THE RELATIONSHIP BETWEEN PSYCHOLOGICAL DYSFUNCTION AND SEXUALITY WITHIN A MARITAL CONTEXT

Report on a literature study

by
Lena Nilsson Schönnesson, Ph.D.

Under contractual agreement with
Sexuality and Family Planning Unit,
WHO, Regional Office for Europe

ICP/MCH 519
RMI/79/P05 (UNFPA)
9959F
English only

January 1987

Note

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted, quoted or translated without the agreement of the World Health Organization Regional Office for Europe. Authors alone are responsible for views expressed in signed articles.

Contents

Foreword

This literature study has been conducted at the request of the Sexuality and Family Planning Unit of the World Health Organization, (WHO) Regional Office for Europe.

The purpose of this study is to highlight the relationship between psychological dysfunction and sexuality within a marital context.

Originally, the intention was to review research studies conducted within the Member States of the WHO European Region. However, in searching for relevant studies through the Medline-system, the majority of relevant research appeared to be American.

This literature study makes no claim to be complete with respect to the extensive research area per se or to cover cultural or historical aspects.

Finally, it has to be emphasized that the term relationship does not permit causal inferences to be drawn. From an etiological perspective several alternatives are possible. Psychological dysfunction may be the result of difficulties in sexuality (in its broadest sense), but the opposite may also be possible; psychological dysfunction may affect sexuality, which then in its turn may affect psychological status.

Introduction

There is no doubt that women and men living in industrial societies are exposed to various stress factors, e.g. unemployment, bad working conditions, work stress. These factors affect women and men, more or less seriously, both physically and psychologically.

Further stress factors of importance to the individual are the rapid changes in family patterns and roles, due to economic and social changes. Neither marriage nor the nuclear family have disappeared, but new alternative family units have been created, for example cohabiting families, step-families, single-parent families.

Gender roles are changing and so is the relationship between women and men, with many women demanding equality between the sexes. Studies have tended to measure gender roles by focusing on either the pattern of power distribution between wife and husband (1-3), the respective role performance or task allocations of wife and husband (4,5), the personal attributes of husband and wife (6,7), or the employment arrangements of the couple (8,9).

Today there is also much greater flexibility than ever before in the way women and men perceive gender roles. However, we really do not know how gender role attributes of wives and husbands contribute to marital satisfaction (10), i.e. whether couples with traditional attitudes are more or less content than couples with egalitarian attitudes. Whereas some studies (11,12) found no relationship between gender role attitudes and marital satisfaction, Bowen & Orthner (10) found that those marriages with a traditional husband and a modern wife had the lowest evaluations of marital quality. In another study (13) women with feminist attitudes were less satisfied with their relationship both generally and sexually. Another study (14) showed that married women had more conventional attitudes than single-parent women, and also that married women with feminist attitudes were more likely to suffer from depression than single-parent women. It is suggested by Keith & Schafer (14) that it may be more difficult to maintain egalitarian attitudes toward gender roles in a marital relationship. However, no explanations are given for this assumption.

We are thus in a time of role transition. Wives and husbands have to define their roles on their own, without much guidance from the larger society. The situation increases the chances of facing considerable role strain and disagreement about who should perform various tasks and make various decisions. "... what differentiates problem marriages is not characterlogical problems with the couples ... but different expectations and attitudes about behaviour and division of labour" (15).

Parenthood has also gone through changes, where the maternal and, in particular, the paternal roles are not as clear-cut as before. Many parents also experience conflicts between their own love-relationship and parenthood as well as between their jobs and parenthood.

Having children necessarily increases role strain. As parents, the couple have new roles to adjust to and more roles to manage between them. In addition, more and more married women with young children are employed outside the home. In most cases the wife still has the responsibility for child care and housework (16-19). There is no evidence that married men have increased their share in the work that has to be done in the home (20-22). In other words, coping with housework, the children and a job as well, many women may simply run out of energy, becoming less and less responsive to the positive aspects of their marital relationships (23). The situation probably raises a lot of anger as well as resentment within the wife.

Various researchers (24-26) have indicated the possibility that there may exist an U-shaped pattern for levels of marital satisfaction at different stages of marital life. The pattern appears to be closely associated with the arrival and departure of children, with marital satisfaction declining as children are born and grow up, but then increasing as the children mature and leave home (27).

