditions. Secondary depression and reactive performance anxiety are frequently associated with it. Primary impotence is a chronic form of the disorder, frequently associated with psychiatric or organic pathology. It may however be partial rather than complete in terms of erections occuring in masturbation or spontaneously in situations other than heterosexual contact. Secondary impotence i.e. occuring in a past history of sexual adjustment, is fairly common if only transient episodes are considered. Physical and psychological factors may be involved. Psychological causes are often reflected in situational impotence, where a man may achieve an erection with one partner but not another, in one setting but not others etc. and the general considerations about causes of psychologically determined inadequacy apply here. Again it is difficult to sort out causes and effect. A transient episode of impotence related to overindulgence in alcohol, stress from other areas of the man's life or the particular situation e.g. in-laws sleeping in the next room may create anxiety which inhibit the likelihood of success at the next attempt. One could hypothesise that the already anxious or insecure man would be most

traumatised by this situation and that where communication is poor between a couple because of personality problems or marital dysharmony the difficulties are likely to be exacerbated. Kaplan feels that impotence can be caused by a variety of individual factors, physical causes, performance anxiety, unconscious intrapsychic conflict and difficulties in the relationship between the man and his partner. The demands of the more liberated wife of today's culture may put increasing pressure on the husband and often performance is seen as proof of love.

b) FEMALE DISORDERS

Vaginismus:

This is a psycho-physiological syndrome which partly or totally prevents penetration of the vagina during intercourse. A spastic contraction of the outer third of the vagina is considered to be an 'involuntary reflex stimulated by imagined, anticipated or real attempts at vaginal penetration', Masters and Johnson (1972). It has to be established by physical examination to avoid treating it where it does not exist, i.e. where other causes of non-consummation exist or to avoid missing its occurrence. Women exhibiting this syndrome are usually very reluctant to allow physical examination. It can be found in cases of infrequent intercourse (presumably due to experienced pain during it) as well as in unconsummated marriages. It is frequently associated with primary impotence in the male. Masters and Johnson comment that it is often difficult to know which occurred first, but the chances of symptoms occurring first in husband or wife are probably about equal.

As already stated, Masters and Johnson found aetiologically that vaginismus was associated with male sexual dysfunction, the inhibiting effect of a severe early upbringing particularly associated with religious views, relationship to early sexual trauma or to homosexual leanings in the woman prior to attempts at heterosexual contacts. Secondary impotence was noted in the husbands of some of the patients who had previously had adequate sexual relationships outside the marriage. Vaginismus can also occur as a secondary symptom of other disorders such as dyspareunia - painful intercourse. The importance of treating the marital unit in cases of vaginismus is stressed because of this finding of involvement of both partners in the aetiology of the disorder. This is also suggested by Dicks who gives an example of a case of vaginismus (which he

associated with a classical snake phobia) which was relieved to be replaced by impotence on the part of the husband. This too was helped, but immediately a relapse occurred in the wife. He also mentioned the exploitation of hysterical vaginismus in wives who were using the sexual relationship as a vehicle for handling inter-personal difficulties.

Dyspareunia:

The experience of pain or difficulty in intercourse is sometimes related to pelvic pathology but is seen also as frequently occurring as a psycho-somatic symptom. At a surface or conscious level it keeps the husband at bay since he is unlikely to be so persistent about establishing sexual contact if his wife is actually experiencing severe distress. Physical examination is necessary to eliminate the presence of pathological states needing medical treatment. Masters and Johnson describe various types of disorder contributing to dyspareunia such as vaginal irritation, damage related to childbirth etc. but they point out that even the type of pain complained of may be a guide to the source of the discomfort - psychologically determined pain is more likely to be described as deep pain on thrusting rather than external irritation.

Insufficiency of vaginal lubrication, while at times physiologically determined, is more often the result of a woman's inability to think or feel sexually and hence to respond. This is thought to be due often to lack of interest in sexual contact altogether or to a particular partner or situation. Fear of pregnancy, underlying lesbian orientation or fear of sexual relationships generally are obvious psychological causes of the functional dyspareunias associated with inadequacy of vaginal lubrication. Masters and Johnson see functional disorders of this type as being very similar to a man's inability to achieve an erection.

Men also at times suffer from pain during intercourse and again there may be physiological or psychological causes for this. However, it is women who more often present with such symptoms.

Frigidity and Orgasmic Dysfunction:

The inability to reach orgasm in the woman has attracted a great deal of professional and public attention. The term orgasmic dysfunction has taken over from frigidity or loss of libido and is sometimes seen as synonymous with these.

However orgasmic dysfunction is a more specific term for inability to reach orgasm which may or may not be associated with arousal problems which are also included to a greater or less extent in the other two terms. In investigation and treatment it seems necessary to keep this distinction. In fact work done by researchers such as Fisher suggests that orgasmic capacity is not directly related to other correlations of sexual functioning (page 11). More recent literature e.g. Kaplan (1975) differentiates clearly general sexual dysfunction which is frigidity with orgasmic dysfunction which she sees as the more common problem in women and does not include disturbance of arousal. By definition general or arousal dysfunction will preclude orgasmic experience. Freud's distinction between cliteral and vaginal orgasm with the former considered a reflection of psychological immaturity led to generalisation about women for several decades which it now appears were based on faulty premises. The secondary anxiety caused by this must undoubtedly have led to further inhibition of orgasmic experience. Masters and Johnson and many other workers have shown that this is not a useful or in fact valid way of looking at female orgasmic experience.

The inability to be orgasmic is often related to the quality of the relationship with the partner but restrictive upbringing, fear of rejection, anxiety about pregnancy, lack of foreplay may all be contributory causes. In many cases timing may be a problem, particularly where the man has a tendency to premature ejaculation. With such couples secondary anxiety and frustration can escalate the situation of one of either open conflict or an avoidance reaction pattern being set up. In the case of the latter the wife becomes apparently frigid showing increased avoidance and often eventually a virtual phobia about physical and sexual contact. Arousal and orgasmic dysfunction may also be partial and situational, occurring in some situations only and with different partners; the latter not necessarily the result of differences in technique but often associated with psychological factors such as the over-idealisation of a lover or the fear of abandonment. Kaplan feels that, although orgasmic capacity is clearly susceptible to psychological aspects, we still do not fully understand whether the initial capacity is determined by physiological factors which show the same individual variation as other physiological aspects of each person.

c) Some activities which in pure form are considered to be sexual deviation may exist in the sexually maladjusted in a mild form. Activities such as voyeurism, exhibitionism and fetishism are deviations if they are main substitutes for more usual means of obtaining sexual satisfaction.

Most people particularly men who seem to be more interested in visual arousal have at one time or another indulged in such activities in a mild form. Often the desire for such activities or for frotteurism (the desire to press up against women) is a passing phase of adolescence from which most individuals mature, but some are left with fantasies, guilt or partly repressed ideas which interfere with their mature sexual adjustment. Voyeurism can be associated with a hangover of anxiety about the size of the genitals so that the voyeur may be looking not at sexual activity but at the same sex to compare size which can become sexually arousing and hence give rise to anxiety over homosexual fantasies.

Although fetishism is often a form of sexual deviation rather than disorder it has also been found among some patients, in a mild way, but inhibitory to mature sexual adjustment. It is the term applied to the fascination and sexually arousing qualities which individuals obtain from parts of the person or objects connected with the person rather than people themselves. A compulsive and irrational sexual attraction may be experienced towards an article of clothing or other object. Although frequently associated with early childhood experience it can be established during adolescence and can be seen in terms of a learned or conditioned response. It is thought that many of these patients are introverted, easily conditioned personalities who often have relationship problems. Although Freud conceived of fetishist activities as being associated with castration complexes this is not generally accepted nowadays. Storr considers that it is a reassurance-type activity, and may in some cases be reassurance against castration anxiety. He sees it as a way of achieving an erection particularly in men who are afraid of sexual contact with women and therefore is often associated with a fear of impotence. Feelings of inadequacy in sexual relationships are therefore sometimes associated with comforting and hence possible erotically exciting objects. It may be associated with a defence against repressed guilt of sexual desire; whether mild and at a fantasy level to increase sexual desire, or a total form of sexual outlet. Such activities tend to be compulsive, often consciously resisted and associated with obsessional personality characteristics. Again

a fetish over an object associated with the male sex may be carried over from adolescent sexuality and prevent, through fears of homosexuality, the adequacy of heterosexual adjustment. Such activities can therefore be considered a form of sexual immaturity if they continue to exist in the otherwise mature adult.

IV RATIONALE OF THE PRESENT STUDY

A review of available literature has confirmed that most of the work carried out on the aetiology of psychosexual problems has focussed on homosexuality. The treatment of psychosexual dysfunction or minor maladjustments has received a great deal of attention in recent years but there is little objective information available about possible aetiological factors in these disorders. Enormous progress has been made in the area of treatment over the past two decades with considerably greater understanding of the actual nature of sexual response and the therapeutic techniques for helping psychosexual problems when these occur. The treatment situation has produced a wealth of clinical data, but as Harbison (1971) says, little has been published on objective assessment and prognostic indications in sexual disorders. Hence our knowledge is based largely on clinical experience, factual surveys about actual behaviour and a few instances of scientifically based research.

This study by nature of its scope cannot hope to provide answers to all the questions raised but it is a serious attempt to look at a group of people presenting at a clinic with psychosexual problems to see is aetiological factors can be understood by assessment and by comparison with a similar group of people who have not had psychosexual disorders.

In reviewing the literature the importance of the quality of family relationships contributing to sexual adjustment emerged in many studies. It seemed advisable therefore to look at the factual data on family relationships such as family position, happiness of the parental marriage as well as the degree of warmth experienced within the family. Similarly the personality strength and weaknesses of the parents and the degree of overprotection could all be considered relevant. Some of this information could be obtained by direct questioning and much from a test of family relationships.

Although the evidence for the importance of personality factors per se is scanty the differences in patterns of dominance, guilt, happiness, and possible emotional disturbance etc, revealed themselves in much of the literature. Similarly, acceptance of oneself, one's sexuality and one's partner were clearly relevant and these more subtle aspects of personality are more clearly studied by repertory grid technique than personality tests so it was decided that, to

cover as many aspects of this area, a standard personality test should be used and a grid technique devised to elicit the ways in which the individual viewed himself/herself, partner and ideal self.

Direct questioning has been shown by Kinsey and Schofield to produce reliable information on sexual behaviour and experience and was used to collect data on aspects of dating behaviour, sex education, first experiences of sexual activity etc. most of which had been found to be of some relevance in normal functioning and certainly contributes to the learning situation and experiental factors discussed by so many authors.

Fisher's work on female sexual responsiveness suggested the interesting idea that it was related to several positive attitudes to people and things. Similarly the likelihood of increased incidence of sexual anxiety in psychological disorders such as depression and discontent made it seem advisable to see whether there was any evidence to support the hypothesis that sexual problems were more likely to occur in discontented individuals. It was decided to use a problem check list to see if they complained of difficulties in other areas of their lives also.

The techniques used to explore the above points are discussed in the next section.

V METHOD AND PROCEDURE

The Research Group

As already mentioned the research group were all people referred to a clinic for psychosexual disorders by their family doctors. These are not part of a normal psychiatric caseload where psychosexual dysfunction may exist in a setting of psychiatric disorder but people who would not normally be referred for psychiatric or psychological help had they not complained to their doctor about some specific sexual problem. Their age range, marital status, etc. is given alongside similar data for the control group.

Classification of psychosexual disorders is rather difficult as frequently it is difficult to specify the problem in terms of one or other disorder. When a couple are referred it may be almost impossible; and from the point of view of treatment, unwise, to disentangle cause and effect. The forty cases chosen for this investigation were the first twenty of each sex from the time of the pilot study, who appeared to present no very serious relationship problem other than related to sexual dysfunction and no apparent psychopathology. They are presenting patients and do not include the partners.

The men formed perhaps a less cohesive group than the women; they feel into two groups - 7 or 8 who had feelings of sexual inadequacy or inferiority which was reflected in anxiety-producing behaviour such as looking in men's toilets, (mild voyeurism), mild fetish behaviour, difficulty in making relationships with girls, all of which at times gave them some doubts about their sexual identity and led to premature fears of homosexuality. These were a group of young men who were in a sense sexually immature and who have subsequently made an excellent adjustment. Whether any of them might have continued with their doubts and become homosexual without intervention is not possible to say. A second group were on average older and usually suffering from mild or partial impotence, sometimes associated with premature ejaculation. All therefore were seen as concerned about feelings of sexual inadequacy, some in relation to early stages of sexual adjustment and others who had developed sexual anxiety after a period of years of sexual adjustment which they frequently reflected upon as having 'never been really satisfactory'.

The women - again there was a wide range in age but the predominant symptom was of some degree of frigidity or loss of interest in sex. In a few cases this

had never really existed and they were dissatisfied with their sexual response. In some cases this appeared to have been better at some earlier stage in the relationship with their present partner or with someone else. Several cases had reached the stage of what was virtually a sexual phobia - these women, who were of all ages, hardly allowing their husbands to touch them or, in some cases, not at all. It is perhaps best to describe these women as suffering from loss of libido or diminished libido. Some therefore had arousal dysfunction, at their worst resulting in phobic behaviour, some had orgasmic dysfunction which in turn in most cases seemed to result from arousal difficulties. This may of course be related sometimes to partners with problems of ejaculatory control. This again illustrates the difficulties and confusion in classification and the problem of cause and effect. There were two cases of vaginismus which in turn could be interpreted as a more complex arousal problem.

The common factor to all the cases referred was anxiety about sexual skills or performance which led to anxiety and doubts about their capacity for sexual response.

The Control Groups

Twenty men and twenty women co-operated in completing the test material which had been administered to the research sample. In their case the questionnaire was given as a questionnaire rather than a structured interview though additional explanation and description was given before completion. Items relating to a previous history of psychiatric or sex problems were included. Two of the original forty-two volunteers, one of each sex, were excluded on these grounds. The people were asked to help with the research in a variety of settings. Some were members of the hospital staff, some student teachers, members of a women's organisation and of an evening class etc. They were matched roughly for age and education level with the research group.

The following information is relevant to this matching:

Table 1

	MEN		WOMEN	
	Research	Control	Research	Control
Age range	20-56	20-50	19-50	21-43
Mean age (standard deviation)	35.5 (±11.0)	30.35 (±9.52)	27.2 (±8.65)	30.2 (±6.1)
Married	8	10	18	17
Single	11	9	2	3
Separated/divorced	1	1	-	-
Years married:				
Mean years married	12.75 (±8.8)	11.9 (±8.3)	5.1 (±4.4)	7.76 (±4.4)
No. of children/mean for married subjects	2.0	2.0	2.1	2.2
Education:				
No qualifications	12	8	13	4
'O' level or equivalent	1	3	1	10
'A' level/college/ university	7	9	6	5
Occupation:				
Untrained, shop assistant etc	6	2	4	3
Clerical	2	2	9	7
Professional, teacher, nurse, doctor	7	11	5	7
Student	4	5	2	3

Discussion: There were no significant differences between the ages of the control and research groups for either sex, though the men research group are significantly ($p<.02$) older than the women research group. Similarly the men in the research sample have been married longer than the women ($p<.05$) but again there are no significant difference between the research and control members for each sex group. The groups seem well matched for marital status but there is a tendency for the control groups to be slightly better educated. If the groups are

combined into 'O' level and below, 'A' level and above these difference disappear and they may therefore not be very significant. Similarly the occupational levels may be slightly higher in the control groups. This is probably an inherent problem in obtaining control groups in the way this had to be done, i.e. finding a representative group of people willing to complete the assessment.

(2) Description of Techniques Used in Investigation

Two of the techniques used here were devised particularly for this investigation, the others are standard psychometric procedures. They are described here in the order in which they were administered to the patients.

a) The Questionnaire

Consideration was given to other methods of collecting information about sex education, experience and attitudes, particularly parental attitudes to sex. Sexual attitudes are included in the Edwards Personal Preference Schedule under the need for heterosexuality, but the test is too lengthy to administer for this score alone and the scores obtained by extracting the items would be absolute scores whereas the whole test is based on the concept of disparate scores. Extraction would not really be valid and the content of the items would be distorted in importance. Similar criticisms could apply to the use of the Spouse sentiment section of Cattell's Motivation Analysis Test which in any case is not particularly suitable for British subjects. The M.F. scale of the M.M.P.I. is not seen as particularly relevant to the present study either.

One of the few tests measuring sexuality is the Thorne Sex Inventory. This test based on 200 items gives ten scale scores which include neurotic conflict, associated with sex, sex role confidence, promiscuity and sociopathy. This inventory has been used mainly with sexual deviants and offenders and the item content was not considered suitable for the group of patients to be studied here. Again extraction of items or scales would pose validation problems. The questionnaire used by Poole in his aetiological study of lesbians was also considered but the item content was differently slanted in terms of sex role identification. Other techniques described in the literature appeared more concerned with sexual orientation (e.g. Feldman, 1966).

It was decided, therefore, not to use any existing techniques as it stood but some of the items are derived in concept if not actuality from these other studies and their help as a source of ideas is acknowledged. The present questionnaire was therefore derived specifically to answer the questions considered relevant to the present study. At the outset of administering the questionnaire the nature and duration of the individual's problem was discussed. Included in the questionnaire data is information about the age, marital status, length of marriage, educational level and occupation of the subject. It also

covers the source, adequacy and attitudes to sexual knowledge in childhood and adolescence (section I), parental attitudes to sex and the parents' marital adjustment (section II), and sexual trauma, sexual experience and attitudes (section III).

