PREMENSTRUAL SYNDROME AND MARITAL DYNAMICS

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Abstract

This study was undertaken to demonstrate the utility of a systems-oriented, family somatic approach to Premenstrual Syndrome. Marital and family dynamics have been acknowledged as being important to symptom selection and exacerbation of other physical illnesses. Current models of family somatics were used to generate specific hypotheses, which were tested in a sample of 130 women selected for severe premenstrual distress.

STATEMENT OF THE PROBLEM

Premenstrual Syndrome is generally regarded as a cluster of symptoms which arise in the last 3 to 10 days of the menstrual cycle and subside shortly after menstrual onset. Women have described changes in their behavioral, emotional and physiological well-being, with symptoms varying in severity from mild discomfort to severe disability. Various studies have reported an increased rate of violent crimes committed by women during the premenstrual phase of their cycle, with similar increases reported in psychiatric emergencies and suicide attempts (Dalton, 1959, 1960, 1964; Janowsky and Gorney, 1969). In an age of liberation, women are demanding information and shared responsibility in managing their own health. In fact, information regarding the etiology and management of premenstrual syndrome is at best incomplete, and often contradictory.

Premenstrual Syndrome is not a new phenomenon, but was relatively obscure until this past decade. With the increase in publicity has come a wide range of reactions, including resentment from women who fear the consequences of "raging hormones" held against them to relief from hundreds of women who have suffered in silence, and are now finding the support and validation to seek help. Premenstrual Syndrome, however, has created almost as much controversy within the Professional system of Health Care Providers, as it has among the lay population. Despite the increase in demographic, clinical and laboratory research, there is a wide range of contradictory theories regarding the definition, etiology, and treatment of this complex syndrome. Dispute exists over the classification of core versus peripheral symptoms, and the degree of disability or discomfort necessary to constitute a basis for positive diagnosis. This disparity has resulted in confusion regarding diagnosis, and failure to achieve standardization.

It is not surprising that premenstrual syndrome has been approached from both the biological and psychiatric perspectives. The biological perspective has primarily focused on the relation-

ship between symptoms and cyclical hormonal imbalances. Psychiatric studies, on the other hand, have pursued the association between symptoms and psychopathology, with particular interest in related neurotic or depressive disorders (Coppen, 1965). Research in both fields has generated major inconsistencies, and failed to support either premise. Progesterone treatment has failed to pass a double blind to support placebo control (Sampson, 1979), and psychiatric treatment of neurotic women has failed to reduce premenstrual distress (Rees, 1953).

It would seem that both approaches have suffered from the restrictions and limitations inherent in a linear concept of causality in medicine. The combination of physiological, behavioral and emotional symptoms indicates that premenstrual changes occur simultaneously, and affect different functions of psyche and soma. The relationships between physical distress, perception, coping mechanisms and emotional reactions are indeed complicated , but appear to be mutual rather than self-contained. In a similar vein, the environment, both in term of stressors and supports, would appear to play an important role in both causation and response to disease. Recognition of these multiple factors calls for a systems perspective which allows interaction among complex, multiple phenomena. A systems, or multifactorial approach, such as that embraced by Psychosomatic Medicine, might provide a more productive framework through which to investigate Premenstrual Syndrome.

The psychosomatic model calls for a holistic approach to disease in which physiological and affective phenomena are viewed as interacting subsystems. The patient is also recognized as a system, who effects and is effected by both the family and the environment. Thus, distress is rarely viewed as arising exclusively from an imbalance in any one area, but is conceptualized as a response to complex interactions among interrelated systems. Psychosocial factors are viewed as impacting upon the susceptibility, development and maintenance of physical symptoms (Groen, 1964), and are viewed as important contributors to prevention, diagnosis and treatment (Lipowski, 1977).

One of the most useful constructs in the Psychosomatic model is marital interaction. Psychosomatic Medicine has increasingly recognized the importance of not only intrapsychic, but of interpersonal transactions on symptom formation and perpetuation. The impact of both the family of origin and the marriage has received considerable attention over the past 20 years, and has provided a theoretical framework commonly referred to as "Family Somatics" (Weakland, 1977).

