GRIMS

The Golombok Rust Inventory of Marital State

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ACKNOWLEDGEMENTS

Thank are due to Ian Bennun, Tricia Barnes, Amanda Cole, John Collier, Faye Cooper, Michael Crowe, Siobhan Hart, Anita Holmes, Alan Ingrams, Jenny Jolly, Audrey Lee, Victor Nehama, Margaret Robinson, Gwyneth Sampson and Margaret Watkinson. We would also like to thank all our colleagues in the National Marriage Guidance Council, London Marriage Guidance Council, Whitely Wood Clinic and the Maudsley Hospital who helped with the development of the GRIMS.

Published by The Psychometrics Centre, University of Cambridge, Judge Business School, Trumpington Street, Cambridge CB2 1AG, United Kingdom.

Contents

1 Aims, Apliccations and Scope

1.1 The Golombok Rust Inventory of Marital State (GRIMS) is a questionnaire for the assessment of the overall quality of the relationship between a man and a woman who are married or living~ together. There are-many different ideas and theories about what an ideal relationship should be like. While we have in the construction of the GRIMS made a deliberate attempt to avoid any of these theoretical preconceptions, ideas about a good or bad relationship cannot exist in an ideological vacuum. We have therefore based the test specification on the expertise of practitioners, therapists, counsellors and clients in the field. Many of these people will, of course, have their own ideas and theories, but taken as a whole they will also have common observations and priorities based on their often considerable experience of those aspects of a relationship which they might hope to see change in their clients. The test specification of the GRIMS is therefore a functional one, and the domain of items in the GRIMS covers those areas in which a marriage guidance counsellor or family therapist would hope to see change during therapy.

1.2 The GRIMS is a companion test to the Golombok Rust Inventory of Sexual Satisfaction (GRISS) which is used in sex therapy and sexual dysfunction clinics and research. For this reason the GRIMS asks no questions directly about the sexual side of the relationship, although it does include expression of warmth and affection. This lack of overlap means that with the GRISS and GRIMS together it is possible to pinpoint a relationship problem as either marital or sexual and to adjust therapy accordingly.

1.3 The GRIMS will be of use in research, either to assess the efficacy of different forms of therapy or to investigate the impact of social, psychological, medical or other factors on a relationship. It can also be used in therapy as a quick and easy-to-administer technique for identifying the severity of a problem, for finding out which of the partners perceives a problem in their relationship, and for identifying any improvement or lack of improvement in either or both partners over time. The objectivity of the GRIMS and its standard format enables a clinic to make use of standard criteria for assessment, independently of which therapist sees the client and of therapists' theoretical standpoints.

1.4 One advantage of the GRIMS over other marital or relationship questionnaires is its simplicity of administration. The client has to answer 28 questions on one side of paper, within a standardized format. This makes it quick and simple for the client. The carbonized self-scoring sheet enables the therapist to obtain the result within

two minutes. The marital relationship itself is, of course, always particularly complex and each couple's problems will have a unique aspect, so that the therapist when first seeing the clients will need to probe particular issues and underlying dilemmas. The GRIMS can provide a useful framework for this venture by giving an objective and standardized view of the severity of the couple's problem, while a quick preview by the therapist of the client's response to the individual GRIMS questions can identify useful avenues to explore and save valuable clinical time.

1.5 The GRIMS is primarily applicable to married or unmarried heterosexual couples who live together. It is further applicable to such couples who are separated for work or similar reasons on a temporary basis, and to couples who are temporarily separated for other reasons so long as either one identifies the other as a primary partner. It may be used to some degree within multiple relationships or homosexual relationships, although no standardization data is available yet for these groups.

2 Marital Discord and Treatment

2.1 Most Western European countries showed a gradual increase in divorce following the Second World War, a decline during the 1950s and a constant upward trend after 1960. At the present rate, one in four marriages heads for dissolution in England and Wales. The accuracy of the statistics remains uncertain because divorce figures record only the number of petitions filed. In 1976, the divorce rate was 10.1 per 1000 married and it was calculated that a least 22 per cent of all females would divorce at least once by the age of 45 years (Thorne and Collard, 1979). Rust et al (1987) have shown that about 20 per cent of marriages have a degree of disturbance.

With the increase in marital breakdown, a substantial number of conciliation and treatment agencies have been established. The original marriage counsellors were clergy, physicians, teachers, social workers and later gynaecologists. The first marriage guidance centres were established in the 1930s and in the United Kingdom a number of services were established to aid distressed couples; for example, the Catholic Marriage Advisory Council (1946) and the Family Discussion Bureau (1948) (now the Institute of Marital Studies). Currently, other agencies such as the Family Welfare Association, Family Services Unit and the Jewish Marriage Education Council offer marital counselling: help is also available within the National Health Service.

2.2 Marital therapy has evolved as a significant psychotherapeutic intervention in mental health. The development of marital therapy has had an impact on a number of different areas. Many professionals are now involved in this field and consequently the application of marital therapy now extends to pre-marital couples, cohabiting couples, homosexual couples and ageing couples. As a result, marital therapy is becoming distinct from family therapy and psychosexual counselling, even though some authors have investigated the relationship between marital and sexual therapy (Bennun et al, 1985). There is general agreement that both of these aspects express an interpersonal difficulty, but both need not necessarily be evident within all couple distress. Similarly, some therapists conceptualize marital therapy under the general heading of family therapy, with the marital couple being just one sub-system of the family.