Researchers have compared married couples who have children with childless couples married for a similar length of time. The results of the studies are highly consistent; couples with children report less satisfaction in their marriage (28-31). No clear pattern seems to appear, however, as to an association between age of the child and reduced marital satisfaction.

Rollins & Galligan (26) emphasize that the negative effect of having children seems to be stronger for wives than for husbands; in wives satisfaction with the companionship aspect of marriage is particularly likely to be reduced after having children. Secondly, they point out that children are much less likely to have a negative effect on marital satisfaction when they are planned and desired than when they are unwanted.

Brehm (27) argues that these findings contradict the expectations of most couples who are thinking about having children. There is a severe conflict between belief and reality: "We believe children to be good for marriage, and yet for many couples, having children exacts a considerable price in terms of the couple's relationship" (27, p.286).

All these family changes have, of course, an impact on the individual, the couple and the family. It is not surprising that these changes both solve and create new problems. If there is a lot of stress, it might be difficult to maintain sexuality (in its broadest sense) and to be good role models for children.

People react to, cope with and express stress in different ways. Some express difficulties in coping with stress factors by means of symptoms, for example depression, anxiety, insomnia, psychosomatic symptoms/illness. Others turn to drugs or alcohol or express difficulties through violent behaviour, and at its extreme this can involve rape, child abuse and battered wives.

Definitions

The keywords in this literature study are: *intimate relationship* within a marital context, *sexuality*, and *psychological dysfunction*. In the following each concept will be defined.

Intimate relationship

One defining characteristic of an intimate relationship is the interdependence of the partners (32). Interdependence refers to the mutual impact that the partners have on one another; when one partner acts the other reacts. In an intimate relationship, interdependence is frequent, strong, diverse and enduring.

Another way to define intimate relationships is in terms of the psychological needs they serve (27). Weiss (33) has suggested that we all have five important needs that can be met only through relationships with other people:

- the need for intimacy - someone with whom we can share our feelings freely;
- the need for social integration - someone with whom we can share our worries and concerns;
- the need for being nurturant - someone whom we can take care of;
- the need for assistance - someone who will help us out when we need it, and
- the need for reassurance of our own worth - someone who will tell us that we matter.

Another important component of an intimate relationship is emotional attachment or love.

In summary, an intimate relationship has at least one of the following three characteristics:

- interdependence in terms of behavioural interaction,
- need fulfillment,
- emotional attachment - love

It has to be borne in mind, that intimate relationships do not exist in a vacuum. On the contrary, they are affected by, and in turn affect, individual, interpersonal and social environmental conditions (34, see Fig. 1). This last category includes, among other things, culture, norms and gender.

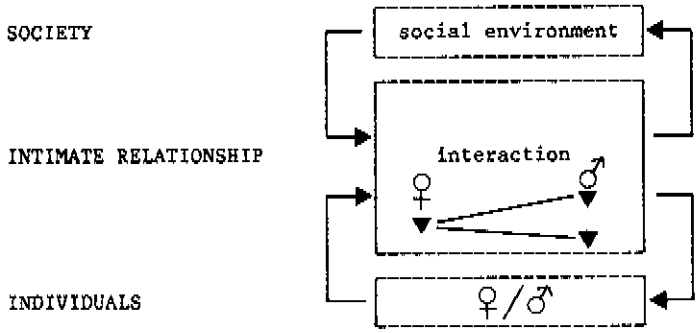


Fig. 1 Schematic outline of an intimate relationship, its link with the social enviroment and individual characteristics.

Sexuality

The human species reproduces itself by sexual behaviour so we can understand sexual behaviour in terms of its reproductive role. However, by exploring human sexual behaviour only as it relates to reproduction, we overlook its enormous significance to human beings.

In other words, the importance of human sexual behaviour must extend far beyond the reproductive role. The feelings and motivations of individuals who engage in sexual behaviour can only be understood and explained from a psychological perspective. The psychological factors are of such great importance that a special term has been created to capture them: *sexuality*. Whereas *sex* refers to the difference between males and females and their potential for reproduction, *sexuality* refers to the awareness of and reaction to sex.