The relationship between organic symptoms and family interaction was pioneered by the work of Don Jackson (Jackson and Yalum, 1966). Detailed assessment of families whose children had colitis revealed an identifiable pattern of limited flexibility,

avoidance of negative affect and conflict, overprotection of the children, and difficulty engaging in friendships and social activities with non-family members (Jackson and Yalum, 1966). Minuchin formulated similar observations into a theoretical model in which the development and maintenance of the ill child's symptoms were related to family structure particularly enmeshment, overprotection, rigidity, and lack of conflict resolution skills (Minuchin, Baker, and Rossman, 1975; Minuchin, 1977).

Meissner has conducted an extensive review of analytic studies relating individual, marital and family dynamics to physical illness (meissner, 1977). From the presented material Meissner has constructed a theoretical model which proposes that the underlying dysfunction of Psychosomatic families is a faulty family emotional system, characterized by lack of differentiation. The dominating affect in such families is believed to be depression, and interactions among family members serve to protect against depressive affects. Meissner links the presence of depression, dependency problems, hypochondriasis and psychosomatic illness as typical phenomena in families which have low levels of differentiation. Such families would show close emotional involvement, but mitigate against the expression of affect. Aggressive impulses and negative affect would be repressed to ensure the psychological survival of the family. In this kind of family structure, somatic symptoms would serve as a neurotic king of control mechanism which would stabilize family functions and mask the underlying depression. Meissner suggests that family dynamics of this nature are most likely multigenerational.

The multigenerational character of Psychosomatic family dynamics has also been theoretically addressed by Waring (1977). Waring draws upon the theories of Framo and Bowen to conceptualize the manner in which illness can be used to maintain homeostasis. The sick role may be acquired by the spouse or transmitted to the children, and serves to control the intensity of conflict operant within the family. Children raised in an environment where family homeostasis was balanced by physical symptoms would repeat this tendency in their own family of procreation.

Waring's clinical work with the families of patients with chronic pain and symptoms of obscure etiology led him to focus on the marital dynamics. Waring has described the marriages of these patients as problematic and as lacking cohesion (Waring, 1982; Waring, 1983). Waring has also noted problems in the area of intimacy characterized by a lack of verbally expressed affection between spouses, a limited incidence of sexual activity, and difficulty verbalizing feelings, thoughts, or needs. Other clinical observations include a pattern of social isolation, and a high level of denial of problems.

Similar observations have been noted by Roy, in a study of patients with chronic pain (Roy, 1982). Roy has reviewed existing literature in the field, and distinguished studies that investigate the role of family dynamics in the etiology of chronic pain form those that study the role of family dynamics in the perpetuation of chronic pain. One recurring theme in the literature presented is the high incidence of disharmonious marriages. Although there is an absence of sound clinical research, Roy concludes that the existing studies suggest that family members in general and spouses in particular, seem to play a significant part in the development and prolongation of chronic pain.

The marriages of women with PMS were studied by Clare, who was primarily interested in the relationship between premenstrual complaint and psychiatric morbidity (Clare, 1980). Clare reported no statistically significant relationship between psychiatric ill health and marital disturbance, but demonstrated a strong relationship between marital maladjustment and premenstrual complaint. Attempts to establish a temporal pattern between marital problems and premenstrual distress were inconclusive.

This study was undertaken to document the relationship between marital dynamics and severity of premenstrual distress. Psychosocial factors, including family dynamics, have always been of particular interest to the Social Work profession, which has historically maintained involvement in clinical, research and policy activities affecting health.

The success of the social work role in a psychosomatic model will ultimately reflect the soundness of the theory upon which practice is based. Although structurally-oriented family therapists have claimed successful intervention in several disease processes, there is a sparsity of empirical evidence associating dysfunctional family interaction with specific disease entities. This study was designed to generate information about the marital dynamics operant in women who suffer from premenstrual Syndrome.

HYPOTHESES

Existing theories of family somatics suggest that there will be a relationship between marital dynamics and premenstrual distress. Specifically, it is proposed that there will be a significant relationship between Marital Intimacy, Marital Satisfaction and Premenstrual distress. Women who experience severe premenstrual symptoms are predicted to show a lack of intimacy on Waring's Measure of Dyadic Intimacy, and to also express a high degree of dissatisfaction of their current dyadic

relationship as measured by Renne's Index of Marital Satisfaction.