Although the data is collected and presented in the questionnaire form, this part of the testing procedure was really a standardised interview and the form was used for note-taking of responses to the questions. This meant that although a 3-point scale of '+ o -' was available comments could be noted which would allow for further sub-division of classified responses of this need arose. As the intention was to seek differences between the experimental and control group the scoring system had to be sufficiently objective for group data yet meaningful for the individual case. Generally a '+' response indicated a positive or favourable answer, a '-' response indicated the subject had answered in terms of unfavourable, repressive, disgusted, hostile, etc. whereas 'o' was used when the subject was undecided or unable to remember.

The questionnaire then is subjectively composed and includes items designed to elicit information to test the hypotheses of the study. Despite Edward's (1957) cautioning on the limitations of direct questioning this was considered a necessary part of the present study. He also suggests statements should refer to the present not the past, but here the past was considered to be likely to be particularly relevant. In addition to this, both the Kinsey and Masters and Johnson studies have emphasised the value and reliability of direct questioning about sexual behaviour and ideas.

b) The Bene-Anthony Family Relations Test (adult version)

This test is described by its authors as "an objective technique for exploring recollected childhood feelings". Its advantage over more subjective means of obtaining information from people about their memories of family relationships is that it obtains the information in a way which is systematic and quantifiable. The authors feel that the individual's 'psychic past' is what influences his behaviour and hence his recollections of his early life have more bearing on the present than the observations of others who could perhaps give a more objective reconstruction of family relationships. A technique which depends on recollections has possible obvious limitations but is perhaps the only method of understanding the individual's view of his early family environment.

Description of the test - the test consists of a series of twenty cardboard figures attached to 'posting boxes'. The subject is asked to choose, from these stereotyped but ambiguous figures, several of them who will represent the members of his childhood family, father, mother, siblings, self and anyone else who was an important member of the family such as a grandparent who lived with them. Another box is included with a back view of a man who represents 'Nobody'. The subject is given ninety-six cards with a statement on each, such as 'this person in the family used to like me very much', and he or she is asked to place them in the box standing for the individual 'it fits best'. If the person feels the card applies equally to more than one person this can be recorded. The authors of the test feel the disappearance of the cards into what might be considered rather childish boxes avoids feelings of guilt and anxiety over the distribution of items. The items can later be easily scored in groups of incoming and out-going feelings which may be mild or strong, positive or negative. Quality of feelings, discrepancy between out-going and ingoing feelings and general family involvement can therefore be measured. The test also gives an indication of remembered patterns of parental over-protection, over-indulgence and competence.

Meyer (1963) in a description of the test comments on work done which supports Bene and Anthony's view that the test has sufficient validity to be a useful technique. He points out that subjects may tend to deny strong feelings of hostility or perhaps strong positive (sexualised) feelings, giving an indication only of those which the subject consciously considers permissible. Meyer

acknowledges that these other feelings may not be obtainable in other ways either and some subjects will admit feelings under these guarded conditions which will not be evident in overt action. Test users have found considerable agreement between the emotional attitudes indicated by the subjects with the reality of their home environment using the Children's version of the test (Bene and Anthony, 1957).

Bene used the test in studies, comparable in some ways to the present one, of "The Genesis of Male and Female Homosexuality" (1965). Several hypotheses were formulated and tested on the basis of responses on the Adult version of the test. The test showed up several differences in the responses of groups of homosexual and married men, lesbians and married women, not all of which supported the original hypotheses. The result of these studies are discussed elsewhere (page 18), but the relevance of the technique to the present topic seemed to indicate its possible value as an indication of early relationships which are considered by most authors to be significant for the aetiology of sexual disorder or deviation. The form of the test allows for statistical comparisons of the quality of relationships experienced by the two groups in the present study.

c) The Repertory Grid

The application of repertory grid techniques in studying particularly the individual has gained considerable support in recent years. Many papers have appeared in the psychological literature on the merits of this new approach to the study of human behaviour. Repertory Grid tests are derived from Kelly's theory of personality, outlined in The Psychology of Personal Constructs (1955), and their use elaborated by many authors.

The basic concept of this theory is that one must try to understand the way in which an individual interprets or 'construes' his world and the people in it. Kelly believes that each individual has a particularly important set of constructs, his core constructs, which he applies to himself and others in judging people and things in his environment. He also has a hierarchical system of other constructs which operate to a lesser extent generally, though they may be particularly operative in his attitude to certain aspects of his life. One would expect, for example, that each individual applies a set of constructs in his attitude to sexuality, to parents and to his or her partner. The constructs may vary between these concepts and will certainly vary from one individual to another. It is for this reason that Repertory Grid techniques are applied in this study, i.e. we shall see whether there are many differences in the constructs applied by individuals to sexual difficulties and whether there are consistent differences in constructs between a group of people who have experienced such difficulties and those who have not.

Although there have been some criticisms of the value of using Grid techniques with groups rather than individuals (Slater, 1965), Caine and Smail (1969) support Mair's (1966) view that despite the risk of losing meaningful individual data in looking for group differences there may be sufficient 'commonality' of constructs for group similarities to be established. Concern with aetiological factors, however, will mean seeking 'commonality' of attitude factors which may be causally relevant. If the constructs to be studied can be selected on the basis of previous research and present hypotheses as likely to be relevant from the clinical or causal viewpoint, similarities, if they exist, should be measurable.

Kelly originally suggested that the elements in the Grid should be people known to the subject - mother, father, friend, etc. This method of using role

titles is widely used in eliciting elements about whom constructs are later studied. Slater (1969) comments that this introduces restriction on grid technique and that any set of elements can be used. The Medical Research Council provides a service for analysis of more complicated test data. This yields data on the principal components of the grid and the interaction of the individual's elements and constructs. The complexity of data revealed by this technique is such that it did not seem applicable in the present study. Bannister and Fransella used a series of photographs of unknown people in their test of Schizophrenic Thought Disorder. The theory of this test is that those patients who are thought disordered have lower scores on 'Intensity' and 'Consistency', obtained from two administrations of the Grid technique. This test has recently been criticised on the grounds that schizophrenics may have difficulty in construing people because they are insensitive to cues to personality rather than being due to a loosening of constructs as suggested by Bannister. Williams (1971) recently demonstrated the likelihood of this being the case, taking as his point the studies of Crockett (1965) and Glixman (1965) which showed that the familiarity with a domain of stimuli markedly affected an individual's categorising about them. This has relevance for the present study as it was obviously important to have elements which were relevant and familiar to the constructs considered worthy of investigation in relation to sexual dysfunction. Hence it seemed important to have as elements, self, ideal self, mother, father and partner. The Grid could have been constructed in such a way that the subject was asked to rate these people on constructs such as aggressive, happy, having sexual problems etc. It was decided, however, that subjects might experience difficulty or discomfort in rating these constructs for their parents, self and partner, particularly as those with sexual problems would be emotionally vulnerable in these areas. It was considered that the use of pictures as elements would avoid this difficulty and that the constructs could include like me, like mother, like father, like partner, etc.

Correlations could be calculated showing relationships between constructs in the same way as if they had been elements, but the method would be less direct and obvious to the subject. Thus the test would have some of the advantages found in projective techniques where the purpose of the judgements is not immediately understood by the subject. A pilot survey using the technique supported this

hypothesis and thus the method of pictures as elements was decided upon. A pilot administration using the standard set of eight photographs used by Bannister and Fransella (1966) showed that the subjects had difficulty in making judgements on like mother, like father, which were not biased by sex differences on the pictures. It was, therefore, decided to use a set of eight photographs of females for the female subjects and of males for the male subjects.

Adjectival constructs were also included - happy, anxious, guilty, aggressive, and self-confident. These were selected on the basis of their probable applicability on theoretical and clinical grounds. Although 'depressed' might have been a more relevant construct than 'happy' it was decided to have a mixture of constructs with positive and negative attributes. Anxiety was chosen as it was hypothesised that those with sexual problems would either experience more anxiety or relate anxiety to these problems. Storr's excellent treatise on sexual deviation as an extreme of sexual dysfunction stresses feelings of guilt and inferiority, so guilty and self-confident were included. Aggression was included as it features in much of the relevant literature and appears to have some possible relationship to the husbands in cases of non-consummation. (Friedman (1962) in Virgin Wives says the husbands in such cases are frequently rather mild, non-aggressive individuals). Like self and like ideal self are frequently used constructs in this type of Grid and show in what way and to what extent, different the individual would wish to be. One would expect the clinical or patient group to show more disparity between self and ideal self, particularly in relation to sex problems. Such discrepancies have previously been found for neurotic groups. Ryle and Breen (1972) in a study using similar techniques in assessing how far mean scores on Grids tested "how far certain features do consistently and significantly differentiate between neurotics and normals". Their evidence supported this greater self/ideal self distance, lower identification with parents (especially with the father in the case of females) and several other common factors.

The data obtained from this technique can be shown graphically for the individual and for the group (see results section) and interpretations made from the group results. It should perhaps be added that despite the significance or otherwise of common factors in causality, the individual Grids obtained by this method were of considerable value in assessing the aetiology of the individual

patient's problem, gave pointers to methodology of treatment, and in some cases revealed prognostic indication. It has therefore proved a useful clinical technique in addition to, and regardless of, its value in the research project.

d) The Sixteen Personality Factor Test

This personality test is perhaps one of the best known in psychology, being used extensively in the applied fields, particularly clinical and occupational. It was first published in 1949 and by 1970 was available in five parallel forms and various related versions which are similar techniques for different age groups, such as the C.P.Q. and H.S.P.Q. When first described it was based on what was then a less usual approach to personality testing - factor analysis of evidence on the structure of personality obtained from questionnaire data and behavioural ratings. Despite periodic discussion and controversy about how many factors should be included in the basic data and second-order factors Cattell has stuck with the idea of 16 primary or source traits and a varying number of second-order factors of which four are most commonly used: extraversion, anxiety, cortertia (alert poise), and independence. Clinical supplements are now also available.

The 16 personality factors are:

A -	Reserved, detached	vs	Outgoing, warmhearted
B -	Less intelligent, concrete-thinking	vs	More intelligent, abstract-thinking
C -	Affected by feelings, emotionally less stable	vs	Emotionally stable, faces reality
E -	Humble, mild	vs	Assertive, aggressive
F -	Sober, prudent	vs	Happy-go-lucky, impulsively lively
G -	Expedient, disregards rules	vs	Conscientious, persevering
H -	Shy, restrained	vs	Venturesome, socially bold
I -	Tough-minded, self-reliant	vs	Tender-minded, clinging
L -	Trusting, adaptable,	vs	Suspicious, self-opinionated
M -	Practical, careful	vs	Imaginative, wrapped up in inner urgencies

N -	Forthright, natural	vs	Shrewd, calculating
O -	Self-assured, confident	vs	Apprehensive, self-reproaching
Q_1 -	Conservative, respecting established ideas	vs	Experimenting, liberal
Q_2 -	Group-dependent, a 'joiner'	vs	Self-sufficient, prefers own decisions
Q_3 -	Undisciplined self-conflict, follows own urges	vs	Controlled, socially precise
Q_4 -	Relaxed, tranquil.	vs	Tense, frustrated

Form C was used for the present study. Although shorter than forms A and B it is found adequately reliable and valid in the clinical setting and seemed more appropriate for the clinic investigation where the patient completed a series of tests in addition to the sometimes lengthy structured interview. British norms were used which give sten scores for men and women separately.

The literature on the 16 P.F. is vast and cross-cultural. From it one can extract various items which could be considered relevant to the present investigation. Cattell (1950) feels that two main principles operate in personalities within a marriage - i) satisfaction of companionship through the choice of partner, i.e. there will be positive resemblances in aspects of the personality and ii) complementary factors in the sense of the partners offering to each other what they need in their dyadic adjustment. The former would suggest that similarity on the 16 P.F. profile would be greater for satisfactory marriages. Cattell and Nesselroade (1967) showed that the profiles of stable partnerships were positively correlated with the exception of factor I, tendermindedness, whereas about half of unstable partnerships were negatively correlated. Similarities on factor B (intelligence), C (ego-strength), F (surgency), H (venturesome), M (imaginative) and Q_3 (self-concept control) seemed to be particularly important. It is thought that the degree of similarity, the direction of the difference and the profile of the individual himself with relevance to marital adjustment are all important. Cattell and Nesselroade (1963) also showed that marital adjustment was associated with higher scores on B (intelligence) and lower scores on Q_4 (ergic tension), and that it is desirable for the husband to score higher than the wife

on C (emotionally more stable). They found high dominance a risk for either partner; A+, Q_1+ and Q_4+ risks in wives and H- a risk for husbands. They acknowledged that these could be effects rather than causes, for example high tension Q_4 could be the result of frustration.

In choosing a personality test for the present investigation various ones were considered. Since the research on personality differences has usually focussed on homosexuality v heterosexuality (Cattell and Moroney 1962, Orford 1971, Feldman and McCulloch 1971) the relevant literature on the topic of psychosexual disorders has been sparse. However it seemed advisable to have a test with more rather than less factors hence the preference for Cattell rather than Eysenck's E.P.I. (1963) and since the 16 P.F. is one of the most used and most validated for a wide number of uses it was selected as a suitable instrument to investigate the likelihood of personality variables contributing to sexual maladjustment.

e) The Mooney Problem Check List

This test is available in several versions, the adult one being used in the present study. It consists of a list of 288 items which can be problems to people and the individual is asked to underline all items which are of concern or anxiety to him or herself and to circle the ones which most concern him. The test form also allows for a summary in his own words, but this was not included since the questionnaire and initial interview had already collected this data. The list is self-administered and takes about fifteen minutes to complete. The problem areas include Health, Economic Security, Self-Improvement, Personality, Home and Family, Courtship, Sex, Religion and Occupation. The list is constructed so that the problem areas fall into horizontal groups while the list is checked vertically, allowing easy scoring, but not readily discovered areas of problems, (Gordon and Mooney, 1950). This is thought to cut down distortion in terms of higher social acceptability.

The list was devised for use with adolescents and adults from the basis of thousands of problem items accumulated in research, counsellors' experience and other check lists. The present form is a revision based on at least three preliminary versions. It is designed basically as an aid to counselling, cutting down the time taken to obtain relevant information and avoiding areas which may be overlooked but could be very relevant to the individual. Clinical experience has shown it to be a useful technique. Its inclusion here was considered beneficial as it covered the areas of courtship and sexual problems and also gave an indication of other areas of anxiety, in the research and control samples, thus allowing the relation of such problems to the total life situation to be observed.

As problems change as the individual's interaction with his world changes, one would not expect the individual to check exactly the same item each time and hence the reliability of a technique such as this is a different problem from the reliability of other types of test. However, repeated administration of the test have shown it to have sufficient stability to be a fair reflection of an individual's problems, some of which may be much more persistent than others. Mooney and Gordon suggest that validity of the technique cannot be established in terms of the usual criterion. They are satisfied on the grounds of responsiveness and constructive attitudes of those tested, coverage of problems and acceptance by

educators; all of which they consider to indicate the validity and usefulness of the list. They also suggest its merit as a research tool for comparing groups of people in the particular way it is being used in the present study.

VI RESULTS.

These will be presented under the headings of the techniques used. Since different factors appear operative for the two sexes the data will be presented separately for men and women with some discussion of any apparent comparability. The groups are designated MR - men research group; MC - men control group; WR - women research group; and WC - women control group.

The Questionnaire: In many cases the answers to the questions are grouped. For example to the question "Did you think your parents were happily married?" those who answered "yes" or "I never thought about it - I suppose so", are considered to form one group contrasting with those who said "no". Because the numbers are very small negative responses such as "did not enjoy", "felt guilty", "felt anxious" etc. are also combined, and shown in the tables below.

Where differences appeared significant the Chi-squared test was applied, corrected for continuity, and the level of significance of the difference is noted where applicable. Since specific hypothesis could not always be made about the direction of the differences, a two-tailed region of rejection was used. In one or two instances where the smallest expected frequency was small the Fisher Exact Probability test was used as recommended by Siegel (1956).

1. Family position:

Table 2

	MR	MC	WR	WC
Only child	5	6	3	4
Oldest child	7	8	7	8
Middle	6	5	3	1
Youngest	2	1	7	7

There was a wide range in family size and the majority in all groups were mixed families. It would appear that family position has no connection with psycho-sexual disorders for this sample.

2. Separation in childhood/adolescence:

Table 3

	MR	MC	WR	WC
Death of parent	3	3	2	4
Death of sibling	2	2	1	2
Death of other relative			1	
Adopted			1	
Boarding school/evacuation			1	2
Illness in family			3	
Parents divorced	1		1	1
Total:	6	5	10	9

There is no difference between the research and control groups for either sex but nearly 50% of all women reported some degree of separation or loss compared with 28% of the men.

3. Sex education:

(a) Source: Several subjects from all groups mentioned more than one source of sex education. Frequently the source was confused, e.g. "I just picked it up at school or from friends".

Table 4 a,b,c

	MR	MC	WR	WC
Parents	3	3	11	11
School	4	5	6	9
Friends	12	8	5	14
Books	4	6	1	6
None	4	3	3	2

Again there were no notable differences between the research and control groups. The women were more likely to have their parents involved in their sex education and the control women showed a tendency to have more discussion with friends. A fairly high proportion of all subjects, 22%, reported having no sex education at all.

(b) Adequacy of sex education: Subjects were asked if they thought their sex education adequate; many gave qualified answers and these groups and those who considered it adequate are contrasted with those who thought it inadequate.

	MR	MC	WR	WC
Adequacy	8	16	10	14
Inadequacy	12	4	10	6

The research groups both thought their sex education less adequate but the difference was significant for men only ($X^2=5.1$, $p<.01$). It was decided that "Would you like your children to have better sex education" had not been a useful question as the vast majority of all groups acquiesced.

(c) Attitude to hearing about sex: Many could not recollect their feelings on hearing the facts of life. Only those remembering feelings of disgust, displeasure or fear are scored as having negative attitudes.