Sexuality, which is an integral part of everyone's personality, is here defined as:

> *a psychic energy which finds physical and emotional expressions in the desire for contact, warmth, closeness, tenderness and often love.*

Individual sexuality - It is here suggested that individual sexuality encompasses two components: sense of identity and the erotic (sexual desire, sexual behaviour and sensuality).

An individual's sense of identity consists of subidentities, such as, for example, core gender identity and gender role identity.

Core gender identity, which constitutes the core of the personality, refers to an individual's own psychological awareness of whether she or he is a woman or a man, a girl or a boy. This awareness is of a conscious as well as an unconscious character.

In contrast to core gender identity, which refers to femaleness and maleness, gender roles refer to "femininity" and "masculinity". Gender roles are the different social and cultural expectations ascribed to the two sexes, and "feminine" and "masculine" gender roles are identified respectively with negative and positive values. There is also a power component built into the concept of gender roles. The "masculine" gender role has a higher status than the "feminine" role.

Gender roles consist of three elements:

1. *Gender role identity* i.e. an individual's self-concept as "masculine", "feminine", androgynous or undifferentiated. An androgynous individual scores high on "feminine" as well as "masculine" personality traits, whereas an undifferentiated person scores low.

2. *Gender role behaviour* refers to whether the person behaves or does not behave according to gender role norms, and it may or may not coincide with

3. *Gender role attitudes* (the person's attitudes toward women's and men's social roles).

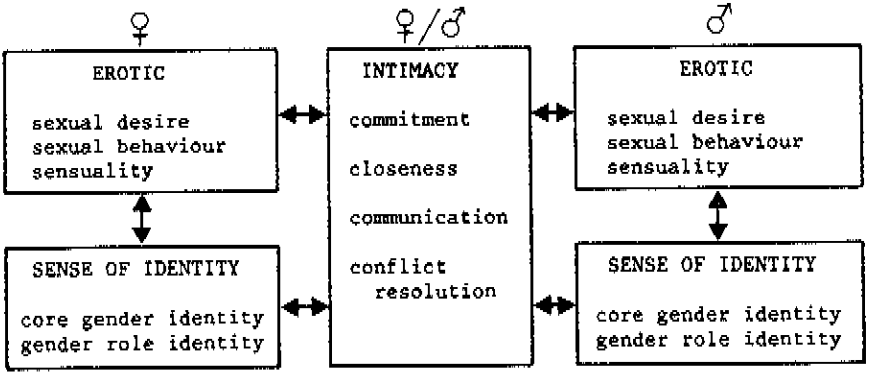
It should be noted, that these three elements are not necessarily congruent with one another. A man, for example, may display a "feminine" gender role identity, a "masculine" gender role behaviour and egalitarian gender role attitudes.

Thus, to summarize, the concept of individual sexuality encompasses two components: the *erotic* (sexual desire, sexual behaviour and sensuality) and *sense of identity* (core gender identity, gender role identity, behaviour and attitudes).

Interpersonal sexuality - When we take into account interpersonal sexuality, besides the other two components, we must add a third, namely intimacy. From the author's perspective the concept of intimacy includes four elements:

1. *commitment*
2. *closeness*
3. *communication*
4. *conflict resolution*

Sexuality within the context of an intimate relationship could be illustrated in the following way:



Psychological dysfunction

A marriage is exposed to various stress factors. These can arise from external (e.g. unemployment, work stress, financial problems, children's day care problems) as well as from internal sources (e.g. role strains, conflict between spouses, individual problems). It should be noted though that there may be an interplay between the two sources, for example unemployment may contribute to marital strains/conflict.

Some people can cope with difficulties in a positive way without too many negative effects. Others cannot, but end up with various forms of psychological dysfunction on an individual, couple or a family level. Psychological dysfunction can be reflected in symptoms, for example depression, anxiety, psychosomatic symptoms and sexual dysfunction as well as in diffuse feelings of dissatisfaction with respect to marriage and/or life in general.

In this literature study focus will be on dysfunction in the couple (depression and sexual dysfunction), and in the children.