METHODOLOGY

Subject Selection

Subjects were recruited through the Premenstrual Syndrome Clinic at the Medical College of Virginia Hospital, and through private physicians and clinics in the Richmond vicinity. Over 25 Gynecologists in central Virginia and North Carolina distributed questionnaires to their patients who complained of Premenstrual Syndrome symptoms.

Health care providers were asked to distribute the questionnaire to women who complained of physiological, emotional, or behavioral premenstrual symptoms. Because the questionnaire was distributed at clinics as well as private practices, women of all socio-economic strata had equal opportunity to participate in the study. The subjects were asked to provide information regarding current prescribed medications they were taking for contraception, depression, anxiety, and for Premenstrual Syndrome, but none of these factors were used as criteria to exclude women form the study.

Instruments

The Menstrual Distress Questionnaire

The T(today) form of the Menstrual Distress Questionnaire was chosen to measure premenstrual distress. This instrument was designed to measure changes in physical well-being, emotions and behavior in relation to the menstrual cycle. Since its creation in 1977 it has been used in over 35 studies of the menstrual cycle, and has become the most widely accepted measure of premenstrual distress (Moos, 1977).

The instrument was modified for the purposed of this study, as respondents evaluated their experience with each symptom on the day they filled out the form and over the previous 2-3 days. The women, in essence, were asked to describe their premenstrual experience that month, rather than limiting their evaluation to the last day of the cycle.

The Waring Intimacy Questionnaire

The Waring Intimacy Questionnaire was chosen to measure intimacy in dyadic relationships (Waring and Reddon, 1983). It is comprised of 8 subscales which were determined to be the core components of dyadic intimacy from theory and clinical research.

These dimensions are defined as expressiveness, autonomy, compatibility, identity, sexuality, cohesion, affection, ad conflict resolution. Each potential subscale item was correlated with the Social Desirability Scale from the Personality Research Form E (Jackson, 1974), to ensure freedom from bias created by the respondent's desire to maintain the status quo.

The Renne Index of Marital Satisfaction

The Renne Index was developed by the California Department of Public Health for a survey of the residents of Alameda County (Renne, 1970). Six questions were found to be useful in discriminating unsatisfactory marriages from satisfactory marriages, and of these, three were found to be particularly sensitive to marital unhappiness. After consultation with the scale originator, the questions were weighted to reflect their import. The instrument is used in this study to measure satisfaction in intimate dyadic relationships.

The Sample

The sample consisted of 130 women who returned a completed questionnaire. The subjects ranged in age from 18 to 48 years, with a mean age of 33. Seventy-four women had received an undergraduate or graduate college degree and 51 had finished high school. Almost all (125) women were Caucasian. Religious background of the subjects varied, with 47 of the women raised as Protestant, 36 as BAptist, 29 as Catholic, 7 as Jewish, and 11 of a religion other than those stated. While 23 women described themselves as being lower or working class, while the vast majority (103) described themselves as middle class.

Only 8 of the respondents were currently taking oral contraceptives, and 15 were taking prescribed medications for depression, anxiety, or both. Eighty-eight women were currently married, and another 18 women were involved in ongoing intimate relationships. None of the women in the sample had been widowed, but 22 were separated or divorced. Twenty women had never been married. Most respondents (83) had children, the mean number being 2.

Many of the women in this sample were active in the work force, with 58 working full time jobs outside the home, and 28 holding part time jobs. Twenty-eight respondents were housewives, and 12 were full time students (see Table 1).

RESULTS

Premenstrual Distress

The mean sample score on the Menstrual Distress Questionnaire was 137.69, with a standard deviation of 37. This mean is considerably higher than the premenstrual scores of 74 and 85 reported for normal women during the premenstruum (Moos, 1980; Rouse, 1978). Item analysis of the most severe physical symptoms revealed that fatigue, painful breasts, food cravings and weight gain were most frequently reported. The strongest complaints of emotional/behavioral symptoms were irritability, tension and mood swings.

Premenstrual Distress and Intimate Relationships

It was hypothesized that women presently involved in intimate relationships would have low levels of Intimacy as measured by the Waring Dyadic Intimacy Scale. It was further hypothesized that women with severe premenstrual symptoms would have high levels of dissatisfaction in their relationships, as determined by the Renne Index of Marital Satisfaction. Both of these hypotheses were found to be statistically significant in the direction stated.