	MR	MC	WR.	WC
Positive attitude or none remembered	18	18	12	17
Negative attitude or feelings	2	2	8	3

There was a tendency for more women in the research group to remember being shocked or worried by information about sex but this did not reach significance.

(d) Nocturnal emissions and menstruation: Questions were included on these topics as their occurrence provides awareness of his or her sexuality to the individual. Again all subjects were asked their source of information, attitude to hearing where remembered, attitude to onset, and if they had had any trouble or anxiety over this.

Table 5

	MR	MC	WR	WC
1) Source of information:				
Parents	-	3	12	16
School or friends	8	13	5	9
Books		3	-	3
Not told	12	6	5	1
2) Attitude to hearing:				
Positive, interested, no strong reaction remembered	7	14	12	18
Fear or disgust	1		3	1
Not told	12	6	5	1
3) Attitude to onset:				
No problem, pleased	9	13	15	16
Worried, disgusted	7	4	5	4
None experienced	4	3		
4) Trouble or anxiety experienced	1	0	12	4
No trouble, not applicable	19	20	8	16

There is an obvious trend for both research groups to be less likely to have been told about these facts and less likely to have had positive attitudes to such information but the only significant finding was for the women research group where more women reported having trouble with menstruation ($X^2=5.10$, $p<.05$).

4. Parental attitudes to sex: These were divided into two areas, remembered parental attitudes to sexual matters generally and in relation to sex and the subjects themselves, e.g. attitudes to their first dates, to steady boyfriends, etc. Many subjects said the subject was rarely mentioned and they had no idea of parental attitudes. The numbers of these were similar for each group and it was decided to look at the significance of negative, i.e. hostile, repressive attitudes as opposed to those where feeling appeared to have been positive or at least non-involved.

Table 6 a,b

	MR	MC	WR	WC
a) Father's attitude to sex:				
Positive, normal, rarely mentioned	15	14	14	14
Negative, embarrassed, victorian	5	6	6	6
Mother's attitude to sex:				
Positive, normal, rarely mentioned	16	17	12	13
Negative, embarrassed, victorian	4	3	8	7
b) Father's attitude to sex in relation to boyfriends, girlfriends, dating etc:				
Positive, normal, rarely mentioned	15	20	18	19
Negative, embarrassed, victorian	5	0	2	1
Mother's attitude to sex in relation to boyfriends, girlfriends, dating etc:				
Positive, normal, rarely mentioned	15	17	14	16
Negative, embarrassed, victorian	5	3	6	4

Parental attitudes to sex appear to show no real difference between the groups - the only significant finding being the more negative memories of father's attitudes to the research men having dates etc.

5. Parents' marriage: Subjects were asked if they considered their parents' marriage had been happy, a) prior to, and b) during their adolescence.

Table 7

During childhood:	MR	MC	WR	WC
Happy	18	17	18	16
Unhappy	2	-	2	2
Not applicable	-	3	-	2
During adolescence:				
Happy	16	16	16	15
Unhappy	3	1	3	4
Not applicable	1	3	1	1

No differences were noted between the groups to suggest the happiness of the parents' marriage had any relevance to subsequent sexual function.

6. Sexual experience: This section covers any early sexual trauma remembered and reactions to physical and sexual contact with the opposite sex.

Table 8

(a) Unpleasant sexual experiences:		MR	MC	WR	WC
1) Childhood	Yes	1	0	4	1
	No	19	20	16	19
2) Adolescence	Yes	0	1	7	0
	No	20	19	13	20

There was a very low incidence of sexual trauma for the men. Several women in the research group had early bad sexual experiences, most of these being indecent exposure but there were also two cases of rape, and there is a significantly

greater occurrence ($p<.01$, Fisher Exact Probability test) among the group with psychosexual problems.

Table 9

(b) Friends of the opposite sex:	MR	MC	WR	WC
Many or at least average number	9	18	14	16
Few	11	2	6	4

The men in the research group had significantly fewer friends of the opposite sex as they grew up ($X^2=7.3$, $p<.001$).

(c)1 Early physical contact, i.e. handholding, kissing etc:

Table 10

	MR	MC	WR	WC
Happy/enjoyable experience	15	19	13	16
Not enjoyed	5	1	7	4

Table 11

2. Early sexual contact such as petting:	MR	MC	WR	WC
Happy/enjoyable experience	15	19	11	14
Not enjoyed, afraid, disgusted, guilty	5	1	7	3
No such activity	-	-	2	3

For both these items, early physical and early sexual contact there is a trend in the expected direction but no significant finding.

Table 12

3. Premarital sexual intercourse:	MR	MC	WR	WC
Pleasurable experience	7	15	4	8
Not enjoyed, guilty, unpleasant	5	4	9	3
Not experienced at all	8	1	7	9

A significantly ($p<.01$, Fisher Exact Probability test) higher proportion of the control men had had intercourse prior to marriage which was a pleasurable experience for them. A much higher proportion of the research men had no experiences of premarital intercourse, ($p<.01$, Fisher Exact Probability test). The differences between the groups of women suggested the research group was marked by a higher incidence of unpleasant experience or guilt feelings but none of these differences reached significance.

A higher proportion of all women had not had any sexual experience, pre-maritally.

Table 13

4. First experience of sexual intercourse:	MR	MC	WR	WC
Pleasurable experience	10	13	7	15
Not enjoyed, embarrassed etc	6	5	13	3
No sexual experience	4	2	0	2

Again the control group are more likely to have had pleasurable first experiences of sexual intercourse but this is significant for the women only ($X^2=7.20$, $p<.01$).

The last three questions dealt with shyness and embarrassment.

Table 14

5. Shyness in early sexual contact:	MR	MC	WR	WC
Yes	10	14	15	11
No	10	6	5	7
Not applicable	-	-	-	2

Table 15

6. Shyness in sexual contact at present:	MR	MC	WR	WC
Yes, some	8	8	7	9
No	12	11	13	11
Not applicable	-	1	-	-

Table 16

7. Embarrassment about undressing in front of partner:	MR	MC	WR	WC
Yes	4	5	2	2
No	15	12	18	18
Not applicable	1	3	-	-

No significant differences between groups were found in this section.

Summary of findings from this section:

The following areas of investigation suggested they bore no relationship to subsequent sexual dysfunction:

1) family position,
2) separation or loss,
3) source of sex education,
4) attitude to onset of menstruation (women only),
5) the happiness of the parents' marriage,
6) maternal attitudes to sex (men and women), paternal attitudes (women only),
7) any shyness or embarrassment in sexual contact.

Areas where non-significant trends were noted:

i) research group (women only) had less positive attitudes to hearing about sex.
ii) research groups less likely to be told and more likely to be shocked or disgusted by hearing about nocturnal emissions/menstruation. The control group (men) were more likely to be pleased or have no anxiety, about the onset of nocturnal emissions and to have no problem with this.
iii) early sexual contact, kissing, petting etc. was more pleasurable for the control groups.

Differences between research and control groups: Sexual dysfunction appeared to be significantly related to:

MEN - i) less adequate sex education*
ii) not being told about nocturnal emissions
iii) fewer friends of the opposite sex in adolescence
iv) less enjoyment of premarital sexual intercourse*
v) less frequent occurrence of premarital sexual intercourse
vi) father's attitude to girlfriends and such sexual matters - less positive for research group

WOMEN - i) experiencing menstrual problems
ii) sexual trauma in adolescence
iii) less pleasure at first experience of sexual intercourse

* These were supported by similar not significant trends for women.

The Family Relations Test

A great deal of data was obtained from the use of this test and it was necessary to group the data and look at particular aspects of it. For most of the comparisons the mild and strong positive and mild and strong negative were combined. Overall distributions are given first and explanations are given with each set of group comparisons. For most of these Chi-squared X^2, corrected for continuity, is used to establish the significance of frequencies. A second step was applied to investigate individual data by means of an index of positive feelings to the parents and there the significance of differences is found by 't' tests to the means and by the Mann-Whitney test.

1. The overall distribution of cards is shown in tables 17 and 18.

Table 17

Distribution of positive and negative cards to family members

a) MEN

OUT	Nobody		Self		Father		Mother		Siblings		Others	
	MR	MC	MR	MC	MR	MC	MR	MC	MR	MC	MR	MC
+	45	40	15	21	48	62	91	54	50	48	17	31
++	119	112	1	1	18	8	36	21	47	14	8	6
IN												
+	42	27	2	2	46	49	88	77	58	29	9	22
++	107	107	0	0	17	5	35	34	45	16	3	10
Total	313	286	18	24	129	124	250	186	200	107	37	69
OUT												
-	94	96	20	9	32	17	51	32	52	39	11	2
--	91	106	1	0	29	14	32	17	58	48	11	1
IN												
-	87	92	0	1	36	29	41	24	71	20	8	3
--	109	124	0	0	15	10	23	5	37	21	10	1
Total	381	418	21	10	112	70	147	78	228	128	40	7

b) WOMEN

OUT	Nobody		Self		Father		Mother		Siblings		Others	
	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC
+	38	42	9	6	55	71	87	72	62	76	17	4
++	83	104	0	0	30	30	44	31	18	16	6	1
IN												
+	36	24	2	0	59	79	63	76	65	54	11	6
++	81	90	0	0	33	35	40	28	19	24	7	3
Total	238	260	11	6	177	215	234	207	164	170	41	14

b) WOMEN (cont'd)

	Nobody		Self		Father		Mother		Siblings		Others	
OUT	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC
-	92	99	18	20	38	22	26	37	23	33	3	9
--	84	77	2	0	24	14	9	26	52	72	4	9
IN												
-	86	80	0	0	29	25	29	47	25	31	1	6
--	110	119	0	0	28	9	8	13	17	22	0	11
Total	372	377	20	20	119	70	72	123	117	158	8	35

2. Positive and negative involvement with people: this first comparison is between the allocation of positive and negative cards to people in the family rather than to nobody and is shown in tables 19 and 20.

Table 18

Positive feelings ascribed to people rather than 'nobody'

	MR	MC	WR	WC
Total people	634	510	627	612
Nobody	313	286	238	260
X^2	1.46		1.02	
p	ns		ns	

Table 19

Negative involvement with people rather than 'nobody'

	MR	MC	WR	WC
Total people	620	293	336	406
Total nobody	381	418	372	377
X^2	70.94		2.70	
p	<.001		ns	

There is no significant difference between the frequency of expression of positive feeling to people between the research and control groups. The research group men however expressed significantly more negative feelings to people than the control group which was not the case for the women.

3. Relationship with parents: differences between research and control groups in expression of outgoing and incoming positive and negative feelings to father and mother (mild and strong combined).

Table 20

Relationship with Parents

a) Outgoing positive	MR	MC	WR	WC
Father	66	70	85	101
Mother	127	75	131	103
X^2	6.25		3.99	
p	<.01		<.05	

	MR	MC	WR	WC
b) Incoming positive				
Father	63	54	92	114
Mother	123	111	103	104
X^2	.01		0.88	
p	ns		ns	
c) Outgoing negative				
Father	61	31	62	36
Mother	83	49	35	63
X^2	.15		13.80	
p	ns		<.001	
d) Incoming negative				
Father	51	39	57	34
Mother	64	29	37	60
X^2	2.39		10.31	
p	ns		<.001	

Whereas both control groups express a surprisingly close proportion of positive feelings to both parents both the men and women research groups express a significant preference towards their mothers. This is further supported for the women in the research group by an increased expression of negative feelings towards the father. When incoming feelings are considered there are no significant differences for men but the research women think they experienced more negative feelings coming from their fathers whereas the reverse is true of the control group. All four significant findings therefore point to better relationships with the mother than the father for the research groups, this being a more consistent finding for the women.

A sex difference is in evidence here, all groups suggesting the men experience more positive feelings from the mother than the women (p at least $<.01$).

4. Relationship with siblings: because of the numbers involved it was not feasible to look at relationships with individual siblings such as older or younger - group data could be used only. In these cases total positive and negative involvement is considered only.

Table 21

Relationship with Siblings

	MR	MC	WR	WC
Positive	200	107	164	170
Negative	228	128	117	158
X^2	.05		2.35	
p	ns		ns	

No difference was seen between positive and negative feelings to the siblings between the research and control groups which would seem to contra-indicate the likelihood of sibling rivalry contributing to sexual maladjustment.

5. Attitudes to self: the number of feelings ascribed to the self was rather small for all groups and there were few differences between the research and control groups in either the total involvement or the direction of it.

Table 22

Attitude to 'self'

		MR	MC	WR	WC
Total positive to self	IN	2	2	11	6
	OUT	16	22	9	6
Total negative to self	IN	0	1	0	0
	OUT	21	9	20	20

When total involvement is considered the control men are found to express significantly more positive attitudes to themselves than the research men ($X^2 = 4.16$, $p<.05$); this was not true of the women.

6. Overprotection or overindulgence: the frequency of allocation of cards indicating maternal overprotection and maternal and paternal overindulgence is shown for the research and control groups.

Table 23

Allocation of cards indicating overprotection and overindulgence

a) MEN	Nobody		Self		Father		Mother		Siblings		Others	
	MR	MC	MR	MC	MR	MC	MR	MC	MR	MC	MR	MC
Maternal Overprotection	67	78	49	46	19	12	14	3	78	43	0	2
Paternal Overprotection	82	74	1	4	3	0	7	10	28	13	2	0
Maternal Overindulgence	76	66	12	16	5	4	5	0	63	19	2	1
b) WOMEN	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC
Maternal Overprotection	83	106	36	35	8	7	0	2	52	31	3	0
Paternal Overprotection	78	66	6	8	1	1	4	3	11	13	0	1
Maternal Overindulgence	71	83	2	3	4	3	0	1	24	11	1	0

The areas investigated here were the difference in the degree of over-protection or indulgence to self between the research and control groups and between self and siblings for all groups which showed:

a) the men tended to see themselves as more overprotected and overindulged by their mothers than did the women but there were no differences between the research and control groups for each sex.

b) self v siblings - no significant differences were found between the women

research and control groups but the men showed a strong tendency to see their siblings as more overprotected and overindulged than themselves particularly for maternal overindulgence ($p<.01$). The research men and to a lesser extent the research women see their siblings as more overprotected and overindulged than do the control group.

7. Personality strength and weakness:

Table 24

Personality strength and weakness

a) MEN	Nobody		Self		Father		Mother		Siblings		Others	
	MR	MC	MR	MC	MR	MC	MR	MC	MR	MC	MR	MC
Personality strength	22	8	1	3	32	56	31	37	5	8	1	4
Personality weakness	54	67	3	6	32	8	4	4	8	20	1	1
b) WOMEN	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC	WR	WC
Personality strength	17	7	2	4	46	55	34	43	4	5	4	4
Personality weakness	62	63	7	3	14	6	13	18	4	11	0	0

The numbers were too small for significant comparisons in attitude to self. All groups are seen to be more likely to ascribe feelings of personality strength rather than personality weakness, and both sexes ascribed a greater number of items indicating personality strength to father than mother. The men and women in the research group were more likely to see their fathers as weak than their counterparts in the control group but this finding did not reach significance. The women in both groups appeared to see more evidence of weakness in their mothers than did the men.

8. Indices of positive feeling: since the main significant findings related to the relationship with the parents and in fact this was the main area of interest of the study it seemed advisable to use a more sophisticated manner of looking at the relationships. An index of positive feelings to each parent was worked out for each individual as follows:

$$\text{Index of positive involvement, } I+ = \frac{n\,(pos) - n\,(neg)}{n\,(pos + neg)} \times 100$$

A further calculation was done to investigate the degree of greater positive involvement, Ip, with the parent of the opposite sex:

I+ (mother) minus I+ (father) for MR and MC

I+ (father) minus I+ (mother) for WR and WC

Means and standard deviations were calculated for all groups and are shown in table 25.

Table 25

Means of indices of positive feelings to parents

	I+(F)				I+(M)				Ip (pref opp sex P)			
	MR	MC	WR	WC	MR	MC	WR	WC	MR	MC	WR	WC
Mean	2.24	24.2	14.85	56.88	30.22	46.63	47.50	31.30	34.96	30.7	-28.2	23.89
S.D.	59.86	69.25	71.32	42.22	47.4	50.67	42.96	44.47	70.94	80.21	43.96	43.96
't'												2.95
p		ns		ns		ns		ns		ns		<.01

When the index of preference for the opposite sex parent was considered the means were positive in all cases except the women research group where they differed very significantly from their control counterparts ($p < .01$), suggesting they were more positively involved with their mothers than their fathers. The results all showed immense individual variation and therefore high standard deviations. This was sometimes caused by one or two individual cases with highly divergent results. For example the range in the case of Ip for the control men was -66 to 200, and for the research men -124 to 200.

Both the men and women research groups showed less positive involvement with their fathers than the control groups; this trend being seen also for the men's involvement with mother. Although not significant differences the consistency of the trend suggests stronger positive relationships among the control groups. The research women on the other hand showed the opposite trend towards their mothers and when the index of preference for the opposite sex parent was calculated for each individual the mean for the research women was the only negative one indicating they were more positively involved with their mothers. This was significantly different from the control women. The results showed immense variation however; for example the range in the case of Ip for the control men was -66 to 200 and for the research men -124 to 200. This meant the standard deviations were very high although sometimes caused by one or two individuals with highly divergent scores.

The Mann-Whitney test was applied to the scores. This is said to be one of the most powerful non-parametric tests to test differences between results obtained by two independent groups.

The following results were obtained by applying this test to the three sets of results $I+_F$, $I+_M$ and I+p.