In 1975, a working party set up by the Home Office in consultation with the Department of Health and Social Security, assembled information relating to marital problems. The working party produced its report (entitled l'l1arriage Matters) in 1979: this addressed the provision of more efficient services for distressed couples

and the development and improvement in training. With regard to research, the document noted that policy makers were les sanguine about the value of research and that practitioners had difficulty incorporating relevant research findings into their clinical practice. As a recommendation, the working party proposed a closer link between researchers and practitioners, failing which the influence and impact of research on clinical practice would be minimized.

Couples requesting marital therapy present a variety of difficulties, some of which may initially appear unrelated to their relationship. Also, an individual may be referred for psychological treatment after presenting with an individual problem, but then will be seen jointly with his/her partner. This perhaps best illustrates the variations in both theory and practice evident within couple therapy.

2.3 In a study evaluating the efficiency of different treatment formats, Bennun (1985a, 1985b) listed some of the problems that distressed couples described as being problematic areas within their relationship. In addition to an overall dissatisfaction with their marriage, couples often requested that their partner alter specific behaviours or habits that were felt to be irritating or unpleasant (19 per cent). These included issues related to punctuality and reliability, cleanliness, nagging, feeling excluded (by the other's interests), tidiness and the like. Three separate areas often raised included communication problems (11.2 per cent), decision making (11.9 per cent) and household/domestic problems (11.9 per cent). Communication problems were caused not only by a lack of communication but also by what was said and how it was expressed. Couples who complained of communication difficulties often experienced problems in communicating about specific topics (for example sex, or finance). Communication difficulties may include the couple's inability to be decisive and make decisions. This may be experienced by both partners, or one may complain about the other's inability to make decisions and then carry them out. Of course, further exploration may uncover reasons for this, for example a fear of failure or not wanting to do anything that may upset the other. Household/domestic problems generally concern the family home, responsibility for financial matters and sharing tasks.

The three next most frequent problems included difficulties I caring for each other and showing affection in a non-sexual was (8.0 per cent), problems related to childcare (7.7 per cent) and relationships with extended family members (6.1 per cent). These two latter areas of conflict show that often marital/relationship problems arise when a third person influences the stability of the dyad. Another problem area that was apparent, especially among young couples, was related to dependence-independence conflicts (5.0 per cent). Moving from a life as a single

person into a two-person and later three-person relationship requires that each individual maintain a boundary to some degree that enables them to have some autonomy and a continuing capacity for individuation. Other problems that were raised included sexual problems, jealousy, financial and work-related problems, violence, and one partner presenting with a psychological disorder that adversely affected the marriage.

2.4 Marital therapy is currently practised in many different forms. Among these, conjoint treatment of the couple is the most common, but others include:

a. individual therapy in succession for both partners;
b. individual therapy for one partner;
c. group therapy with individual partners;
d. group therapy with couples;
e. concurrent therapy, v/here both partners are treated separately by the same therapist;
f. combined conjoint and concurrent therapy;
g. collaborative therapy with two therapists, each seeing one partner;
h. four-way sessions where the two therapists and the couple meet together.

2.5 Together with the different forms of marital therapy, there are a number of theoretically-based treatment approaches (Dryden, 1985; Sholevar, 1981). The behavioural approach was developed from research that focused on the differences between distressed and non-distressed couples. The findings led to the development of a skills-oriented intervention based on reversing behavioural deficits and facilitating adaptive interpersonal marital skills. The major treatment components include helping the couple to develop more appropriate ways of communicating, teaching them a method of problem solving and making 'contracts'. The combined treatment approach which aims to improve couple exchanges has now been expanded to include cognitive components in a cognitive-behavioural treatment. Both clinicians and researchers noted that interpersonal difficulties were due, in part, to the effect of misperceptions eliciting and maintaining disturbed dyadic behaviour. In addition to the three behavioural components, the treatment includes exploring and modifying unrealistic expectations that each holds regarding the other' and their relationship, correcting faulty attributions within marital interaction and self-instructional procedures to decrease destructive exchanges.

The therapy derived from the systemic approach places the couple in a psychosocial context, viewing them as part of a family; each has several roles, including marital partner, parent, and child. Within systems theory, the couple represents a functioning operational system or unit, with each partner's functioning being determined partly by the relationships between all family members (generational and inter-generational). The couple therefore organize themselves in a self-regulating, homeostatic way that determines how they deal with their environment. The goal of therapy is to explore how the couple fit into their existing psychosocial system and to uncover the rules, roles, boundaries and hierarchical structures that influence their interpersonal lives.

Strategic marital therapy includes diverse approaches, but has one notable feature: the therapist places him/herself in the responsible position of planning a strategy (as opposed to a technique) for solving the couple's problems. As with the systemic approach, therapy focuses on the social context of the couple's dilemmas with the interventions designed for that particular social situation. Within this approach, problems are viewed as contracts between people: as such they are seen as being functional and as ways of communicating. The goals of the treatment are primarily to prevent the repetition of sequences that result in discord, whilst simultaneously introducing more complexity during the search for alternatives. The interventions may be fairly task-oriented but unlike the behavioural approach the task is often symbolic and therefore analogical. Alternatively, the therapist may attempt to place the couple in a therapeutic bind or paradox and so put the couple in a situation where they cannot-not-change.

The psychodynamic approach to marital therapy varies according to a number of different analytic writers. However, they share the belief that each partner's inner world is important, and that the nature of their shared circumstances underlies change. In working with the couple there is a need to recognize that the presenting adult's marital problems may have as their source early childhood experiences and that the choice of partner and the sustaining elements within the relationship, are related to both conscious and unconscious factors. This means that couples have both a conscious and an unconscious marital contract in terms of what each expects from the other. The marital relationship itself is seen as a psychic entity that is greater than the personalities that comprise it.