Dyadic Intimacy

Sample scores of dyadic intimacy ranged from 5 (low) to 29 (high), with a mean of 17.2 and a standard deviation of 5.6. This is considerable lower than the standardized mean of 25.3 established by Waring. Correlation of Dyadic Intimacy with the Menstrual Distress questionnaire showed a statistically significant negative relationship ($r=.32$, $p=0.001$) which demonstrates that women with low levels of intimacy were found to have high levels of Premenstrual Distress. (See Table 2).

The respondents were divided into two groups, using one standard deviation (3 points) below the standardized mean of 25 to separate high and low levels of dyadic intimacy. Only 30 respondents (28%) were found to score above the cut-off point of 22, and 77 respondents (72%), fell within the parameters of low dyadic intimacy and premenstrual distress. As was anticipated, the group with low dyadic intimacy was found to score high in premenstrual distress. This group was found to have a mean of 146 on the Menstrual Distress Questionnaire, which is 9 points above the sample mean (see Table 3). The group who scored normal levels of dyadic intimacy was found to have a Premenstrual Distress score of 127, which is 10 points below the sample mean. This statistical relationship is significant at the .016 level, allowing the negative hypothesis of no difference between groups to be rejected.

To clarify the nature of the problems inherent in lack of marital intimacy, the global measure of Marital Intimacy was broken into its component subscales. Although several subscale items were deleted from the global intimacy measure, the respon-

dent's perception of dyadic Cohesion, Affection, Conflict Resolution, Expressiveness, Compatibility, Sexuality, and Personal Identity can be determined. When these subscales were correlated with Premenstrual Distress, it became apparent that high premenstrual distress was related to only three subscales (see Table 4). Cohesion and sexuality were found not to relate significantly with global premenstrual distress. The subscales of Conflict Resolution, Compatibility and Identity were found to be strongly related to premenstrual distress, and to function in a negative direction. Thus, in a sample of women chosen for Premenstrual Distress, the dynamics of problematic conflict resolution, incompatibility and insecurity were related to high premenstrual distress.

Relationship Satisfaction

Scores on the Renne Index were found to range form 0 (no satisfaction) to 12 (high dissatisfaction), out of a possible range of 0 - 12. This instrument has not been used before, and lacks standardized means for comparison purposes, but does seem to reflect some sensitivity to a range of dyadic relationship fulfillment. Although standardized scores were not available, the frequency of responses to each question had been reported in a large sample of randomly selected women (Renne, 1970). In order to facilitate comparison between the two groups, the frequency of responses to each item was calculated (see TAble 5). As can be seen, the women with premenstrual distress differed considerably from the larger sample of married women. After the expected cell frequencies were calculated, chi square statistical analysis was performed, and the differences were found to be statistically significant at the .005 level.

The mean score on the Renne Index in this sample was 3.4, with a Standard Deviation of 3.1. After collaboration with the scale originator, a cutoff point of 3 was established to separate high and low scores. This reflects that any negative response on the weighted items suggests dissatisfaction in the relationship (Renne, 1983). Thirty-nine respondents (25%) of the sample scored higher than 3, and fulfilled the criteria of being dissatisfied with their intimate relationship.

To test the hypothesis of a positive relationship between marital satisfaction and premenstrual distress, a Pearson correlation statistic was calculated, and found to be significant ($r=.257$, $p=.004$). Thus, women who were not satisfied in their dyadic relationships were more likely to experience troublesome Premenstrual symptoms (see Table 2).

This strong relationship between marital satisfaction and premenstrual distress was further demonstrated through the use of a T-test (see TAble 3). Women were divided into two groups of satisfaction, with the score of 3 used to separate low satisfac-

tion from high satisfaction groups. The group with low marital satisfaction was found to have a mean of 150.8 on the Menstrual Distress Questionnaire (14 points higher than the established sample mean). Women who had high levels of satisfaction in their dyadic relationships were found to have a mean score of 135 on the Menstrual Distress Questionnaire, which is 2 points below the sample mean. The relationship was statistically at the .02 level, allowing the null hypothesis of no difference between groups to be rejected.