Table 26

Mann-Whitney test applied to indices of positive involvement

a) Positive involvement with Father:

MR v MC-No significant difference between MR and MC
WR v WC-Control group show greater $I+_F$ than the research women ($p<.05$)

b) Positive involvement with Mother:

MR v MC-No significant difference between MR and MC
WR v WC-No significant difference between WR and WC

c) Preference for parent of opposite sex:

MR v MC-Control group show significantly greater positive involvement with M than F than the research group ($p<.02$)
WR v WC-Control group show significantly greater positive involvement with F than M than the research group ($p<.002$)

This second analysis of the results confirms the research women's poor relationship with the father and the lesser positive involvement on the part of the research men also reaches significance here when I+p is tested.

Summarising, from this section it appears that both research groups express a greater preference for their mothers than their fathers. In fact sections 3 and 8 give evidence of the research women having particularly poor relationships with their fathers. The men in both groups seemed to feel more positive feeling and degree of overprotection from their mothers compared with the women. The research men were more likely to see their fathers as weak, suggesting again a more positive relationship to the mother. There was no evidence to suggest the relationships with siblings or other relatives contributed to sexual maladjustment.

Repertory Grid Technique:

This proved to be a useful technique for eliciting differences between the groups but it involved a vast number of calculations and cumbersome results. For individual patients a graph could be easily made to illustrate the construct levels and mean graphs were prepared for each group. These are included in the results (pages 69 - 80) and will illustrate immediately the lack of consistency in the construing of the research group women compared with the other groups. From the results Like me, Ideal self, Like partner and Like people with sex problems were used as elements and means and standard deviations calculated for each of the remaining constructs, i.e. happy, anxious, guilty, aggressive, self-confident and like mother and father. The interrelationship of the constructs chosen as elements is also investigated and illustrated. The data is presented in two sections - the first shows the means and standard deviations for each group on the chosen elements. 't' tests were applied to measure the significance of difference if any between the research and control groups for each sex and the results, plus the level of confidence shown by this, given where the differences are significant. Graphs are shown for each of the four main elements illustrating the differences between groups; where this is significant the more extreme of the two measures is circled.

The second section deals with intra-group differences and investigates differences on the constructs between the elements of each group in turn. For example the ways in which self and ideal self are construed by each group are looked at to see if there are differences on the constructs such as happy and anxious. Although one could perhaps hypothesise that the control group would see themselves as more similar on 'happy' to their ideal self, than the research group, no assumptions were made regarding the direction of any expected differences and hence two-tailed tests of significance are used throughout. The significance of differences is noted in the tables and the direction and interpretations of them included in the text.

Table 27

Results of Grids - Means, Standard Deviations and 't' tests for each group

1. LIKE ME

	HAPPY	ANXIOUS	GUILTY	LIKE M	LIKE F	AGGRESSIVE	IDEAL SELF	LIKE PARTNER	SEX PROBLEMS	CONFIDENT
MR	.37 ±.52	-.28 ±.43	-.30 ±.54	.35 ±.53	.39 ±.55	-.22 ±.56	.47 ±.43	.42 ±.47	-.29 ±.52	.08 ±.49
MC	.59 ±.39	.52 ±.45	.54 ±.40	.50 ±.45	.44 ±.52	.43 ±.34	.68 ±.28	.62 ±.31	-.51 ±.36	.43 ±.37
't'	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
p	-	-	-	-	-	-	-	-	-	-
WR	.04 ±.60	.08 ±.54	-.09 ±.58	.37 ±.36	.31 ±.42	-.06 ±.47	.28 ±.44	.34 ±.45	.15 ±.48	-.17 ±.67
WC	.50 ±.26	-.37 ±.35	-.40 ±.36	.32 ±.51	.27 ±.38	-.34 ±.35	.61 ±.33	.47 ±.31	-.46 ±.30	.24 ±.47
't'	3.15	3.13	2.03	ns	ns	2.14	2.68	ns	4.82	2.26
p	<.01	<.01	<.05	-	-	<.05	<.02	-	<.001	<.05

Table 28

Means, Standard Deviations and 't' tests

2. IDEAL SELF

	HAPPY	ANXIOUS	GUILTY	LIKE M	LIKE F	AGGRESSIVE	IDEAL SELF	LIKE PARTNER	SEX PROBLEMS	CONFIDENT
MR	.57 ±.30	-.49 ±.37	-.59 ±.26	.43 ±.47	.30 ±.57	-.51 ±.39		.72 ±.19	-.36 ±.44	.27 ±.50
MC	.63 ±.26	-.63 ±.31	-.64 ±.34	.54 ±.34	.36 ±.60	-.55 ±.25		.66 ±.46	-.69 ±.27	.53 ±.31
't'	ns	ns	ns	ns	ns	ns		ns	2.86	ns
p	-	-	-	-	-	-		-	<.01	-
WR	.47 ±.48	-.45 ±.45	-.52 ±.32	.13 ±.51	.06 ±.54	-.42 ±.38		.26 ±.57	-.35 ±.57	.37 ±.41
WC	.49 ±.38	-.45 ±.47	-.53 ±.32	.16 ±.46	.19 ±.56	-.53 ±.40		.63 ±.26	-.59 ±.25	.42 ±.40
't'	ns	ns	ns	ns	ns	ns		2.66	ns	ns
p	-	-	-	-	-	-		<.02	-	-

Table 29

Means, Standard Deviations and 't' tests

3. LIKE PARTNER

	HAPPY	ANXIOUS	GUILTY	LIKE M	LIKE F	AGGRESSIVE	IDEAL SELF	SEX PROBLEMS	CONFIDENT
MR	.62 ±.33	-.59 ±.52	-.57 ±.31	.39 ±.56	.34 ±.63	-.51 ±.45			.13 ± .50
MC	.70 ±.25	-.55 ±.52	-.50 ±.59	.56 ±.39	.32 ±.56	-.51 ±.43			.33 ±.43
't'	ns	ns	ns	ns	ns	ns			ns
p	-	-	-	-	-	-			-
WR	-.23 ±.52	-.20 ±.50	-.23 ±.45	.08 ±.58	.31 ±.45	-.19 ±.46			-.03 ±.52
WC	.34 ±.43	-.28 ±.49	-.38 ±.35	.16 ±.51	.09 ±.54	-.40 ±.32			.37 ±.39
't'	3.78	ns	ns	ns	ns	ns			2.75
p	<.001	-	-	-	-	-			<.01

Table 30

Means, Standard Deviations and 't' tests

4. SEX PROBLEMS

	HAPPY	ANXIOUS	GUILTY	LIKE M	LIKE F	AGGRESSIVE	IDEAL SELF	SEX PROBLEMS	CONFIDENT
MR	-.27 ±.46	.30 ±.46	.33 ±.33	.02 ±.52	.08 ±.56	.10 ±.49			-.42 ±.40
MC	-.54 ±.30	.64 ±.24	.54 ±.33	-.37 ±.39	-.24 ±.60	.47 ±.32			-.47 ±.35
't'	2.20	2.93	2.01	2.82	1.7	2.85			ns
p	<.05	<.01	-	<.01	-	<.01			-
WR	-.30 ±.42	.41 ±.43	.26 ±.47	.07 ±.57	.08 ±.46	.06 ±.51			-.53 ±.37
WC	-.54 ±.32	.51 ±.35	.46 ±.38	-.12 ±.50	.00 ±.49	.50 ±.33			-.46 ±.38
't'	2.03	ns	ns	ns	ns	3.24			ns
p	<.05	-	-	-	-	<.01			-

SECTION II

Table 31

Differences between elements, i.e. self, partner etc. on the constructs of happy, anxious etc. for all groups. The level of significance of any differences found is shown only.

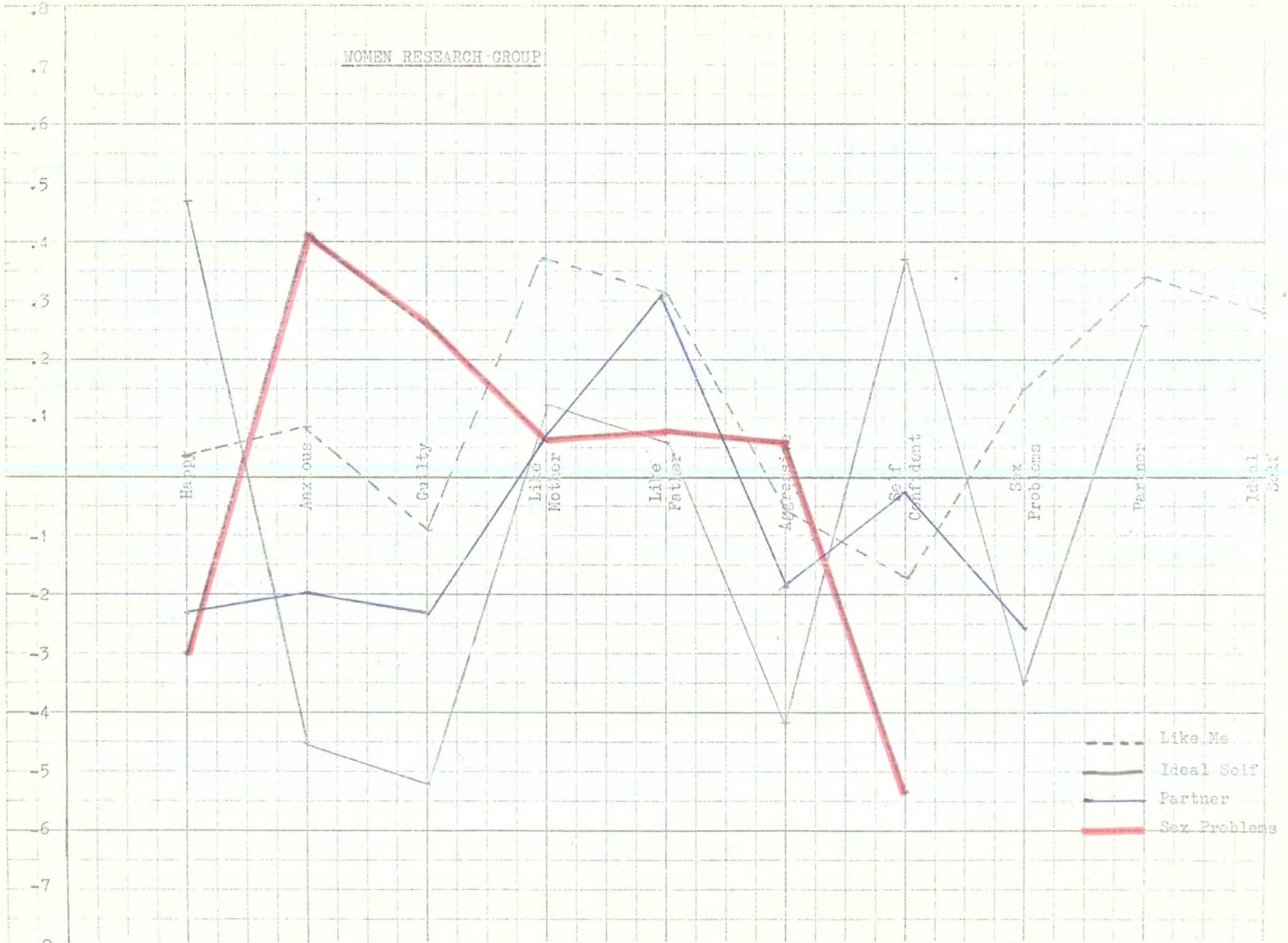
		H	A	G	LM	LF	Ag	IS	LP	SP	C
Like Me v Ideal Self	MR	-	-	-	-	-	-	-	.05	-	-
	MC	-	-	-	-	-	-	-	-	-	-
	WR	.05	.01	.01	.01	-	.05	-	-	.01	.01
	WC	-	-	-	-	-	-	-	-	-	-
Like Me v Partner	MR	-	.05	.05	-	-	-	.05	-	-	-
	MC	-	-	-	-	-	-	-	-	-	-
	WR	-	-	-	-	-	-	-	-	.02	-
	WC	-	-	-	-	-	-	-	-	-	-
Like Me v Sex Problems	MR	.001	.001	.001	-	-	-	.001	-	-	.001
	MC	.001	.001	.001	.001	.001	.001	.001	.001	-	.001
	WR	-	.05	.05	-	-	-	.001	.001	-	-
	WC	.001	.001	.001	.02	-	.001	.001	.001	-	.001

Table 31 (cont'd)

SECTION II (cont'd)

		H	A	G	LM	LF	Ag	IS	LP	SP	C
Ideal Self v Partner	MR	-	-	-	-	-	-	-	-	-	-
	MC	-	-	-	-	-	-	-	-	-	-
	WR	.001	.005	.05	-	-	.001	-	-	-	.02
	WC	-	-	-	-	-	-	-	-	-	-
Ideal Self v Sex Problems	MR	.001	.001	.001	.02	-	.001	-	.001	-	.001
	MC	.001	.001	.001	.001	.01	.001	-	.001	-	.001
	WR	.001	.001	.001	-	-	.01	-	.01	-	.001
	WC	.001	.001	.001	-	-	.001	-	.001	-	.001
Partner v Sex Problems	MR	.001	.001	.001	.05	-	.001	.001	-	-	.001
	MC	.001	.001	.001	.001	.01	.001	.001	-	-	.001
	WR	-	.001	.01	-	-	-	.01	-	-	.01
	WC	.001	.001	.001	-	-	.001	.001	-	-	.001

MEN RESEARCH GROUP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Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Like Me
Ideal Self
Partner
Sex Problems

MEN CONTROL GROUP
Like Me
Ideal Self
Partner
Sex Problems
Hardy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Ideal Self
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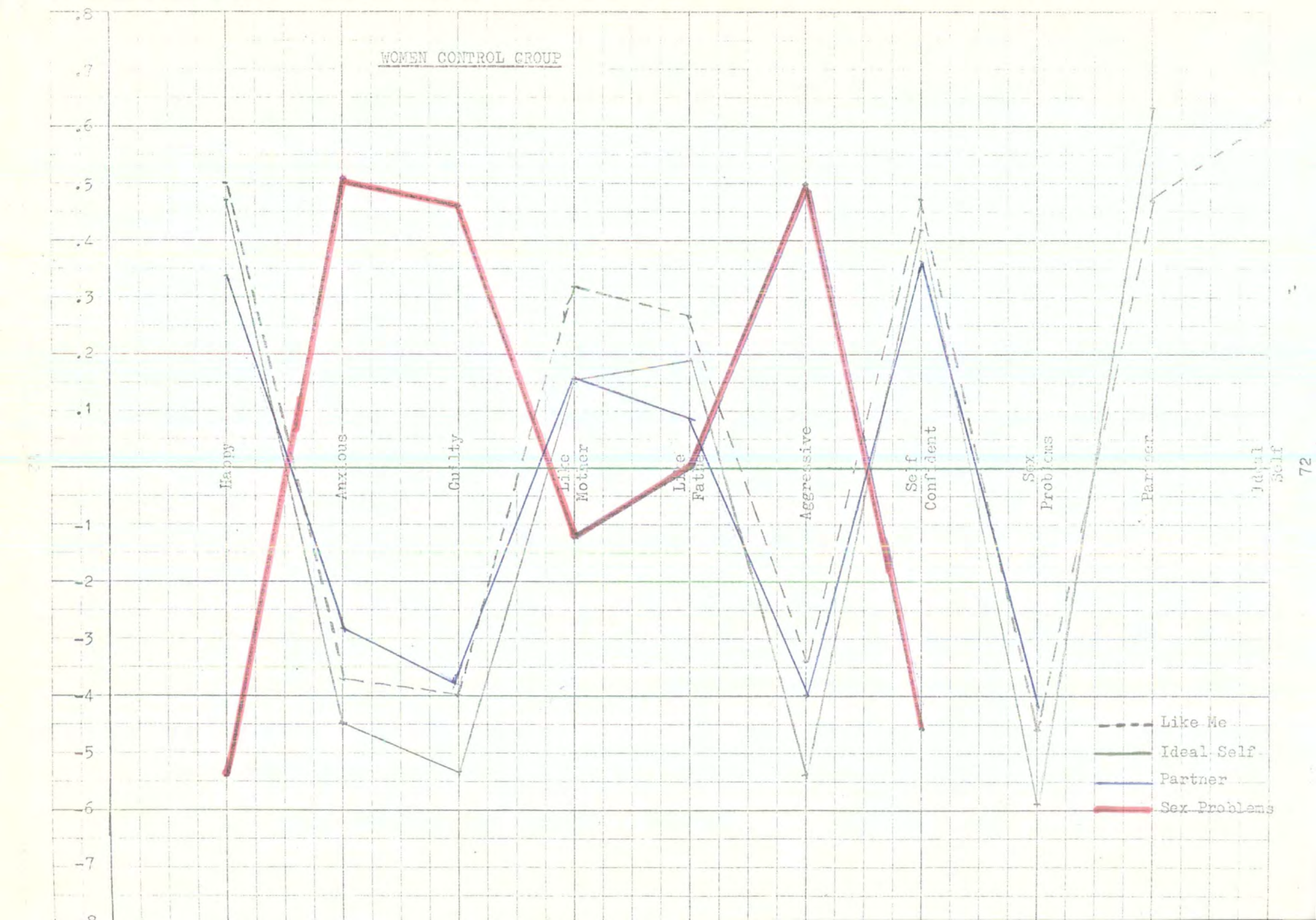
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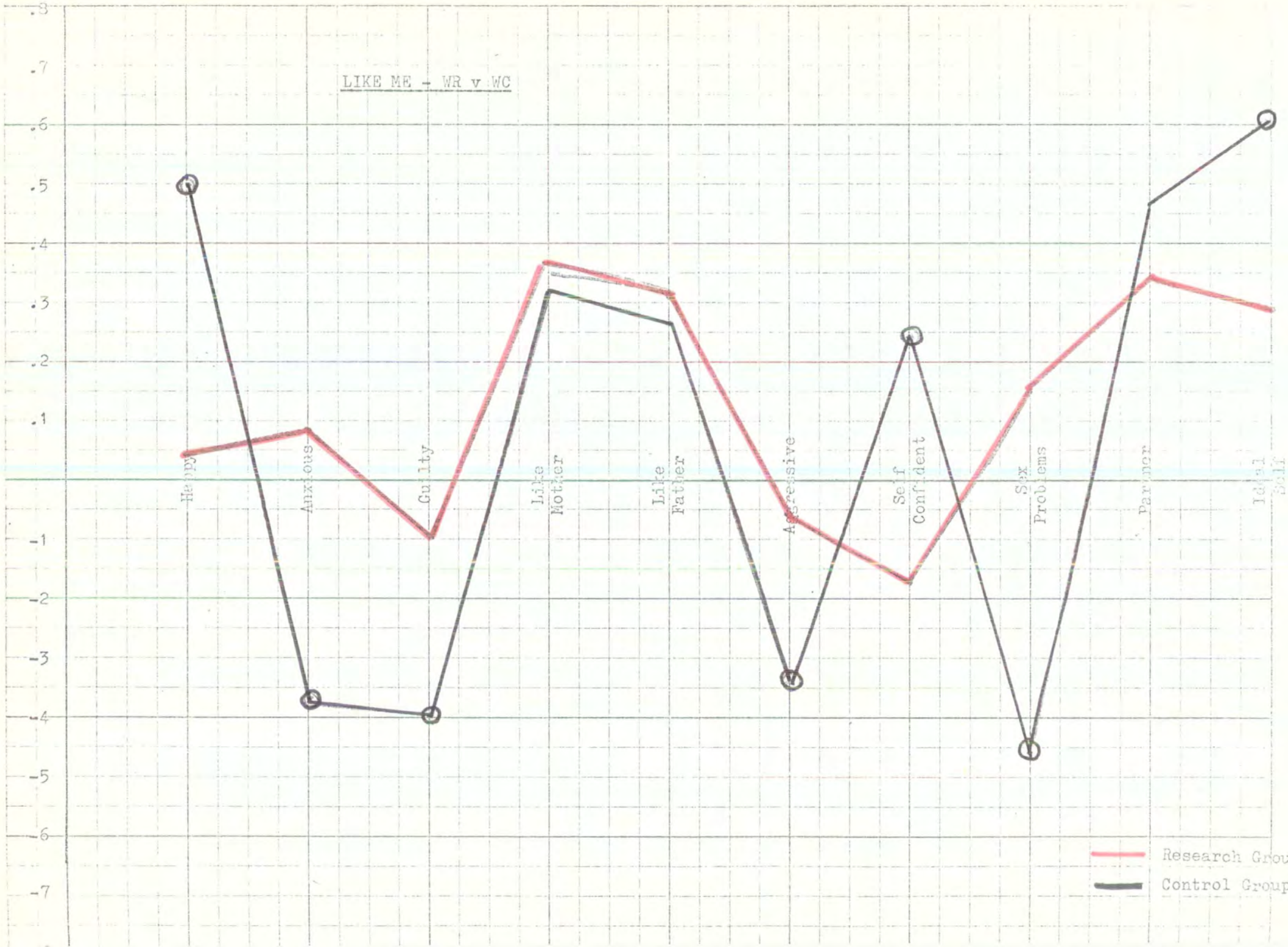
-6
-7
-8
Happy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Ideal Self
Like Me
Ideal Self
Partner
Sex Problems