2.6 The areas of research within marital therapy are as diverse as its practice. There are studies that have accumulated important demographic data and that have been

descriptive and epidemiological in nature (see Chester, 1985). Another mode of research has been the development and evaluation of one particular approach to therapy, whereby the efficacy of various treatment components is then tested (for example, Jacobson et al, 1985). Extending this, other studies have examined the application of the same approach in different formats (Bennun, 1985a) and have evaluated contrasting approaches (Crowe, 1978).

Research has also been conducted into the prevention of marital discord (Markmam et al, 1984) and the link between discord and a coexisting psychological problem presented by one partner (Cobb et al, 1980).

3 The Assessment of Marital State

3.1 Research in marital therapy in the United Kingdom has been disadvantaged by the lack of a good, short, up-to-date questionnaire that is capable of assessing objectively the state of a marriage for demographic, research and therapeutic purposes. Most of the questionnaires that have been used were developed in the United States, thus introducing a culture bias into the assessment. Of the existing questionnaires, the Locke- Wallace Marital Adjustment Test (Locke and Wallace, 1957) was one of the earliest instruments developed and is now somewhat dated. The Dyadic Adjustment Scale (Spanier, 1976) suffers from the same culture bias, but is nevertheless widely used. The Spouse Observation Check List (Weiss and Margolin, 1977) comprises 400 items and is therefore tedious to complete. Other scales used in the assessment of marital satisfaction include the Marital Communication Inventory (Bienvenu, 1978), the Marital Satisfaction Inventory (Snyder, 1982), the Areas of Change Questionnaire (Weiss et al, 1973) and the Marital Pre-Counselling Inventory (Stuart and Stuart, 1972). Some of these instruments were developed to be consistent with a theoretical perspective of marital satisfaction and as such have a restricted definition of marital adjustment/satisfaction.

3.2 The scales mentioned above, while receiving subsequent validity and reliability estimations, have not generally been psychometrically constructed: consequently they tend to contain large numbers of redundant items. A more popular scale used in the UK has been the Maudsley Marital Questionnaire (Crowe, 1978; Arrindell and Schaap, 1985). Yet while this scale has been successful (in both the nine- and the 20-item versions) at demonstrating reliability and validity (Arrindell et al, 1983, Arrindell and Schaap, 1985) it still raises doubts concerning the comprehensiveness and specificity of its original development.

3.3 The Golombok Rust Inventory of Marital State (GRIMS) has been constructed to address the shortcomings of existing instruments. In developing the Inventory, a great deal of attention has been paid to the conceptual blueprint of marital discord. Widespread consultation with a range of practising counsellors, therapists and clients has provided the test specification, which reflects the practical situations encountered. The specification particularly addressed the areas in which change was required or noted during the course of therapy. The large number of items under this specification has been reduced, first conceptually and then psychometrically, to yield a scale that is short and efficient.

4 The Design of the GRIMS

4.1 To generate the test specification, marital therapists and their clients were asked to clarify specific areas of distress. Fifteen therapists were asked to identify (a) areas which they believed to be important in marital harmony and (b) the areas they would assess during the initial interviews. Information from clients was obtained in the context of a marital therapy study (Bennun, 1985a), where 57 couples were specifically requested to identify their targets for change.

The views of these experts were collated, reviewed and structured to produce a two-dimensional test specification. Axis One specified the following areas:

a. interests shared (for example, work, politics and friends) and degree of dependence and independence;
b. communication (verbal and non-verbal);
c. sex;
d. warmth, love and hostility;
e. trust and respect;
f. roles, expectations and goals;
g. decision making;
h. coping with problems and crises. Axis Two specified areas in which the content of Axis One may become manifest;

a. beliefs about, insight into, and understanding of the nature of dyadic relationships;
b. behaviour within the actual relationship;
c. attitudes and feelings about relationships;
d. motivation for change, understanding the possibility of change and commitment to a future together;
e. extent of agreement between the partners.

This eight-by-five design produces 40 cells.

4.2 Between three and six items were constructed for each cell of the test specification, generating 183 items. The items chosen could be answered meaningfully by either sex. Consultation and review among experienced marital therapists led to a reduction of this item pool to a 100-item pilot version of the test, with between two and four items per specification cell. Six 'lie' items were also included. Items were prepared as statements to which the respondent was asked to strongly agree, agree, disagree or strongly disagree. The items were thus forced

choice (there was no 'don't know' category), but also allowed for strength of feeling to affect scores where views were strongly held.

4.3 The pilot version of the test was administered to both partners in 60 client couples from marital therapy and marriage guidance clinics throughout the country, but predominantly from the South.

4.4 Preliminary item-screening of the data eliminated all items that had a difficulty value of greater than 0.8 or less than 0.2 for either men or women: that is, items to which less than 20 per cent either agreed or disagreed (whether strongly or otherwise) were excluded

Further items were excluded where the number of non-responses exceeded 1 per cent. While clients were strongly urged to answer all the items, there were some that they found impossible to answer because of non-applicability, or for other special reasons: this is inevitable in a pilot version. The remaining 58 items were factor-analysed using principal factoring. This was done for the men and women separately. Apart from some differentiating items, the overall results were similar. The factor structure clearly suggested a main factor which accounted for about 20 per cent of the variance. For men, four subsequent factors accounted for 7.2 per cent, 4.6 per cent, 3.1 per cent and 2.6 per cent of the variance respectively, with a similar pattern for women.