LIMITATIONS OF THE STUDY

Weaknesses in the study's methodology were created by sampling methods, the nature of the instruments, and the choice of a cross-sectional, self-report survey approach to data gathering. The sampling method departed from random sampling procedures, and the sample, accordingly, is not a true probability sample. Bias may likely have been created by the reliance on health care providers to distribute the questionnaires, as physicians may have imposed their own diagnostic criteria in selecting women as appropriate for inclusion to the study. It is also probable that the attitude of the health care provider influenced the patients' decision to participate or decline from participation in the study.

The decision to restrict the response-time to the premenstruum may also have created a bias in the sample selection. Women were instructed to keep the questionnaire for several days in order to record the day that their menstrual flow began. it is quite likely that women who were not highly motivated or who were disorganized did not follow through. The imposed time delay may have caused women to lose the questionnaire and/or their interest, and thus effected the results.

IMPLICATIONS

The findings of this study support the existing models describing marriages of patients with psychosomatic illness. Sample scores were well below the established mean on the Dyadic Intimacy Questionnaire and women with low levels of dyadic intimacy had higher levels of Premenstrual distress. The respondents' assessment of the satisfaction in their intimate relationships was also strongly related to degree of premenstrual distress. Although there are no standardized scores for the REnne Index, the frequency of women who responded to questions indicating severe dissatisfaction is higher than the expected frequency established in a large, random, sample. Within the sample, marital satisfaction was strongly related to degree of

premenstrual distress, as women who were not satisfied in their relationships had higher levels of premenstrual distress.

The question of temporality cannot be avoided in a discussion of Premenstrual distress and Marital dynamics. The findings suggest that premenstrual distress is significantly related to dyadic satisfaction and intimacy, but there are not criteria to establish whether the relationship problems preceded or were created by the Premenstrual distress.

While the determination of temporality may have special import in a linear model of causation, it is less critical to a systems model of analysis. Regardless of causation, marital distancing and dissatisfaction should be viewed as important stressors which could hamper a woman's capacity to cope with other concurrent stressors, be they environmental, physical, or intrapsychic. it would be more beneficial from a systems perspective to determine the nature of the cycle between Premenstrual distress and marital stress, and question the usefulness of marital stress and marital dissatisfaction as potential entry points into existing dysfunctional systems.

Renne has described the consequences of marital dissatisfaction on health, and suggests that the impact of marital dissatisfaction is profound in all areas of functioning (Renne, 1971). Lack of dyadic intimacy would similarly impact upon the woman's coping capacities throughout the cycle. It is possible that the additional stresses created by normal physiological premenstrual changes add to the existing stresses to overwhelm the system's ability to maintain homeostasis.

It is interesting that despite the low levels of intimacy, very few women rated their marriages as being unhappy. This also contradicts the high response rate of women who had seriously considered getting a separation or divorce. One is left to speculate about the definition of happiness, or the need for women to believe themselves to be happy, despite obvious problems, disappointments and regrets.

The breakdown of the components of the Waring Dyadic Intimacy Questionnaire greatly contributes to our understanding of the importance of successful problem negotiation and conflict resolution in a marriage. Women with sever premenstrual distress, have difficulty resolving differences with their mates, and have increased incompatibility. They also have self doubts and insecurities around identity.

Anecdotes of Premenstrual Syndrome describe the rageful, uncontrollable wife viciously attacking her unsuspecting husband, and losing her temper over trivial matters. It is possible, however, that these anecdotes describe an ineffective pattern of conflict resolution, where important issues and differences of

opinion are not resolved to the wife's satisfaction throughout the menstrual cycle. The episodic outbursts, typically associated with Premenstrual Syndrome, may accomplish two functions to perpetuate the cycle of dysfunctional conflict resolution within the marital dyad. Firstly, the outburst may allow an expression of tension, anger and frustration that had been building up during the cycle. Secondly, the outbursts may be "blamed" on a physiological disorder that is beyond the woman's control. The woman is accordingly excused for her outburst, and of greater importance, the content of the outburst is dismissed. The unresolved issues would add to the woman's feeling of incompatibility with her mate, and cause the cycle to be perpetuated. The woman is left ashamed of her lack of control and loss of temper, and possible doubtful of her self competence.