LIKE ME - MR v MC

Research Group
Control Group

Happy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Perfect


LIKE ME - WR v WC
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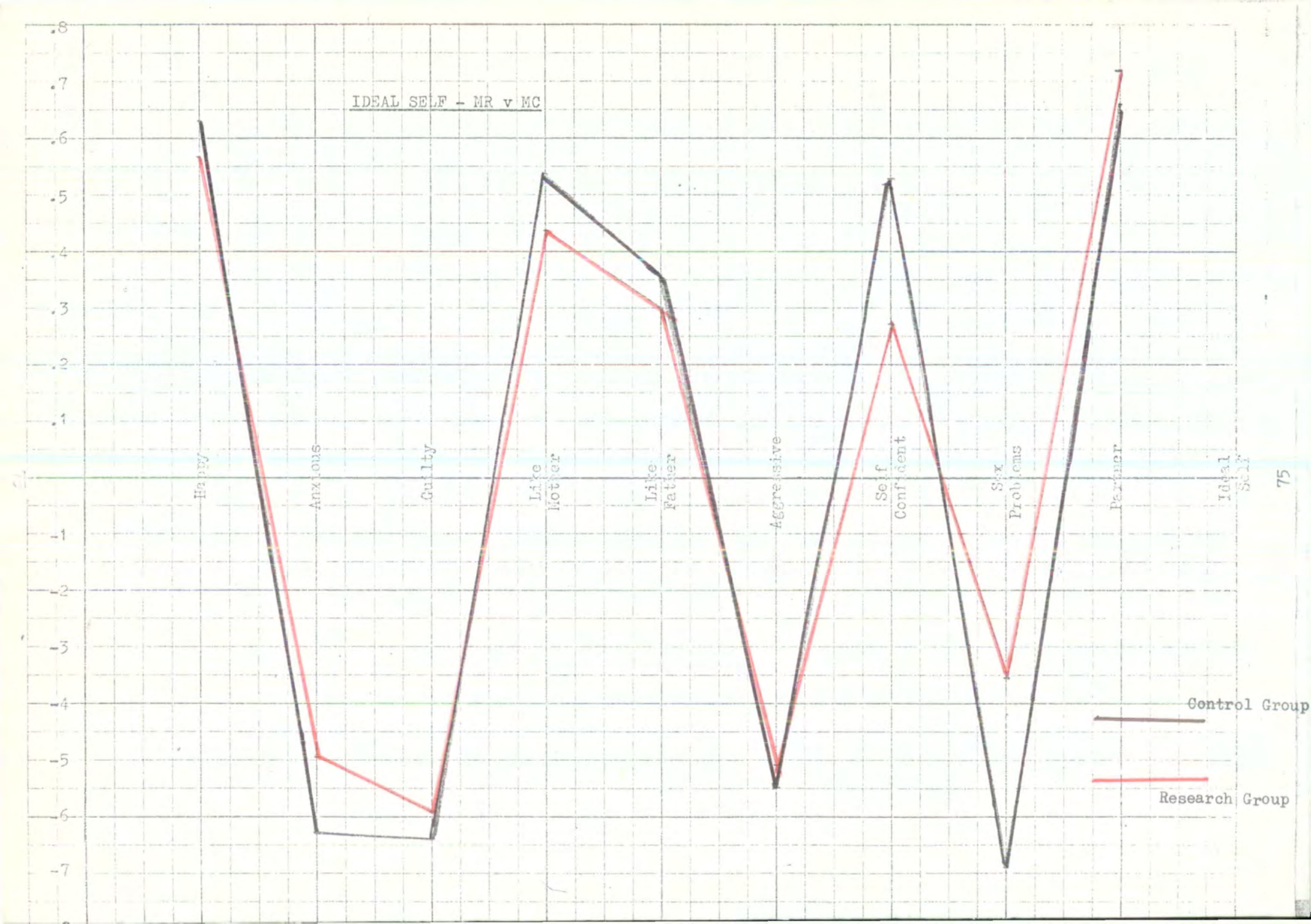
Happy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Ideal Self
Research Group
Control Group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-1
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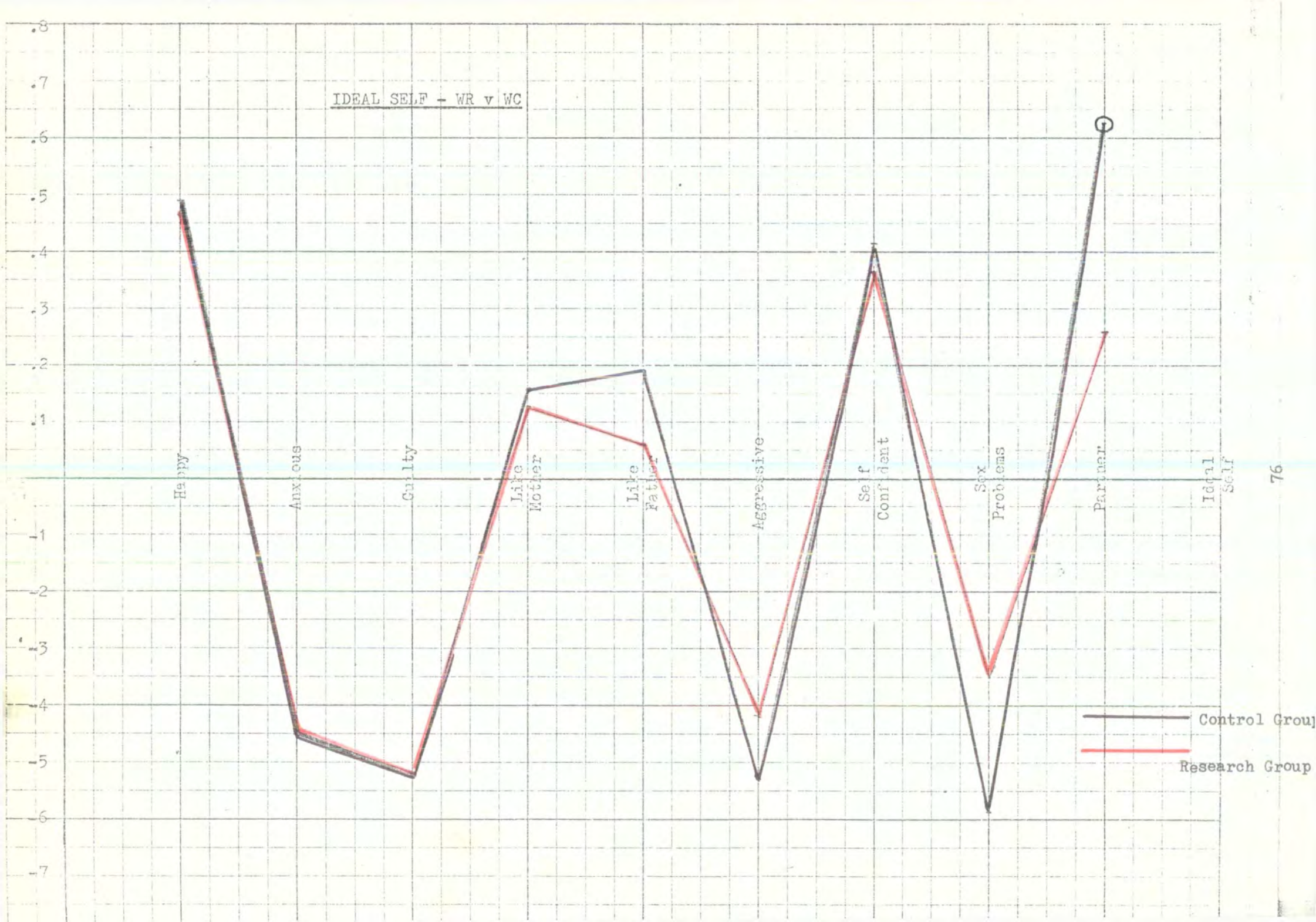
-5
-6
-7
Happy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Ideal Self
Control Group
Research Group


IDEAL SELF - WR v WC
Happy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Ideal Self
Control Group
Research Group

Control Group

Research Group

PARTNER - MC v MR

Happy

Anxious

Guilty

Like Mother

Like Father

Aggressive

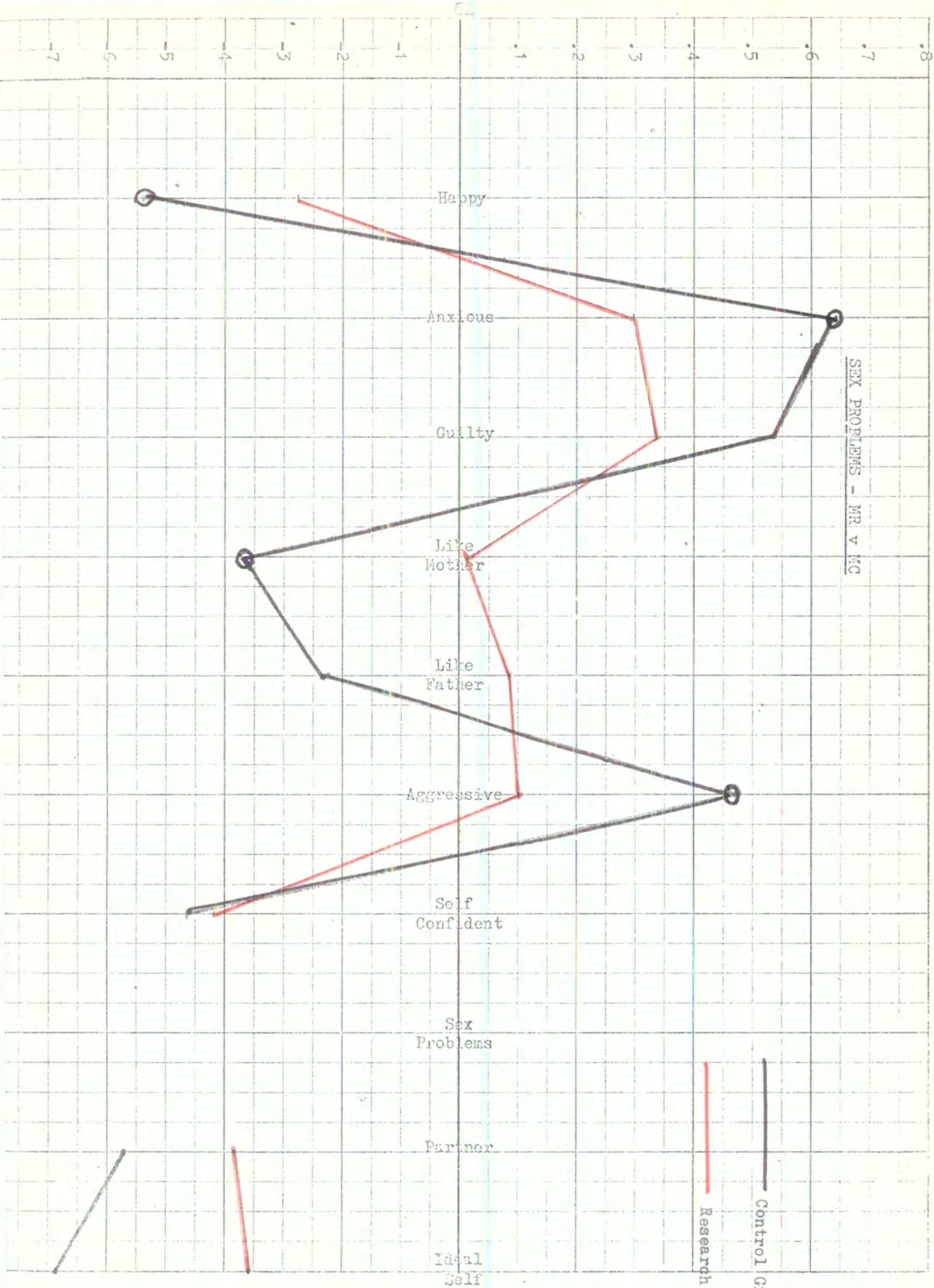
Self Confident

Sex Problems

Ideal Self

.8 .7 .6 .5 .4 .3 .2 .1 1 2 3 4 5 6 7

PARTNER -- WR v WC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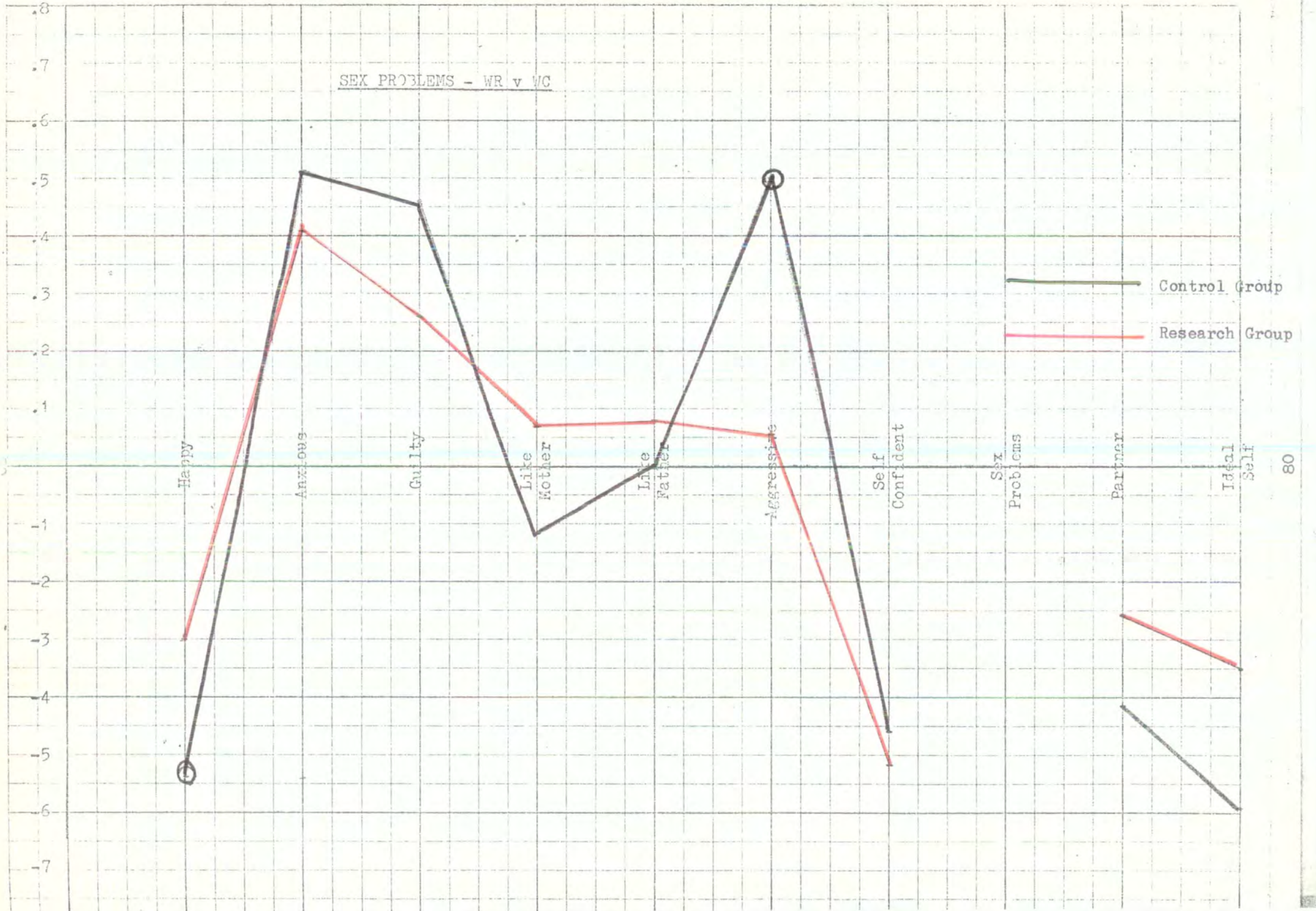
Happy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Ideal Self
SEX PROBLEMS - MR v MC
Research Group
Control Group