Factor identification, by inspection of both the male and female items, identified factor one as a general marital discord factor with some relation to a second factor which had an increased emphasis on sexuality and 'lie' items. The low communality of subsequent factors at this stage is a strong indication of a unidimensional scale: however, steps were taken to at least attempt to identify a subscale structure as this can be informative in certain circumstances. Re-analyses of the first four-, five-, six-, and seven-factor solutions with oblique rotations were carried out to identify signs of stability. These analyses looked at men and women together and separately. Factors other than the first proved to be unstable under these conditions, although factors which could be named did occasionally emerge (for example, jealousy, the traditional marriage, outside relationships, sex problems, violence, the 'man-at-the-pub' marriage). Although these elements are important to the quality of a marriage, it appears that the interactions across and between possible sub-categorizations are so strong that they cannot on their own generate unidimensional scales. Directions of causality can point in either direction, and non-linear relationships may well abound. In spite of this, the large general factor indicates that from this pool of

interacting situations, feelings, motivations and coping strategies, there does arise a strong and measurable single scale of marital quality.

Elimination of items with low communalities on first a five- and then a three-factor solution reduced the 58 items to 42. These were further reduced to six major criteria:

a. balance across the original test specification;
b. balance of positive and negative items to avoid acquiescence effects;
c. balance of items to which more than 50 per cent agreed, with items to which less than 50 per cent agreed, to reduce social desirability bias;
d. similarity of item behaviour in men and women;
e. size of loading on the general factor, and
f. low correlation with 'lie' items.

Criterion (a) ensured content validity and eliminated duplication; criteria (b), (c) and (t) reduced bias, while (e) achieved the aim of classical item analysis in selecting items with good discrimination.

Criterion (d) enabled us to develop an identical scale for men and women: this simplifies administration. The resultant scale has 28 items. It is scored in such a way that a high score represents problematic relationship.

5 Standardisation of the GRIMS

5.1 The 28 item GRIMS was standardized using two groups:

a. a sample of attendees at a General Practitioners' clinic in central London (30 men and 48 women)

b. 80 couples presenting as clients at Marriage Guidance Clinics, sexual and marital counselling clinics throughout England, but predominantly in London, South Yorkshire and Devon.

5.2 The item scale correlations (with the scale adjusted for each item) for both the pilot and the standardization studies are given in Table 1.

5.3 For the 60 couples (120 subjects) in the pilot sample, the mean GRIMS score for men was 37.12 (s. d. = 10.99), and for women 41.54 (s. d. = 11.26). For the standardization clinical sample, the male GRIMS mean was 30.76 (s. d. = 13.03), and the female GRIMS mean 35.51 (s. d. = 10.37). These are both significantly lower than those for the pilot clinical sample. However, there were some differences in sampling between the two populations. In the pilot study, the majority of the subjects came from Marriage Guidance Council and marital therapy referrals, while in the standardization group there were a much larger number of couples referred for general relationship therapy, including therapy for sexual problems. For the General Practitioner group the mean GRIMS male score was 28.37 (s. d. = 9.03) and the mean female GRIMS score was 27.21 (s. d. = 10.02). See the section on validity (page 15) for further consideration of the difference between these means.

5.4 A closer investigation of particular items containing substantive information showed that 19 (31 per cent) of the couples from the clinical sample considered themselves on the verge of separation, while only two (7 per cent) of the General Practitioner group did so. Furthermore, 42 of the men in the clinical group (51 per cent) were dissatisfied with their relationship, while only two (7 per cent) men in the GP group were dissatisfied with theirs. The apparently anomalous group of 27 men in the clinical sample who were very satisfied with their relationship (33 per cent), accounts for the relatively low GRIMS mean of the clinical group. It may be that some of these men were presenting primarily with sexual problems and were making the point that the relationship itself (sex apart) was fine. However, only eight women in the clinical sample were very satisfied with their relationship. A further explanation for this discrepancy may be that these men believe that it is only their partner who

has a problem, and that they are attending the clinic to provide support and to aid the therapist. This explanation receives support from the literature.

5.5 While these factors have militated against a significant mean difference between General Practitioner and clinical groups for the men (and reduced it for women) the raw GRIMS scores show much larger proportions of persons with high scores in the clinical group. Thus, 23 men in the clinical group (21 per cent) have a GRIMS score of greater than 40, compared with one (3 per cent) in the GP group. For women, the comparative figures were 26 (23 per cent) in the clinical group, and one (4 per cent) in the GP group.

5.6 A combination of norm referencing and criterion referencing yielded a transformed GRIMS scale which was able to give a good indication of the existence and severity of any relationship problem. Transformation was to pseudo-stanine scores (from 1 to 9, with higher scores indicating a worse relationship); the transformation is shown in Table 2 and appears in the scoring sheet.