Although this pattern is not demonstrated in this study, it is one clinical speculation which integrated the findings of marital dissatisfaction, incompatibility, poor conflict resolution skills and cyclical episodes of negative affect. Further exploration and verification is needed before any conclusions can be made about a "Premenstrual marital pattern," but the specific nature of marital problems in women with PMS should be carefully investigated.

It can be seen that women with premenstrual distress differ from other women in the extent of marital distancing and dissatisfaction. Furthermore, the extent of these marital problems is directly related to the degrees of Premenstrual distress experienced and reported. There are many clinical observations about the role of marital dynamics in psychosomatic families, and speculations of how the marital dysfunction might operate specifically within the marriages of women with premenstrual distress. While these have not been adequately demonstrated in this study, there is strong evidence to support the hypothesis that problematic marital dynamics are related to severity of premenstrual distress, and should be recognized as important factors in clinical, policy and research activities.

BIBLIOGRAPHY

Bowen, M. (1972). The differentiation of self in one's own family. In J, L. Framo (Ed.), Family interactions: A dialogue between family research and family therapists, New York: Springer.

Clare, A.W. (1980). Psychiatric and social aspects of premenstrual complaint. Dissertation, National University of Ireland.

Coppen, A. & Kessel, N. (1963). Menstruation and personality. British Journal of Psychiatry, 4(4), 23-28.

Dalton, K. (1959). Menstruation and acute psychiatric illness. British Medical Journal, 1, 148-149.

Dalton, K. (1964). The premenstrual syndrome. Springfield, Illinois: Charles C. Thomas.

Dalton, K. (1960). Menstruation and crime. British Medical Journal, 2, 1425-1426

Framo, J.L. (1965). Rationale and technique of intensive family therapy. In J.L. Framo & I. Borsormenyi-Nagi (eds.), Intensive family therapy. New York: Harper Row.

Groen, J.J. (1964). Psychosomatic research. New York: MacMillan Company.

Jackson, D.N. (1974). Personality research form manual. London, Ontario: Research Psychologists Press.

Jackson, D. & Yalum, I. (1966). Family research on the problem of ulcerative colitis. Archives of General Psychiatry, 15, 410-419.

Janowsky, D. & Gorney, R. (1969). Premenstrual-menstrual neurosis in psychiatric admission notes. American Journal of Obstetrics and Gynecology, 103, 189-191.

Lipowski, Z. (1977). Psychosomatic medicine in the seventies: An overview. The American Journal of Psychiatry, 134, 233-244.

Meissner, W.W. (1966). Family dynamics and psychosomatic disease. Family Process, 5, 142-161.

TABLE ONE

DESCRIPTION OF SAMPLE (N=156)

Age	Mean	33
	Range	18-48
Marital Status	Married	106
	Divorced/Separated	23
	Single	27
Parous		106
Race	Caucasian	105
Socioeconomic Status	Middle class	125
	Lower/Working class	26
Work status	Full time	68
	Part time	35
	Student	14
	Not employed	35
Education	High School incomplete	8
	High School graduate	64
	College graduate	84
Medication	None	124
	Birth control pills	8
	Anxiety/depression	24

TABLE 2

Correlation Coefficients of Premenstrual Distress, Intimacy and Satisfaction in Intimate Dyads (N-106)

	Marital Satisfaction	Dyadic Intimacy
Premenstrual Distress	r .257	r -.324
	p 0.004	p 0.000
Marital Satisfaction		r -.481
		p 0.000

TABLE 3

PREMENSTRUAL DISTRESS ACCORDING

TO MARITAL DYNAMICS

(n = 106)