SEX PROBLEMS - WR v WC
Control Group
Research Group
Happy
Anxious
Guilty
Like Mother
Like Father
Aggressive
Self Confident
Sex Problems
Partner
Ideal Self
80

Discussion of Repertory Grid results

Men - Section I results

a) Like Me: the way in which the subjects in each group saw or construed themselves is seen by these results. If the positive poles of happy, not anxious, not guilty, like mother and father, not aggressive, similar to one's ideal self and one's partner, not having sex problems and being self-confident are considered then the control men see themselves consistently in a more positive light. The trend is only significant however for self-confidence, the control group being significantly more self-confident.

b) Ideal Self: again there is a trend for the control men to have a more strongly positive image of their ideal self but the only significant difference is on the wish not to be like people with sex problems. This is perhaps due to the research group being patients at a psychosexual disorder clinic and it is known that people do not like to have too conflicting attitudes - one could assume that the gap between one's ideal self and people with sexual problems is narrower for this group because of compensatory attitudes.

c) Like Partner: both groups appear to have similar and positive views of their partners' personalities.

d) Like People with Sex Problems: here some significant differences are seen. The research group do not see people with sex problems in quite such a negative way as the control men who tend to have more extreme attitudes; again presumably a result of the control group's non-identification with this category. Both agree on groups construing sexual problems as being related to lack of confidence.

Section II results

When we look at the differences within each group between the way the individual construes himself and others we see that there is little difference for the control or research groups in the way they construe themselves and their ideal self, the only significant differences being on like partner, the research group seeing their ideal self as more like their partner than themselves. The research group construe their partners as rather less anxious and guilty than themselves whereas the control group see themselves as very similar in all respects

to their partners.

Both groups saw large discrepancies between themselves and people with sex problems, the differences again being less marked for the research group. Ideal self and partner are construed as very similar by both groups and both as dissimilar to people with sex problems.

Women - Section I results

a) Like Me: the trend for the research group to construe themselves less positively is more marked when the women are considered. The control group see themselves as significantly more happy, less anxious, guilty and aggressive, more confident and more like their ideal self and less like people with sexual problems. The research group appear therefore to be more dissatisfied with their personalities, which reflects a poorer self-image.

b) Ideal Self: this is construed remarkably similarly, in fact almost identically by both groups - the only significant difference being on like partner, suggesting the research group admires their partners less.

c) Partner: the research group construes their husbands or boyfriends as significantly less happy and less self-confident than the control group.

d) Sex Problems: both groups see people with sex problems in a fairly similar way, the control group construing them as more unhappy and more aggressive than the research group. All see them as rather guilty, anxious and lacking confidence.

Section II results

A very noticeable difference occurs when we look at the different ways in which the women construe themselves and their ideal self. The research group see a disparity in all the adjectival constructs - they are less than their ideal on happiness, lack of guilt, anxiety, aggression, sex problems and confidence. They appear therefore to be significantly less satisfied with their own personalities. There are no differences between how they see themselves and their partners except for sex problems where the research group see their husbands/lovers as being less unlike those with sexual problems. (Note: this is a

relative difference only - the research group do not actually see their partners as being similar to those with sex problems).

Neither group sees themselves as similar in personality to those with sex problems - the difference again being more marked for the control group.

There is further evidence of lack of admiration for the partners of the research group in the disparities seen between the way they construe their ideal self and the partner's personality. This is consistently significant for the adjectival constructs which is not the case at all for the control group.

Both groups see similar differences between their ideal self and people with sex problems; to a lesser extent they see differences between their partners and people with sex problems, the research group not seeing them as significantly happier or less aggressive than such people.

3. Sex differences:

Like Me: there appear to be no sex differences between the control groups but the research women see themselves as more anxious ($P<.05$) and guilty and less self-confident than the men in the research group. They also see themselves as more similar to people with sex problems. This would seem to confirm the poorer self-image seen compared with the control group - they also seem to have a poorer self-image than men with similar problems.

Ideal Self: it has already been noted that the ideal self is very similar for research and control groups. There is also a close similarity across the sexes, suggesting considerable 'commonality' of the construct ideal self for all groups; the only noticeable difference being on like mother, like father which suggests the men tend to admire their parents, particularly the mother more than women do ($p<.001$, for MC v WC on like mother).

Like Partner: the men tend on the whole to see their partners in a more positive or admiring way than do the women. This is significantly true for all groups on happy ($p<.001$ MR v WR. $<.01$ MC v WC) and for the research group only on anxious, guilty and aggressive, where the women consistently and significantly see their partners more so ($p<.05$). A sex difference is seen also on like mother, the men predictably seeing their partners as more like their mothers. ($p<.01$ for MC v WC). There seems to be no overall sex difference on like father though

the women in the research group see their partners as less like their fathers than do the control group.

Sex Problems: again there is a fair measure of agreement on how all groups construe people with sex problems. In this case the control men see such people as being less like their parents than do the control women.

4. Identification with parents:

The general conclusion for the above points and from examination of the group mean graphs is that the men have a more positive view of their parents, seeing greater and more consistent relationships between the parents and like me, ideal self and partner. The women seemed to have had less commonality of construct in this area. Only very slight and non-significant differences occur so no conclusions can be drawn about parental preference or identification

The 16 Personality Factor Test

Means and standard deviations of the sten scores of the sixteen primary factors and four second order factors of anxiety, extraversion, cortertia and independence were calculated for the four groups of twenty subjects.

Table 32 - Means and S.D's of 16 P.F. results

Factor		MR	MC	WR	WC
A - Reserved/outgoing	Mean	5.30	6.15	5.15	5.90
	S.D.	1.89	1.60	1.81	1.58
B - Less intelligent/more intelligent	Mean	5.60	6.30	6.60	6.70
	S.D.	2.30	1.13	2.01	1.41
C - Affected by feelings/emotionally stable	Mean	4.45	5.25	4.10	5.50
	S.D.	2.04	1.48	1.80	2.01
E - Humble/assertive	Mean	5.20	5.50	4.95	5.45
	S.D.	1.99	1.79	1.76	1.60
F - Sober/happy-go-lucky	Mean	4.15	5.20	3.80	5.15
	S.D.	1.80	1.58	2.30	1.98
G - Expedient/conscientious	Mean	5.10	4.85	4.70	4.90
	S.D	2.10	1.76	1.75	1.94
H - Shy/venturesome	Mean	3.95	5.80	4.70	5.15
	S.D.	1.80	1.36	1.92	1.63
I - Tough-minded/tender-minded	Mean	5.95	4.55	5.70	5.55
	S.D.	1.90	1.79	1.65	1.93
L - Trusting/suspicious	Mean	5.25	5.10	5.15	6.15
	S.D.	1.90	1.37	2.20	1.30
M - Practical/imaginative	Mean	5.50	4.45	6.15	5.35
	S.D.	1.99	1.50	2.32	1.26
N - Forthright/shrewd	Mean	5.95	4.80	6.10	4.25
	S.D.	1.70	2.38	1.65	1.44
O - Self-assured/apprehensive	Mean	7.00	5.05	6.25	5.30
	S.D.	1.68	2.01	2.44	2.31
Q_1- Conservative/experimenting	Mean	5.30	5.00	4.65	5.55
	S.D.	2.11	2.43	2.05	1.82
Q_2- Group-dependent/self-sufficient	Mean	7.35	5.95	7.05	6.05
	S.D.	1.72	1.36	1.87	1.76
Q_3- Undisciplined self-conflict/controlled	Mean	5.40	5.45	5.40	4.90
	S.D.	2.18	1.88	2.03	1.80
Q_4- Relaxed/tense	Mean	5.70	5.40	7.55	6.25
	S.D.	2.10	2.39	1.66	2.31

	MR		MC		WR		WC	
Anxiety	6.39	2.18	5.09	1.63	6.63	1.78	5.96	1.66
Extraversion	3.80	1.92	5.54	1.40	3.96	2.11	5.14	1.63
Cortertia	4.97	1.75	5.77	1.84	4.78	1.68	5.13	1.31
Independence	6.03	1.81	5.20	1.51	6.04	2.11	5.67	1.77

Mean profiles are shown for the groups of MR and MC, WR and WC, pages 86-89.

MEN

16 PF TEST PROFILE

Control
Research

FACTOR	Raw Score Form A	Raw Score Form B	Raw Score Total	Standard Score	LOW SCORE DESCRIPTION	HIGH SCORE DESCRIPTION
A					**RESERVED**, DETACHED, CRITICAL, ALOOF (Sizothymia)	**OUTGOING**, WARMHEARTED, EASY-GOING PARTICIPATING (Affectothymia, formerly cyclothymia)
B					**LESS INTELLIGENT**, CONCRETE-THINKING (Lower scholastic mental capacity)	**MORE INTELLIGENT**, ABSTRACT-THINKING, BRIGHT (Higher scholastic mental capacity)
C					**AFFECTED BY FEELINGS**, EMOTIONALLY LESS STABLE, EASILY UPSET (Lower ego strength)	**EMOTIONALLY STABLE**, FACES REALITY, CALM, MATURE (Higher ego strength)
E					**HUMBLE**, MILD, ACCOMMODATING, CONFORMING (Submissiveness)	**ASSERTIVE**, AGGRESSIVE, STUBBORN, COMPETITIVE (Dominance)
F					**SOBER**, PRUDENT, SERIOUS, TACITURN (Desurgency)	**HAPPY-GO-LUCKY**, IMPULSIVELY LIVELY, GAY, ENTHUSIASTIC (Surgency)
G					**EXPEDIENT**, DISREGARDS RULES, FEELS FEW OBLIGATIONS (Weaker superego strength)	**CONSCIENTIOUS**, PERSEVERING, STAID, MORALISTIC (Stronger superego strength)
H					**SHY**, RESTRAINED, TIMID, THREAT-SENSITIVE (Threctia)	**VENTURESOME**, SOCIALLY BOLD, UNINHIBITED, SPONTANEOUS (Parmia)
I					**TOUGH-MINDED**, SELF-RELIANT, REALISTIC, NO-NONSENSE (Harria)	**TENDER-MINDED**, CLINGING, OVER-PROTECTED, SENSITIVE (Premsia)
L					**TRUSTING**, ADAPTABLE, FREE OF JEALOUSY, EASY TO GET ALONG WITH (Alaxia)	**SUSPICIOUS**, SELF-OPINIONATED, HARD TO FOOL (Protension)
M					**PRACTICAL**, CAREFUL, CONVENTIONAL, REGULATED BY EXTERNAL REALITIES, PROPER (Praxernia)	**IMAGINATIVE**, ABSORBED UP IN INNER URGENCIES, CARELESS OF PRACTICAL (Autia) MATTERS, BOHEMIAN
N					**FORTHRIGHT**, NATURAL, ARTLESS, UNPRETENTIOUS (Artlessness)	**SHREWD**, CALCULATING, WORLDLY, PENETRATING (Shrewdness)
O					**SELF-ASSURED**, CONFIDENT, SERENE (Untroubled adequacy)	**APPREHENSIVE**, SELF-REPROACHING, WORRYING, TROUBLED (Guilt proneness)
Q_1					**CONSERVATIVE**, RESPECTING ESTABLISHED IDEAS, TOLERANT OF TRADITIONAL DIFFICULTIES (Conservatism)	**EXPERIMENTING**, LIBERAL ANALYTICAL, FREE-THINKING (Radicalism)
Q_2					**GROUP-DEPENDENT**, A "JOINER" AND SOUND FOLLOWER (Group adherence)	**SELF-SUFFICIENT**, PREFERS OWN DECISIONS, RESOURCEFUL (Self-sufficiency)
Q_3					**UNDISCIPLINED SELF-CONFLICT**, FOLLOWS OWN URGES, CARELESS OF PROTOCOL (Low integration)	**CONTROLLED**, SOCIALLY PRECISE, FOLLOWING SELF-IMAGE (High self-concept control)
Q_4					**RELAXED**, TRANQUIL, UNFRUSTRATED (Low ergic tension)	**TENSE**, FRUSTRATED, DRIVEN, OVERWROUGHT (High ergic tension)

STANDARD TEN SCORE (STEN)

Average

1 2 3 4 5 6 7 8 9 10

A sten of	1	2	3	4	5	6	7	8	9	10	*is obtained*
by about	2.3%	4.4%	9.2%	15.0%	19.1%	19.1%	15.0%	9.2%	4.4%	2.3%	*of adults*

Name:

Comments:

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WOMEN

16 PF TEST PROFILE

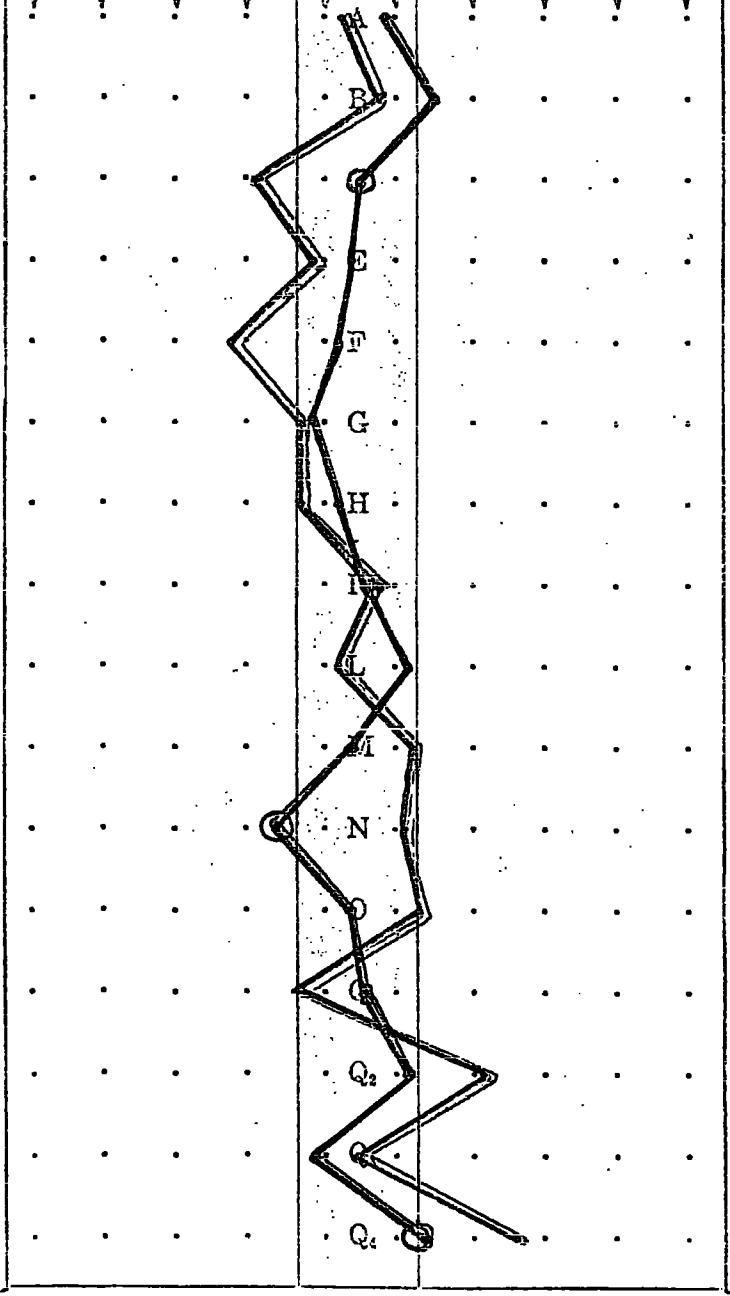
Control
Research

FACTOR	Raw Score Form A	Raw Score Form B	Raw Score Total	Standard Score	LOW SCORE DESCRIPTION	HIGH SCORE DESCRIPTION
A					**RESERVED,** DETACHED, CRITICAL, ALOOF (Sizothymia)	OUTGOING, WARMHEARTED, EASY-GOING, PARTICIPATING (Affectothymia, formerly cyclothymia)
B					**LESS INTELLIGENT,** CONCRETE-THINKING (Lower scholastic mental capacity)	MORE INTELLIGENT, ABSTRACT-THINKING, BRIGHT (Higher scholastic mental capacity)
C					**AFFECTED BY FEELINGS,** EMOTIONALLY LESS STABLE, EASILY UPSET (Lower ego strength)	EMOTIONALLY STABLE, FACES REALITY, CALM, MATURE (Higher ego strength)
E					**HUMBLE,** MILD, ACCOMMODATING, CONFORMING (Submissiveness)	**ASSERTIVE,** AGGRESSIVE, STUBBORN, COMPETITIVE (Dominance)
F					**SOBER,** PRUDENT, SERIOUS, TACITURN (Desurgency)	**HAPPY-GO-LUCKY,** IMPULSIVELY LIVELY, GAY, ENTHUSIASTIC (Surgency)
G					**EXPEDIENT,** DISREGARDS RULES, FEELS FEW OBLIGATIONS (Weaker superego strength)	**CONSCIENTIOUS,** PERSEVERING, STAID, MORALISTIC (Stronger superego strength)
H					**SHY,** RESTRAINED, TIMID, THREAT-SENSITIVE (Threctia)	VENTURESOME, SOCIALLY BOLD, UNINHIBITED, SPONTANEOUS (Parmia)
I					**TOUGH-MINDED,** SELF-RELIANT, REALISTIC, NO-NONSENSE (Harria)	TENDER-MINDED, CLINGING, OVER-PROTECTED, SENSITIVE (Premsia)
L					**TRUSTING,** ADAPTABLE, FREE OF JEALOUSY, EASY TO GET ALONG WITH (Alaxia)	**SUSPICIOUS,** SELF-OPINIONATED, HARD TO FOOL (Protension)
M					**PRACTICAL,** CAREFUL, CONVENTIONAL, REGULATED BY EXTERNAL REALITIES, PROPER (Praxernia)	**IMAGINATIVE,** WRAPPED UP IN INNER URGENCIES, CARELESS OF PRACTICAL (Autia) MATTERS, BOHEMIAN
N					**FORTHRIGHT,** NATURAL, ARTLESS, UNPRETENTIOUS (Artlessness)	**SHREWD,** CALCULATING, WORLDLY, PENETRATING (Shrewdness)
O					**SELF-ASSURED,** CONFIDENT, SERENE (Untroubled adequacy)	APPREHENSIVE, SELF-REPROACHING, WORRYING, TROUBLED (Guilt proneness)
Q_1					**CONSERVATIVE,** RESPECTING ESTABLISHED IDEAS, TOLERANT OF TRADITIONAL DIFFICULTIES (Conservatism)	**EXPERIMENTING,** LIBERAL ANALYTICAL, FREE-THINKING (Radicalism)
Q_2					**GROUP-DEPENDENT,** A "JOINER" AND SOUND FOLLOWER (Group adherence)	SELF-SUFFICIENT, PREFERS OWN DECISIONS, RESOURCEFUL (Self-sufficiency)
Q_3					**UNDISCIPLINED SELF-CONFLICT,** FOLLOWS OWN URGES, CARELESS OF PROTOCOL (Low integration)	**CONTROLLED,** SOCIALLY PRECISE, FOLLOWING SELF-IMAGE (High self-concept control)
Q_4					RELAXED, TRANQUIL, UNFRUSTRATED (Low ergic tension)	TENSE, FRUSTRATED, DRIVEN, OVERWROUGHT (High ergic tension)

STANDARD TEN SCORE (STEN)

Average

1 2 3 4 5 6 7 8 9 10



A sten of	1	2	3	4	5	6	7	8	9	10	is obtained
by about	2.3%	4.4%	9.2%	15.0%	19.1%	19.1%	15.0%	9.2%	4.4%	2.3%	of adults

Name:

Comments:

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RESEARCH GROUPS

16 PF TEST PROFILE

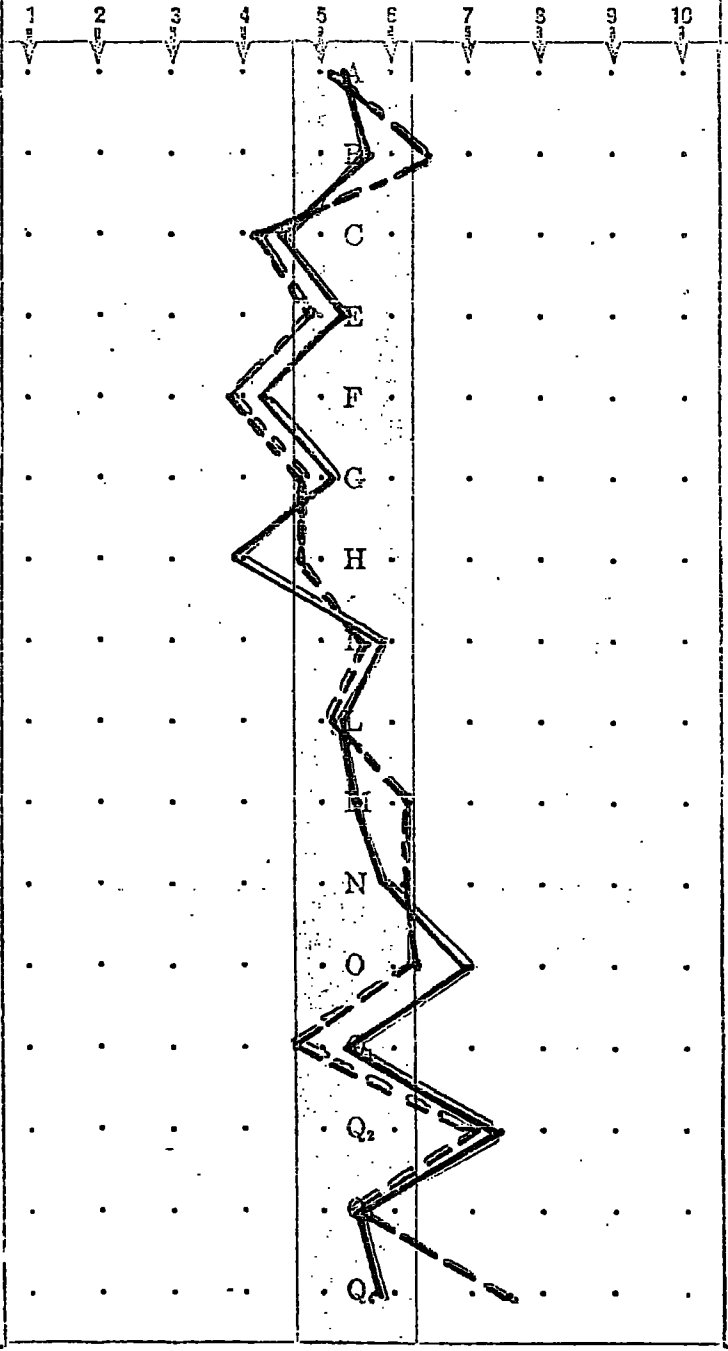
Men
Women

Name:_____

Comments:

FACTOR	Raw Score Form A	Raw Score Form B	Raw Score Total	Standard Score	LOW SCORE DESCRIPTION	HIGH SCORE DESCRIPTION
A					RESERVED, DETACHED, CRITICAL, ALOOF (Sizothymia)	OUTGOING, WARMHEARTED, EASY-GOING, PARTICIPATING (Affectothymia, formerly cyclothymia)
B					LESS INTELLIGENT, CONCRETE-THINKING (Lower scholastic mental capacity)	MORE INTELLIGENT, ABSTRACT-THINKING, BRIGHT (Higher scholastic mental capacity)
C					AFFECTED BY FEELINGS, EMOTIONALLY LESS STABLE, EASILY UPSET (Lower ego strength)	EMOTIONALLY STABLE, FACES REALITY, CALM, MATURE (Higher ego strength)
E					HUMBLE, MILD, ACCOMMODATING, CONFORMING (Submissiveness)	ASSERTIVE, AGGRESSIVE, STUBBORN, COMPETITIVE (Dominance)
F					SOBER, PRUDENT, SERIOUS, TACITURN (Desurgency)	HAPPY-GO-LUCKY, IMPULSIVELY LIVELY, GAY, ENTHUSIASTIC (Surgency)
G					EXPEDIENT, DISREGARDS RULES, FEELS FEW OBLIGATIONS (Weaker superego strength)	CONSCIENTIOUS, PERSEVERING, STAID, MORALISTIC (Stronger superego strength)
H					SHY, RESTRAINED, TIMID, THREAT-SENSITIVE (Threctia)	VENTURESOME, SOCIALLY BOLD, UNINHIBITED, SPONTANEOUS (Parmia)
I					TOUGH-MINDED, SELF-RELIANT, REALISTIC, NO-NONSENSE (Harria)	TENDER-MINDED, CLINGING, OVER-PROTECTED, SENSITIVE (Premsia)
L					TRUSTING, ADAPTABLE, FREE OF JEALOUSY, EASY TO GET ALONG WITH (Alaxia)	SUSPICIOUS, SELF-OPINIONATED, HARD TO FOOL (Protension)
M					PRACTICAL, CAREFUL, CONVENTIONAL, REGULATED BY EXTERNAL REALITIES, PROPER (Praxernia)	IMAGINATIVE, WRAPPED UP IN INNER URGENCIES, CARELESS OF PRACTICAL (Autia) MATTERS, BOHEMIAN
N					FORTHRIGHT, NATURAL, ARTLESS, UNPRETENTIOUS (Artlessness)	SHREWD, CALCULATING, WORLDLY, PENETRATING (Shrewdness)
O					SELF-ASSURED, CONFIDENT, SERENE (Untroubled adequacy)	APPREHENSIVE, SELF-REPROACHING, WORRYING, TROUBLED (Guilt proneness)
Q_1					CONSERVATIVE, RESPECTING ESTABLISHED IDEAS, TOLERANT OF TRADITIONAL DIFFICULTIES (Conservatism)	EXPERIMENTING, LIBERAL ANALYTICAL, FREE-THINKING (Radicalism)
Q_2					GROUP-DEPENDENT, A "JOINER" AND SOUND FOLLOWER (Group adherence)	SELF-SUFFICIENT, PREFERS OWN DECISIONS, RESOURCEFUL (Self-sufficiency)
Q_3					UNDISCIPLINED SELF-CONFLICT, FOLLOWS OWN URGES, CARELESS OF PROTOCOL (Low integration)	CONTROLLED, SOCIALLY PRECISE, FOLLOWING SELF-IMAGE (High self-concept control)
Q_4					RELAXED, TRANQUIL, UNFRUSTRATED (Low ergic tension)	TENSE, FRUSTRATED, DRIVEN, OVERWROUGHT (High ergic tension)

STANDARD TEN SCORE (STEN)



A sten of	1	2	3	4	5	6	7	8	9	10	is obtained
by about	2.3%	4.4%	9.2%	15.0%	19.1%	19.1%	15.0%	9.2%	4.4%	2.3%	of adults

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CONTROL GROUPS

16 PF TEST PROFILE

Men
Women

Name:

Comments:

FACTOR	Raw Score Form A	Raw Score Form B	Raw Score Total	Standard Score	LOW SCORE DESCRIPTION	STANDARD TEN SCORE (STEN) 1 2 3 4 5 6 7 8 9 10 (Average)	HIGH SCORE DESCRIPTION
A					RESERVED, DETACHED, CRITICAL, ALOOF (Sizothymia)		OUTGOING, WARMHEARTED, EASY-GOING, PARTICIPATING (Affectothymia, formerly cyclothymia)
B					LESS INTELLIGENT, CONCRETE-THINKING (Lower scholastic mental capacity)		MORE INTELLIGENT, ABSTRACT-THINKING, BRIGHT (Higher scholastic mental capacity)
C					AFFECTED BY FEELINGS, EMOTIONALLY LESS STABLE, EASILY UPSET (Lower ego strength)		EMOTIONALLY STABLE, FACES REALITY, CALM, MATURE (Higher ego strength)
E					HUMBLE, MILD, ACCOMMODATING, CONFORMING (Submissiveness)		ASSERTIVE, AGGRESSIVE, STUBBORN, COMPETITIVE (Dominance)
F					SOBER, PRUDENT, SERIOUS, TACITURN (Desurgency)		HAPPY-GO-LUCKY, IMPULSIVELY LIVELY, GAY, ENTHUSIASTIC (Surgency)
G					EXPEDIENT, DISREGARDS RULES, FEELS FEW OBLIGATIONS (Weaker superego strength)		CONSCIENTIOUS, PERSEVERING, STAID, MORALISTIC (Stronger superego strength)
H					SHY, RESTRAINED, TIMID, THREAT-SENSITIVE (Threctia)		VENTURESOME, SOCIALLY BOLD, UNINHIBITED, SPONTANEOUS (Parmia)
I					TOUGH-MINDED, SELF-RELIANT, REALISTIC, NO-NONSENSE (Harria)		TENDER-MINDED, CLINGING, OVER-PROTECTED, SENSITIVE (Premsia)
L					TRUSTING, ADAPTABLE, FREE OF JEALOUSY, EASY TO GET ALONG WITH (Alaxia)		SUSPICIOUS, SELF-OPINIONATED, HARD TO FOOL (Protension)
M					PRACTICAL, CAREFUL, CONVENTIONAL, REGULATED BY EXTERNAL REALITIES, PROPER (Proxernia)		IMAGINATIVE, WRAPPED UP IN INNER URGENCIES, CARELESS OF PRACTICAL (Autia) MATTERS, BOHEMIAN
N					FORTHRIGHT, NATURAL, ARTLESS, UNPRETENTIOUS (Artlessness)		SHREWD, CALCULATING, WORLDLY, PENETRATING (Shrewdness)
O					SELF-ASSURED, CONFIDENT, SERENE (Untroubled adequacy)		APPREHENSIVE, SELF-REPROACHING, WORRYING, TROUBLED (Guilt proneness)
Q_1					CONSERVATIVE, RESPECTING ESTABLISHED IDEAS, TOLERANT OF TRADITIONAL DIFFICULTIES (Conservatism)		EXPERIMENTING, LIBERAL ANALYTICAL, FREE-THINKING (Radicalism)
Q_2					GROUP-DEPENDENT, A "JOINER" AND SOUND FOLLOWER (Group adherence)		SELF-SUFFICIENT, PREFERS OWN DECISIONS, RESOURCEFUL (Self-sufficiency)
Q_3					UNDISCIPLINED SELF-CONFLICT, FOLLOWS OWN URGES, CARELESS OF PROTOCOL (Low integration)		CONTROLLED, SOCIALLY PRECISE, FOLLOWING SELF-IMAGE (High self-concept control)
Q_4					RELAXED, TRANQUIL, UNFRUSTRATED (Low ergic tension)		TENSE, FRUSTRATED, DRIVEN, OVERWROUGHT (High ergic tension)

A sten of	1	2	3	4	5	6	7	8	9	10	is obtained
by about	2.3%	4.4%	9.2%	15.0%	19.1%	19.1%	15.0%	9.2%	4.4%	2.3%	of adults

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MEN:

The following factors showed significant differences between the means of the research and control groups, the research group being more:

		Value of t	p
H-	shy, restrained, timid	3.67	<.01
I+	tenderminded, clinging, sensitive	2.40	<.05
O+	apprehensive, self-reproaching, guilt prone	3.33	<.01
Q_2+	self-sufficient, prefers own decisions	2.85	<.02
Anxious	(second order factor of anxiety)	2.13	<.05
Introverted	(second order factor of introversion)	3.27	<.01

WOMEN:

The women in the research group differed from the women control group in being more:

		Value of t	p
C-	affected by feelings, easily upset	2.32	<.05
N+	more shrewd, calculating, worldly	3.78	<.001
Q_4+	tense, frustrated, overwrought	2.36	<.05

There were no significant differences on any of the second order factors.

Discussion:

Personality factors appear to be more related to sexual dysfunction in men than in women. The men are more anxious and more introverted and the primary factors on which they differ from their controls are factors which contribute to these scales. Several other differences support this trend although they do not quite reach significance, notably A-, C- and F-. The women showed fewer differences and although again there was a trend towards more divergent scores on factors contributing to anxiety and introversion, none of the differences on the latter scales reached significance. The difference on factor N is interesting as it is supported by a trend on the men's scores. Factor N is not often mentioned in the literature - it is possibly associated with a calculating aspect of the personality which does not allow the individual to act in a spontaneous natural way which may interfere with sexual adjustment.

Perhaps a more interesting finding on the 16 P.F. is the similarity between the men and women in the research groups and control groups. The women in the research group have a remarkably close mean profile to the men - they are significantly different only on Q_4+ (tense, overwrought). The profiles suggest that

both men and women with sexual disorders are less stable emotionally (C-), more sober and serious (F-), more shy (H-), more apprehensive (O+) and more self-sufficient (Q_2), compared with the average. Between the control groups there are no differences on factors which appeared relevant to sexual dysfunction but the men score significantly lower on factors L ($t=2.49$, $p<.05$) suggesting they are more trusting than the women in the control group.

Mooney Problem Check List

The total number of problems in each area was calculated for each group. The number in brackets is the number of items which were circled in addition to underlined, i.e. seen as more serious problems. Since the numbers were low in many of the sections and the distribution was uneven it was not considered appropriate to calculate means and standard deviations, except for the total figures and the area of personality problems. 't' tests were applied to test the significance of these differences and are shown in table

Table 33

Number of problems underlined (circled)

	MR	MC	WR	WC
Health	48(9)	18(4)	58(13)	32(8)
Economic Security	15(1)	34(6)	25(2)	20(3)
Self-improvement	63(14)	42(5)	79(5)	68(15)
Personality	121(29)	81(17)	247(54)	108(30)
Home and Family	27(6)	47(24)	75(23)	32(14)
Courtship	20(7)	14(6)	21(6)	7(4)
Sex	34(18)	7(2)	43(18)	5(1)
Religion	13(2)	19(2)	20(2)	10(1)
Occupation	17(10)	20(10)	17(0)	11(3)
Totals	358(96)	282(76)	585(125)	293(79)

Table 34

Means and S.D's of total problems and personality problems

	Mean Total Problems			Mean Total Problems	
MR	17.9	16.02	WR	29.25	20.8
MC	14.1	7.76	WC	14.75	10.75
t	.95		t	2.77	
p	ns		p	<.01	
	Mean Personality Problems			Mean Personality Problems	
MR	6.05	5.3	WR	12.35	9.9
MC	4.05	2.96	WC	5.40	4.78
t	1.47		t	2.83	
p	ns		p	<.01	

Significant differences on both total number and personality problems are seen for the women, the research group reporting more than double the number of the control group. The control and research men underlined a fairly similar number to the control women but the difference between the groups of men was minimal though in the same direction.