Table 1: Item analysis

	Pilot group		Standardization group			
Sample	Clinical		Clinical		GP	
Sex	M	F	M	F	M	F
N	60	60	82	80	30	48
Item						
1	.67	.51	.52	.58	.48	.67
2	.60	.51	.46	.27	.53	.44
3	.74	.67	.74	.56	.28	.57
4	.37	.33	.33	.14	-.23	.31
5	.51	.44	.51	.15	.60	.17
6	.64	.48	.57	.70	.66	.35
7	.44	.42	.38	.23	.45	.52
8	.44	.46	.65	.53	.49	.43
9	.54	.29	.25	.24	.19	.37
10	.74	.39	.61	.30	.21	.06
11	.43	.34	.44	.20	.00	-.06
12	.43	.50	.56	.44	.35	.39
13	.39	.35	.58	.36	.35	.53
14	.46	.32	.43	.35	.53	.42
15	.61	.45	.73	.45	.63	.60
16	.59	.57	.72	.51	.54	.62
17	.56	.64	.64	.54	.31	.58
18	.40	.55	.23	.34	.32	.26
19	.68	.39	.41	.47	.50	.41
20	.64	.51	.71	.57	.57	.63
21	.47	.51	.45	.45	.14	.26
22	.57	.41	.61	.54	.44	.28
23	.42	.45	.13	.17	.49	.13
24	.46	.54	.61	.39	.52	.60
25	.60	.56	.60	.38	.52	.43
26	.58	.48	.52	.52	.31	.42
27	.63	.64	.66	.58	.56	.67
28	.44	.45	.68	.53	.42	.65

The correlations are between each single item and the total GRIMS scale adjusted for that item, for men and women in the pilot and standardization clinical groups and in the General Practitioner group.

The correlations are between each single item and the total GRIMS scale adjusted for that item, for men and women in the pilot and standardization clinical groups and in the General Practitioner Group

Differences between male and female raw scores were not sufficiently large to justify separate transformations. These are therefore the same for men and women. A transformed score of 5 (average) represents a normal relationship that is just slightly worse than average in the population at large. Scores of 9 (very severe problems) and 8 (severe problems) will only be found where a relationship is in serious difficulty. Scale points 7 (bad) and 6 (poor) represent moderate and mild relationship problems respectively. Scores of 4 (above average), 3 (good) and 2 (very good) represent varying degrees of above average relationships. Transformed GRIMS scores of 1 should be treated cautiously. The respondents are either lying (see section 10, page 10), or are at such a tender stage of the relationship that prediction of its future course would be invalid on the basis of their responses alone.

Table 2: Transformation of raw scores to transformed scores

Transformed score	Interpretation	Raw score	Frequency (per 100)			
			Men		Women	
			GP	Clin	GP	Clin
1	(undefined)	-16	7	12	14	5
2	very good	17 - 21	14	19	16	3
3	Good	22 - 25	14	8	8	5
4	above average	26 - 29	11	7	10	7
5	Average	30 - 33	22	12	19	11
6	Poor	34 - 37	18	9	17	18
7	Bad	38 - 41	7	7	12	14
8	severe problems	42 - 46	3	9	0	18
9	very severe problems	47-	0	14	2	12

Observed frequencies are adjusted on a percentage basis, for men and women separately in the General Practitioner and clinical groups of the standardization study.

6 Reliability

6.1 Split-half reliabilities and Cronbach alpha coefficients were obtained for men and women separately for the construction group and for both standardization groups (see Table 3). The figures for the construction group will, however, be upwardly biased as they are not independent of selection criteria. In both standardization groups taken together, the split-half reliability was 0.91 (N= 132) for men, and 0.87 (N = 128) for women.

Table 3: Split-half reliabilities and Cronbach alpha coefficients for subject groups

Sample	Pilot		Standardization			
Nature	Clinical		Clinical		Out Patient	
Sex	M	F	M	F	M	F
N	60		82	80	30	48
Split-half reliability	.94	.86	.93	.87	.81	.89
Cronbach's alpha	.92	.89	.91	.86	.85	.86

7 Validity

7.1 Content validity of the scale is high with respect to its specification, and high face validity has been incorporated into the item selection.

7.2 Initial evidence of diagnostic validity was obtained within the test construction group, where use was made of the fact that many couples at marital clinics present with primarily sexual problems and with marriages which are otherwise satisfactory. Therapists were asked to make this diagnosis for the sample on the basis of their clinical interviews. Of the 60 couples, nine were diagnosed as having a sexual rather than a marital problem, and another 15 as having a strong sexual element to their marital problem. For men, these three groups had GRIMS means of 40.87 for the marital problems group, 32.54 for the sexual complications group and 27.89 for the sexual problems only group. Analysis of variance gave a significance of 0.0028 for the difference between these means. For women the GRIMS means were 45.37, 39.23 and 30.11 respectively ($p < 0.0003$). As expected, patients with problems that were predominantly sexual in nature had significantly lower scores on the GRIMS.

7.3 In the standardization study there was no significant difference in ages between the General Practitioner group (mean age = 34.97 years, s. d. = 13.01, N = 29) and the clinical group (mean age = 36.33 years, s. d. = 12.13, N = 24, with some missing age data), the t-value being 0.40. For the men in the standardization study, group means for the GRIMS were 28.37 (s. d. = 9.03, N = 30) in the General Practitioner group, and 30.76 (s. d. = 13.03, N = 84) in the clinical group. The difference between these means was not significant (t = 0.93). However this result needs considerable qualification. Cochran's C-test for non-homogeneity of variance was significant at the 0.01 level, and a multivariate t-test between the 28 GRIMS items in the two groups was significant at the 0.0001 level. The explanation lies in the diverse nature of couples presenting for marital therapy. It must be remembered that these couples are not a random sample of bad marriages, but a group of couples who are sufficiently concerned about specific factors in their relationship to seek help. This is demonstrated quite clearly when the men in the marital therapy group are subdivided on the basis of critical items. Thus when we look at Item 27 ('I suspect we may be on the brink of separation') we find that 19 men in the clinical group (32 per cent) agree to this item, while in the GP group only two (7 per cent) of the men agree. The men in the clinical group were separated into four sub-groups on the basis of their responses to four key items. Item 27 identified men who believed that their relationship was on the verge of separation (GRIMS mean = 41.74, s. d. = 6.79, N = 19). Item 24 ('1 wish there was more warmth and affection between us') identified men who saw the problems as being sexually related (GRIMS mean = 22.75, s. d. = 6.18, N = 12). Items 28 and 26 ('We can always make up quickly after an