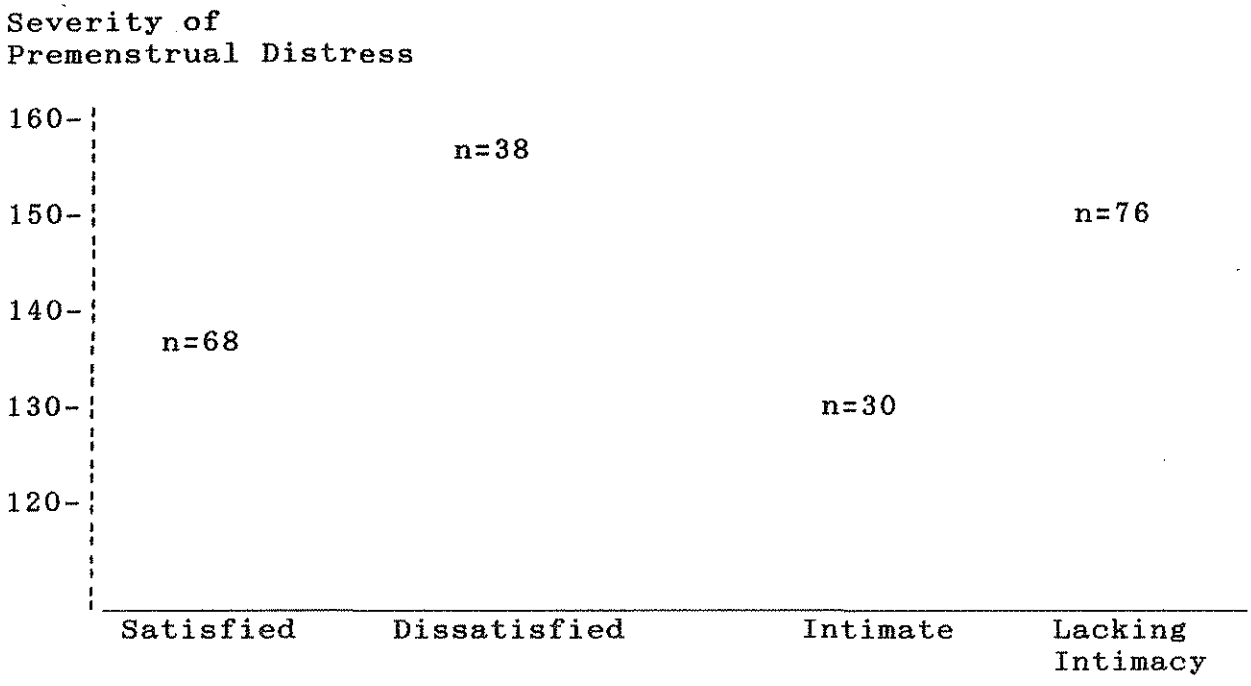

TABLE 4

Correlation Matrix of Dyadic Intimacy Subscales and Premenstrual Distress (n=98)

	Affection	Conflict Res	Expression	Compatibility	Sex	I.D.
Premenstrual distress	-.14 p=.08	0.23 p=.01	-.14 p=.08	-.19 p=.02	N.S.	-.22 p=.02
Affection		.32 p=.001	.33 p=0.0	.35 p=0.0	.19 p=.02	.19 p=.03
Conflict Resolution			.32 p=001	.46 p=0.0	N.S.	.21 p=.02
Expressiveness				.24 P=.008	.43 P=0.0	N.S.
Compatibility					.16 p=.05	N.S.
Sexuality						.22 p=.01

TABLE 5

Renne Index of Marital Satisfaction; Weighting of Questions and Distribution by Percentage in Two Samples

		Wives in Alameda County (N=2510)	Premenstrual Distress (N=109)
		Percent	
1.	Does your husband give you as much understanding as you need?		
(+)	no, not really	15	22
	yes, but not totally	45	61
	yes, completely	40	17
2.	Does your husband show you as much affection as you would like?		
(+)	more than I like	7	10
	as much as I like	71	38
(+)	less than I like	22	51
3.	Even happily married couples sometimes have problems getting along. How often does this happen with you?		
(+)	often	8	14
	sometimes	43	55
	a few times	40	29
	never	10	2
4.	Do you ever regret you marriage?		
(*)	often	3	4
(+)	sometimes	13	27
	a few times	19	29
	never	66	34
5.	Have you seriously considered a separation or divorce recently?		
(*)	yes	9	29
	no	91	70
6.	All in all, how happy has your marriage been for you?		
(*)	very unhappy	1	3
(*)	unhappy	1	3
(*)	somewhat unhappy	5	6
	somewhat happy	13	26
	happy	37	31
	very happy	42	30

(+) an indicator of dissatisfaction, (1 point)
(*) an indicator of extreme dissatisfaction, (3 points)