In addition to differences between means it appeared that the areas of concern varied between the groups. Although for example problems associated with occupation were fairly evenly distributed across the groups, the research groups clearly and predictably experienced more worries about sex. Percentages of the

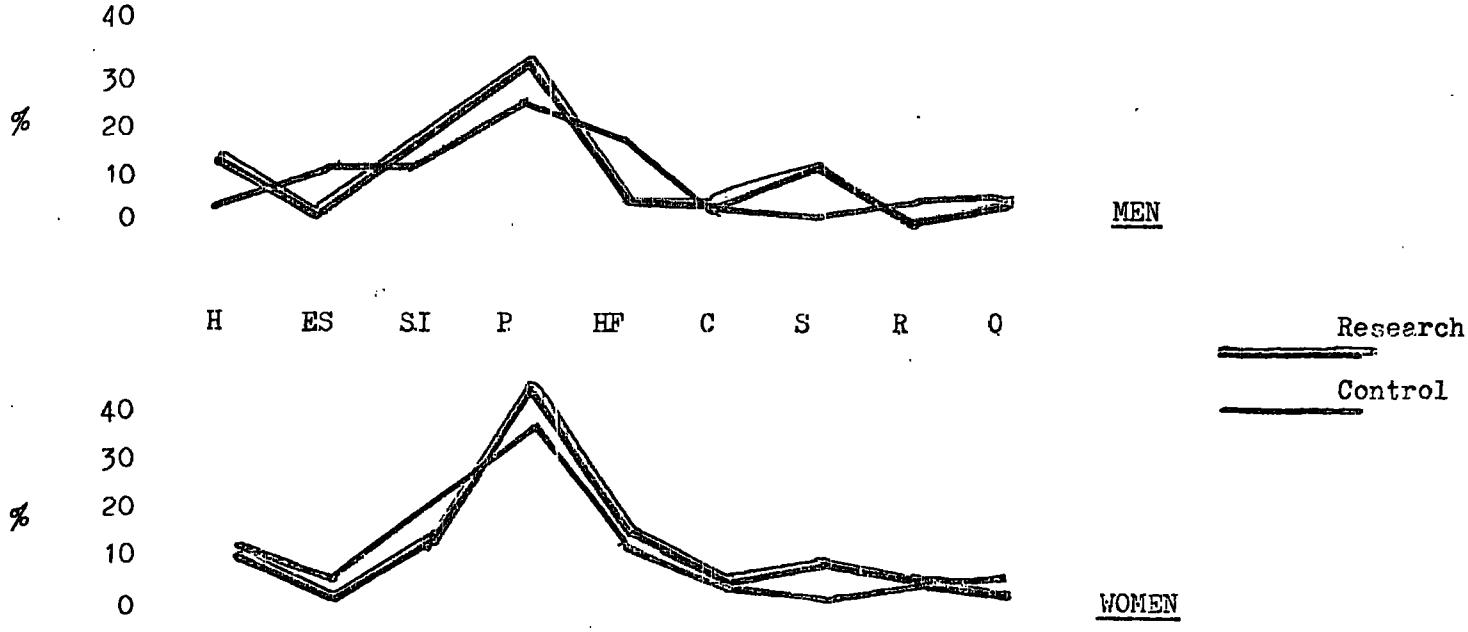
total number were calculated for each area of problems for each group. The figures used were the total numbers added to the circled numbers.

Table 35

	MR		MC		WR		WC	
	No	%	No	%	No	%	No	%
Health	57	12.6	22	6.1	71	10.0	40	10.8
Economic Security	16	3.5	40	11.2	27	3.8	23	6.2
Self-improvement	77	17.0	47	13.1	84	11.9	83	22.3
Personality	150	33.0	98	27.4	301	42.5	138	37.1
Home and Family	33	7.3	71	19.8	98	13.8	46	12.4
Courtship	27	5.9	20	5.6	27	3.8	11	3.0
Sex	52	11.4	9	2.5	61	8.6	6	1.6
Religion	15	3.3	21	5.9	22	3.1	11	3.0
Occupation	27	5.9	30	8.4	17	2.4	14	3.8

Fig. 1

Graphical Representation of Percentages of Problem Areas



These graphs illustrate that the variation between the groups is fairly small when percentage distribution rather than actual figures is considered. There seems therefore to be a considerable comparability about the areas in which people experience anxiety or problems, whether men or women or research or control group. Using a percentage basis reduced the differences between the research and control group on personality problems.

In most cases however the differences seem to follow a trend for the research men to have more problems in the areas of health, self-improvement, personality and sex, whereas the control men are more concerned about economic security and home and family. The women research group of course reported a considerably high number of problems overall but the trends seem to suggest a greater proportional concern over personality and sex whereas the control group are more concerned with self-improvement.

The main conclusion from this section must be that the research women report a considerably higher total number of problems which either reflects real problems or a higher dissatisfaction with their life. The fact that the distribution of problems is so similar for all groups perhaps suggests the latter explanation is more likely - they seem to have a lower threshold for expressing dissatisfaction.

VII DISCUSSION OF RESULTS

It was thought that all areas of this investigation had produced interesting and worthwhile data. An overall look at the findings particularly their relevance to other studies can most easily be discussed under two headings: a) experiential factors and b) personality factors.

a) Experiential aspects leading to sexual adjustment or maladjustment can be further divided into family background and the more specific sexual learning situation. Family position, sibling conflict, marital dysharmony of the parents, and separation or loss did not appear significant. There was strong evidence however to suggest the relationship with the father was very important for both sexes. Both patient groups markedly preferred mother and the women patients showed some strong negative feelings to their fathers whom they more often saw as weak and ineffectual. The differences were particularly marked for outgoing rather than incoming feelings. Both groups of men experienced more warmth from their mothers and thought they had been over-protected by them to a greater extent than did the women. In general the results support previous findings - they are very similar to Bene's findings with the homosexual groups and confirm Fisher's stress on the quality of the relationship with the father contributing to sexual adjustment in women.

During adolescence the patient group of men was notably different in having fewer friends and the women patients had significantly more sexually traumatic experiences. Both control groups were more likely to remember having had pleasurable early sexual experiences; such experiences being more frequent among the control groups. Schofield's finding that early sex education and sexual behaviour were not related was to a certain extent confirmed by this study. A comparable figure, 22%, had had no sex education. The patient group of women were more likely to have had menstrual problems which was not consistent with Fisher's findings. There seems therefore to be a slight, but consistent trend for the early sexual experiences where one's sexual self is learned about, to be fraught with more problems for the patient groups and there is some evidence to support Schofield's view that the inexperienced may be more likely to have difficulties. As the patient group experience more problems in their learning experiences this would seem to confirm Cauthery and Cole's view that

these shape one's sexual identity and confidence in one's sexual self.

b) There is evidence from the present study to support the importance also of personality variables in relation to sexual dysfunction. The men and women in the patient groups show a remarkable similarity in personality profiles, appearing to be more serious-minded, forthright and natural, apprehensive and self-sufficient than the control groups. These trends did not always reach significance for the men and women groups separately - in fact personality factors as seen on a standard personality test seemed more significant for men, who were seen to be more introverted and anxious - the former probably also being associated with their fewer friends and lesser early sex experience. Eysenck, Schofield and others have suggested that extraverts are more likely to have greater early sex experience which is in accord with this finding.

When the repertory grids are considered however, the women patient group appear to have some interesting differences, both from the comparison group and from their men counterparts. The most striking finding is a lack of satisfaction with themselves, their self-image being seen as consistently different from their ideal self. Their view of their partners is also a rather dissatisfied one, whereas the other three groups see the partner as very similar to the ideal self. It is interesting to note the remarkable similarity of the ideal self for all groups, suggesting a commonality of construct, as discussed on page 40 and giving some additional creditability to the use of this technique. Similarly there was agreement on the factors associated with sexual problems. Although the patient groups did not see themselves as very similar to these groups they clearly saw less disparity between them and themselves than did the control groups. Lack of confidence appeared, even more than guilt and anxiety, to be consistently associated with sexual difficulties.

The Problem Check list again revealed sex differences and the lack of satisfaction with life on the part of the women patients. This technique showed however that the group were dissatisfied not just with the marital situation, but with all areas of their lives, reporting as they did twice as many problems in all areas as the other groups. This ties in interestingly with Fisher's work on female responsiveness being related to satisfaction with other areas of life. He saw sexual gratification as but one aspect of the capacity to feel positively to people and objects.

VIII CONCLUSION

In conclusion therefore this project has highlighted some areas which could be considered significant in the aetiology of sexual dysfunction, the principal findings providing, in the main, confirmation of clinical impressions and other work. There is marked evidence for the importance of the relationship with the parents, particularly the father. There is no real evidence for psychosexual disorders being an equivalent of neuroticism but it seems likely that personality differences in terms of seriousness, lack of naivety, anxiety and introversion, especially for men, may contribute to and prolong any difficulties in the early sexual learning situation. There is a significant and consistent trend for the women patient group to be dissatisfied with many areas of their lives, perhaps again as a result of their early experiences within their families and during adolescence. The study therefore seems to confirm the importance of early relationships providing for individuals a sense of value and self-confidence in themselves which allows them to go on to make confident and secure relationships with the opposite sex.

IX BIBLIOGRAPHY

BANNISTER, D. and FRANSELLA, F. "A Grid Test of Thought Disorder". Brit J Soc Clin Psychol, 1966, 5, 95-102.

BANNISTER, D. and FRANSELLA, F. 1971, Inquiring Man - The Theory of Personal Constructs, Penguin, Middlesex.

BENE, E. and ANTHONY, E. 1957, Manual for the Family Relations Test, London, N.F.E.R.

BENE, E. "On the Genesis of Male Homosexuality". Brit J Psych, 1965, 111, 803-813.

BENE, E. "On the Genesis of Female Homosexuality". Brit J Psych, 1965, 111, 815-821.

BELLIVEAU, F. and RICHTER, L. 1970, Understanding Human Sexual Inadequacy, London: Hodder.

BRECHER, E.M. 1970, The Sex Researchers, London: Andre Deutsch.

CAINE, T.M., and SMAIL, D.J. "A Study of the Reliability and Validity of the Repertory Grid Technique as a Measure of the Hysteroid/Obsessoid Component of Personality". Brit J Psych, 1969, 115, 1305-8.

CATTELL, R.B., and MORONEY, J.H. "The Use of the 16 P.F. in Distinguishing Homosexuals, Normals and General Criminals". J Consult Psychol, 1962, 26, 531-540.

CATTELL, R.B. 1964, Handbook for the Motivation Analysis Test, Illinois: I.P.A.T.

CATTELL, R.B., and NESSELROADE, J.R. "Likeness and Completeness Theories Examined by 16 P.F. Measures on Stably and Unstably Married Couples". J Person & Soc Psychol, 1967, 7, 351-361.

CATTELL, R.B., and NESSELROADE, J.R. "Note on Analysing Personality Relations in Married Couples". Psychological Reports, 1968, 22, 381-382.

CATTELL, R.B. 1970, Handbook for the 16 Personality Factor Questionnaire. et al Illinois: I.P.A.T.

CAUTHERY, P., and COLE, M. 1971, The Fundamentals of Sex, London. W.H. Allen & Co Limited.

COMFORT, A. 1966, Sex in Society, New York: Citadel Press.

CROCKETT, W.H. 1965, Cognitive Complexity and Impression Formation: in B. Maher (ed) Progress in Experimental Personality Research, Vol 1, New York: Academic Press.

DIAMOND, M. "A Critical Evaluation of the Ontogeny of Human Sexual Behaviour", Quarterly Review of Biology, 1965, 40, 147-175.

DICKS, H.V. 1967, Marital Tensions, London: Routledge and Kegan Paul.

EDWARDS, A. 1954, Personal Preference Schedule, New York: Psychol. Corp.

EDWARDS, A.L. 1957, Techniques of Attitude Scale Construction, New York: Appleton-Century-Crofts.

EYSENCK, H.J. 1963, The Eysenck Personality Inventory, London: University Press.

EYSENCK, H.J. "Personality and Sexual Adjustment". Brit J Psych, 1971, 118, 593-608.

FELDMAN, M.P., McCULLOCH, M.J., MELLOR, V., and PINSCHOF, J.M. "The Sexual Orientation Method". Behavioural Research and Therapy, 1966, 4, 289-299.

FELDMAN, M.P., and McCULLOCH, M.J. 1971, Homosexual Behaviour: Theory and Assessment. Oxford: Pergamon Press.

FISHER, S., and OSOFSKY, H. "Sexual Responsiveness in Women". Arch Gen Psychiat, 1967, 17, 214-226.

FREUD, S. Complete Works of S Freud. Vol 3 and 7, 1953, London: Hogarth.

FRIEDMAN, L.J. 1962, Virgin Wives - A Study of Unconsummated Marriages, London: Tavistock Publications.

GLIXMAN, A.F. "Categorising Behaviour As a Function of Meaning Domain". J Pers Soc Psychol, 1965, 2, 370-7.

HAMPSON, J.L., and HAMPSON, J.G. 1961. The Ontogenesis of Sexual Behaviour in Man; in Sex and Internal Secretions (W.C. Young ed), Baltimore: Williams and Wilkins.

HARBISON, J.J.M. "Psychological Assessment of Sexual Dysfunction- Paper Presented to First European Conference on Behaviour Modification", 1971.

HARLOW, H.F., HARLOW, M.K., and HANSEN, E.W. "The Maternal Affectional System in Monkeys; in Maternal Behaviour in Mammals, (H.L. Rheingold, ed), 1963, New York: Wiley.

KAPLAN, H.S. 1975, The New Sex Therapy. London: Bailliere Tindall.

KELLY, G.A. 1955, The Psychology of Personal Constructs. New York: W.W. Norton & Co Inc.

KINSEY, A.C., POMEROY, W.B., and MARTIN, C.E. 1948, Sexual Behaviour in the Human Male. Philadelphia: W.B. Saunders.

KINSEY, A.C.,POMEROY, W.B., MARTIN, C.E., and GEBHARD, P.H. 1953, Sexual Behaviour in the Human Female. Philadelphia: W.B. Saunders.

LITMAN, E., and SWEARINGEN, C. "Bondage and Suicide". Arch Gen Psych, 1972, 27, 80-85.

MAIR, J.M.M. "Prediction of Grid Scores". Brit J Psychol, 1966, 57, 1 and 2, 187.

MASTERS, W.H., and JOHNSON, V.E. 1966, Human Sexual Response. Boston: Little, Brown.

MASTERS, W.H., and JOHNSON, V.E. 1970, Human Sexual Inadequacy. London: Churchill.

MEYER, M.M. "Family Relations Test". J Project Tech, 1963, 27, 309-314.

MICHEL-WOLFROMM, "Interferences du Psychisme sur les troubles genitaux. Semaine des Hopitaux, 1953, 29, 835.

MOONEY, R.L., and GORDON, V. 1950, Mooney Problem Check List. New York: The Psychological Corporation.

ORFORD, 1971; in Feldman and McCulloch, Homosexual Behaviour. Oxford: Pergamon Press.

PARSON, T., and BALES, R. 1955, Family, Socialisation and Interaction Process. New York: Free Press.

POOLE, K. "The Aetiology of Gender Identity and the Lesbian. J Soc Psychol, 1972, 87, 51-57.

RABACH, J., and SUPARA, I. "Sexual Disorders and the Family Environment - Sexualni poruchy a rodime prostradi, C.S.L. Psychiatry, 1961, 57/4 , 246-254.

ROSENBERG, B.G., and SUTTON-SMITH, B. 1972, Sex and Identity. Holt, Reinhart & Winston.

RYLE, A., and BREEN, D. "Some Differences in the Personal Constructs of Neurotic and Normal Subjects". Brit J Psych, 1972, 120, 483-489.

SCHACHTEL, (1959); in Handbook of Socialisation and Research. (ed Goslin) 1969, Rand, McNally & Co.

SCHOFIELD, M. 1965, The Sexual Behaviour of Young People. London: Longman.

SCHOFIELD, M. 1973, The Sexual Behaviour of Young Adults. London: Allen Lane.

SIEGEL, S. 1956, Non-Parametric Statistics for the Behavioural Sciences. Japan: McGraw-Hill, Kogakusha Ltd.

SLATER, P. "The Use of the Repertory Grid Technique in the Individual Case". Brit J Psych, 1965, 111, 965-975.

SLATER, P. "Theory and Technique of the Repertory Grid". Brit J Psych, 1969, 115, 1287-1296.

STORR, A. 1964, Sexual Deviation. Middlesex: Penguin Books.

THORNE, F.C. "The Sex Inventory". J Clin Psychol, 1966, 22, 367-374.

WALLIS, J.H. 1970, Marriage Observed. London: Routledge and Kegan Paul.

WILLIAMS, E. "The Effect of Varying the Elements in the Bannister-Fransella Grid Test of Thought Disorder". Brit J Psych, 1971, 119, 207-212.