argument' and 'Our relationship is sometimes strained because my partner is always correcting me') identified men who saw straightforward marital problems (GRIMS mean = 36.79, s. d. = 11.94, N = 29). The men who remained had a mean GRIMS score of 18.79 (s. d. = 7.50, N = 24): they were an interesting group in that they seemed to believe that they had no problems although they had presented for therapy, presumably blaming any problem on their partner. This belief is in fact quite common in men presenting for marital therapy. Analysis of variance with these four groups and the General Practitioner group, adjusted for items used in selection, was significant at the 0.00001 level (F = 23.51).

For women in the standardization groups, the mean GRIMS scores were 27.21 (s. d. = 10.02, N = 48) in the General Practitioner group, and 35.51 (s. d. = 10.37, N = 80) in the clinical group. The t-test for the difference between women's GRIMS scores in these groups was significant at the 0.00001 level (t = 4.44). For the same sub-grouping system as used for the men in the clinical group, it was found that the 'about-to-separate' women (identified by 'I suspect we may be on the brink of separation') had a mean GRIMS score of 41.75 (s. d. = 8.72, N = 20). The women with sexual problems (identified by 'I wish there was more warmth and affection between us') had a GRIMS mean of 29.30 (s. d. = 7.37, N = 20). For the 'general marital problems' women (identified by 'Our relationship is sometimes strained because my partner is always correcting me' and 'We can always make up quickly after an argument') the GRIMS mean was 39.25 (s. d. = 7.01, N = 32). The remaining clinical women had a mean GRIMS score of 20.50 (s. d. = 9.97) but were only eight in number. The discrepancy between the number of men and the number of women who think they have no problem is statistically significant (Chi-square = 10.00, $p < .005$), so that most of the men in this group were presenting with a partner with identifiable problems. For women, the analysis of variance of GRIMS scores, adjusted for items used in sub-group selection, on the four clinical sub-groups and the General Practitioner group was significant at the 0.00001 level (F = 19.16). This data is summarized in Table 4.

Table 4: Group means for the GRIMS

Group	Pilot		Standardization				
	Clinical				Clinical		
Sub-group	1 Marital therapy	2 Sexual therapy	GP	1 About to separate	2 Marital problems	3 Sexual Problems	4 Other
Men	40.87 (N = 36)	27.89 (N = 9)	28.37 (N = 30)	41.74 (N = 19)	36.79 (N = 29)	22.75 (N = 12)	18.79 (N = 24)
Women	45.37 (N = 36)	30.11 (N = 9)	27.21 (N = 48)	41.75 (N = 20)	39.25 (N = 32)	29.30 (N = 20)	20.50 (N = 8)

Note: Standardization Clinical Sub-groups 3 and 4 have a negative bias from the use of GRIMS items in identification.

The group means indicate that as far as raw scores are concerned, a GRIMS score of below 30 is fairly standard in a reasonable relationship, GRIMS scores of 40 and above indicate very problematic relationships. Varying degrees of relationship difficulty are found in GRIMS scores between 30 and 40.

7.4 A rating of the validity of the GRIMS as an estimator of change was obtained from 24 couples from the clinical sample who received marital therapy: they completed the GRIMS before therapy began and again after the fifth session (or the final session, if earlier). The therapists, who were blind to the GRIMS results, were asked to rate the couple on a five-point scale ranging from

'0: improved a great deal' through '1: improved moderately', '2: slightly improved', '3: not improved at all' to '4: got worse'.

For the men, the GRIMS score changed from 50.29 (s. d. = 16.48) before therapy to 36.67 (s. d. = 12.60) after therapy. The improvement was statistically significant at the 0.001 level (t = 4.64). For the women the initial GRIMS score was 52.52 (s. d. = 14.24) and following therapy it was 39.93 (s. d. = 10.09). This improvement was also statistically significant at the 0.001 level (t = 5.10). The average overall change

resulting from therapy for men and women together was 13.23 GRIMS raw scale points.

Evidence of the validity of the GRIMS in assessing change was obtained. The GRIMS scores for the male and female partner were averaged for each couple. This average GRIMS score from before therapy was subtracted from the average GRIMS score following therapy (or at the fifth session) to give a GRIMS change score for change during therapy (a large negative score representing a large improvement). This GRIMS change score was correlated with the therapists' ratings of change, giving a correlation coefficient of 0.77 ($N = 24$, $p < 0.0001$). This is very firm evidence for the validity of change in the GRIMS score as an estimate of change in the quality of the relationship, or of the effectiveness of therapy.

8 Sex Differences

8.1 While the scores of both the male and female partners are indicators of the state of the relationship itself, we would expect some differences between them, particularly when one of the partners is tired of the relationship while the other is keen on its continuation. The scores of both partners can be seen as representing some common and some specific variance. The extent of the communality is indicated by the correlation between the partners' scores, which for the pilot study was 0.73 (representing a common variance of 50 per cent). Within the standardization study the correlation between male and female partners' scores was 0.53 ($p < 0.0001$, $N = 73$). This correlation is a good indication of the power of the test, and is significant enough to give us some confidence in predicting the state of a relationship from the responses of one of the partners alone.

8.2 For the data from the pilot study, an investigation was made of the extent to which it was possible to predict the score of an absent partner from all of the 100 data items collected from a presenter. A multiple regression was carried out, with the male score as the dependent variable and both the female score and all 100 female items as independent variables. A step-down procedure was used to extract successive amounts of variance. As would be expected, the first variable to be extracted was the female score, which accounted for 0.52 of the variance. But in addition a further eight items added extra information to such an extent that when all were included the multiple correlation was 0.89, showing a predictive power of 79 per cent of the variance. This is indicative of a very high level of reliability for the scale. Of the eight further items which contributed, four were clearly suppressor variables. This is to be expected as, given that we have a clinical group, a particularly low GRIMS score by one partner should mean that the other must have a high score. For the prediction of the female score by the male score and male items, again 52 per cent of the variance was common, and eight further items made significant additional contributions up to a multiple correlation of 0.88 (79 per cent of variance). In this case five of the eight items were clearly suppressor variables.

In looking at the four remaining significant female items on this regression analysis, and at the three remaining significant male items, several of these indicate an irritation of one person with the negative attitude to the relationship by the other. Thus 'We waste too much time trying to make decisions' predicts a high GRIMS score by the partner for both men and women, as does 'My partner has sometimes refused to talk to me' by men about their partner.

Some interesting patterns emerged, which indicate differences between the sexes in the perception of relationships. Particular attitudes in both men and women can predict the likelihood of the partner finding the relationship unsatisfactory. Thus the belief (or recognition) by women that 'Marriage is really more about security and money than about love' significantly predicts ($p < 0.0002$) that the male partner will have a higher GRIMS score. The belief by a woman that she 'has fixed roles within her marriage for which she is responsible' makes it more likely that the man will not perceive a problem. Perhaps paradoxically (or perhaps not!), the reverse holds for the male view of tradition in marriage. The agreement by men that 'They both have fixed roles within the marriage' makes it more likely ($p < 0.002$) that the woman will see the marriage as problematical. A final difference between the sexes lies in the perception by either partner that 'We may be on the brink of separation'. For men this adds no extra prediction to the woman partner's score, while for women its additional predictive power is about 4 per cent and significant at the 0.0002 level. This seems to suggest that women are much better than men at recognizing that their partner is thinking in terms of ending the relationship.

9 The GRIMS and the GRISS

9.1 Both the GRIMS and the GRISS were administered to 24 subjects in the clinical standardization group (Rust et al, in press). The correlations between the GRIMS and the GRISS overall score and sub scale scores appear in Table 5.

Table 5: Correlations between the GRIMS and GRISS main and subscale scores in a group of 24 relationship therapy presenters

GRISS	Male GRIMS		Female GRIMS	
		Significance		Significance
Male overall	.47	<.005	.39	<.02
Female overall	.06	Ns	.26	ns
Impotence	.44	<.05	.47	<.01
Premature ejaculation	.35	<.05	.30	ns
Non-sensuality (Male)	.17	Ns	.08	ns
Avoidance (Male)	.38	<.02	.31	ns
Dissatisfaction (Male)	.61	<.001	.57	<.001
Infrequency	.37	<.05	.18	ns
Non-communication	.32	<.05	.35	<.05
Dissatisfaction (Female)	.25	Ns	.50	<.005
Avoidance (Female)	.00	Ns	.10	ns
Non-sensuality (Female)	.11	Ns	.36	<.05
Vaginismus	-.06	Ns	-.09	ns
Anorgasmia	.12	Ns	.28	ns

It can be seen that for men the correlation between sexual and marital dissatisfaction is 0.47 ($p < 0.005$), while for women it is rather lower at 0.26 and not statistically significant. There is considerable literature on the relationship between sexual and marital dysfunction, with Ables and Brandsma (1977) arguing for an important link and Hartman (1980) arguing for independence. In fact our result agrees with that of Persky et al (1982), who find correlations of 0.54 for men and 0.39 for women between the Locke-Wallace Marital Adjustment Test (Locke and

Wallace, 1957) and the Couple Interactions Scale (Persky et al, 1978). The higher correlations found by Persky et al may be due to common sexuality items between the two scales. The results clearly indicate that the two forms of distress are related, and further indicate that this relationship is particularly strong for men. Of course, we cannot assume that one problem is always causing the other. It may seem common sense that, for some couples, sexual dysfunction leads to marital problems so that if the sex problem is tackled first, the marital distress may subsequently be reduced. For other couples, a lowering of sexual desire may come about as a result of marital problems and it may be pointless addressing the sexual problem in the first instance. However, in most couples a complex interaction between the two sets of problems is likely, involving mutually supportive or destructive systems, so that a joint approach using both sexual and marital techniques may often be the most fruitful. A study by Bennun, Rust and Golombok (1985) showed that giving marital therapy reduces sexual problems.

9.2 An interesting discrepancy can be seen in Table 5 when the correlation between male sexual dysfunction and female marital dissatisfaction (0.39, $p < 0.02$) is compared with that between female sexual dysfunction and male marital dissatisfaction (0.06, not significant). This result is again supported by the results of Persky et al, who found correlations of 0.44 and 0.19 respectively with their measures. This appears to be a major sex difference. While male sexual dysfunction is related to the woman's dissatisfaction with the marriage, female sexual dysfunction has little influence on the man's satisfaction with the relationship. A closer look at the GRISS subscale scores indicates that the relationship between marital and sexual dissatisfaction works in both directions. Dissatisfaction of either partner with their sexual relationship seems to lead to lower satisfaction with the marriage by the women. Another factor sometimes leading to female dissatisfaction with the marriage is sexual impotence in her partner. The subscale scores also seem to show that male satisfaction with the marriage is relatively unaffected by any sexual dysfunction in the woman.

10 Sampling, Refusal and Lying

10.1 Within clinical settings, very few people are likely to refuse to fill in the GRIMS as the scale is short and items likely to lead to refusal or cause extreme embarrassment have been eliminated during item analysis. In non-clinical settings, individuals may refuse; however, this is very much a matter of how the topic is broached. With skilled and sympathetic interviewers, or through an approach from authority figures such as General Practitioners, refusal can be reduced to a minimum.

10.2 A particular problem for questionnaires in both the sexual and marital domains lies in the embarrassment many people feel about the subject matter, and the consequent danger that replies may be dishonest. In particular, the respondent may be frightened that their partner may come to know about their responses, either by peeping or by direct questioning. To obtain reliable results it is particularly important to assure anonymity from the partner. Unfortunately this must apply even though knowledge of the partner's responses may in certain circumstances be therapeutic. Particular care should be taken in this; it is unwise to allow the respondents to take the questionnaires away to fill in at home because this, perhaps unfairly, would impose on them the responsibility for secrecy. Clinical settings are best for obtaining accurate responses.

10.3 Non-clinical male respondents may give dishonest replies through attempts to portray a 'macho' image. Women may also have reasons for trying to conceal any problems in their relationship. In clinical settings, dishonesty arises because a person may wish to convey the message that the problem is not theirs but their partner's. Occasionally, the dishonesty may aim to convey the message that (again, in their view) the problem is only one to do with sex, and that the relationship otherwise is as they would wish. Dishonesty can fairly easily be identified by extremely low GRIMS scores (a transformed score of 1 or, in some cases, 2), particularly when these appear out of context. When GRIMS scores of 1 are found, the therapist should seek to find the reason, even if it turns out to be that the couple are indeed exceptionally well-adjusted in their marriage. Most good marriages should score 2 or 3.

10.4 It is particularly important with the GRIMS that confidentiality should be respected, particularly when filing or disposing of the completed questionnaire. Many of the items, as well as the final transformed scores, can be particularly revealing, so that data stored for research purposes should include no code which identifies the client. Paper filing systems containing the GRIMS should be shredded

when they are disposed of. Computerized files must, of course, be protected under the auspices and guidelines of the Data Protection Act (1986).

11 Administration and Scoring Instructions

11.1 The client should be given the GRIMS Questionnaire and asked to fill in his or her personal details in the section at the top of the page. The Questionnaire should then be completed according to the instructions given: the client reads in turn each of the 28 statements, circling the response that seems most appropriate. There are four responses to choose from: 'Strongly disagree', 'Disagree', 'Agree' and 'Strongly agree'.

11.2 The GRIMS is scored as follows:

SD = Strongly Disagree = 0

D = Disagree = 1

A = Agree = 2

SA = Strongly Agree = 3

Positively scored items 3, 6, 7, 8, 11, 13, 16, 18, 19, 21, 23, 24, 26, 27

Negatively scored items 1, 2, 4, 5, 9, 10, 12, 14, 15, 17, 20, 22, 25, 28

Raw GRIMS Score = Sum of positively scored items – sum of negatively scored items +42

(Note: A high score represents a problematic relationship)

11.3 After the raw score has been obtained, it can be converted to a standard score as in Table 6. Standardisation is to a pseudo-stanine scale.

Table 6

Transformation of the Raw GRIMS Score to a standardised GRIMS Score

Raw Score	Transformed Score	Interpretation
47 or more	9	very severe problems
42 to 46	8	severe problems
38 to 41	7	bad
34 to 37	6	poor
30 to 33	5	average
26 to 29	4	above average
22 to 25	3	good
17 to 21	2	very good
16 or less	1	(undefined)

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Appendix

The GRIMS Questionnaire Items

1. My partner is usually sensitive to and aware of my needs.
2. I really appreciate my partner's sense of humour.
3. My partner doesn't seem to listen to me any more.
4. My partner has never been disloyal to me.
5. I would be willing to give up my friends if it meant saving our relationship.
6. I am dissatisfied with our relationship.
7. I wish my partner was not so lazy and didn't keep putting things off.
8. I sometimes feel lonely even when I am with my partner.
9. If my partner left me life would not be worth living.
10. We can 'agree to disagree' with each other.
11. It is useless carrying on with a marriage beyond a certain point.
12. We both seem to like the same things.
13. I find it difficult to show my partner that I am feeling affectionate.
14. I never have second thoughts about our relationship.
15. I enjoy just sitting and talking with my partner.
16. I find the idea of spending the rest of my life with my partner rather boring.
17. There is always plenty of 'give and take' in our relationship.
18. We become competitive when we have to make decisions.
19. I no longer feel I can really trust my partner.
20. Our relationship is still full of joy and excitement.
21. One of us is continually talking and the other is usually silent.
22. Our relationship is continually evolving.
23. Marriage is really more about security and money than about love.
24. I wish there was more warmth and affection between us.
25. I am totally committed to my relationship with my partner.

26. Our relationship is sometimes strained because my partner is always correcting me.

27. I suspect we may be on the brink of separation.

28. We can always make up quickly after an argument.