Psychological dysfunction and marital status

For many years it has been recognized that the unmarried are more disposed than the married to emotional problems. Married people tend to be healthier (35) and to live longer (36). People who regard their marriage as happy and satisfying have a greater sense of wellbeing than people who are dissatisfied with their marriage (27).

There is a remarkably consistent trend among various studies from different countries that the divorced of both sexes are greatly over-represented in psychiatric hospital admissions. The same trend holds for outpatient psychiatric services as well. It can thus be reasonably concluded that the divorced and separated are high risk groups for psychiatric hospitalization and outpatient treatment (38). These studies did not, however, distinguish people who initiated the marriage breakup from those who were left by their partner.

Renne's study (39) is of particular interest. She studied the relationship between various health indices and marital adjustment as well as marital status. Her findings were comparable to those of previous studies in finding the divorced to have the poorest psychological wellbeing. When data were re-analysed by degree of marital adjustment she found another picture: marriage appeared to be associated with better psychological wellbeing only among the happily married, and there were few differences between the divorced and those who were unhappily married.

Kessler & Essex (40) studied the effects of three sets of coping resources on financial and parental strains, among other things. The coping resources were: social resources (access to and use of networks); intimacy (feelings of oneness and openness) and intrapsychic resources (mastery over one's own fate and a feeling of self-esteem). Data showed that married people possessed higher levels of a sense of mastery over their own fate and more self-esteem than the nonmarried and that married people had greater access to both intimate and close relationships. It was also found that concern over financial matters contributed less to depression among the married than nonmarried people due to the relatively high levels of self-esteem and mastery.

Another finding was that married homemakers were less depressed than were nonmarried homemakers. The intrapsychic resources helped reduce the depression. Intimacy helped homemakers cope with these strains, in part because intimacy bolsters up feelings of self-esteem and mastery.

Levels of parental strain were very much the same among married and nonmarried people. At the same time, the presence of a child in the home, especially of preschool age, had a much more seriously depressing effect on nonmarried than married people.

Social resources and employment in particular reduced the depressing effects of young children. This effect was much more pronounced among women than men. Intimate relationships were so important, that without them married people would have been much more depressed by the presence of young children. Intrapsychic resources had little effect on the depression "caused" by children.

Explanatory models

How can we explain the observed relationship between marital status and psychiatric problems? The main hypotheses can be divided into two groups: the premarital and postmarital hypotheses.

The premarital hypotheses postulate that seriously psychiatrically impaired individuals have difficulties with close relationship and therefore have difficulties in becoming married and staying married and that this explains the relationship between marital status and mental health service usage.

Segraves (41) was able to identify five prospective studies on the impact of premarital personality traits on subsequent marital adjustment. Four studies (42-45) reported that premarital neurotic personality traits were related to subsequent marital maladjustment. However, these studies suggested that only about 10% of the variability in marital adjustment could be predicted from premarital personality impairment. A more recent study (46) indicated higher correlations between premarital factors and subsequent marital adjustment. However, most of these variables appeared unrelated to psychopathology.

Another interpretation attributes psychological distress to the powerful norms defining marriage as the most desirable state adults can attain. Single people are considered as being outside the normative pattern of living (47,48) and come to be seen as deviant and unfit. Their disposition to psychological distress is a consequence of being objects of contempt.

The postmarital hypotheses include protection and stress hypotheses. The protection hypothesis (39) posits that marriage protects against psychiatric impairment primarily because close emotional ties are protective against emotional illness.

A second interpretation postulates that a good marital relationship engenders emotional security and helps define one's role in life as parent, relative and friend. According to this model, a bad relationship with a spouse might create impairment in an otherwise normal person (41).

Kessler & Essex (40) emphasize a third explanation. They suggest that married people are less emotionally vulnerable than nonmarried people. Recent research has shown that married people are particularly resilient to the emotional damage caused by a variety of strains and frustrations. The author's assumption is that series of specific coping resources (social, intimate and intrapsychic) are at work for married people, which help manage the psychological distress that can come on the heels of life's problems.

Pearlin & Johnson (49) emphasize the *stress-provoking problems* of daily life which, with rare exceptions, are ignored by present studies. A comprehensive understanding of the relationship between marital status and psychological function must recognize more than transitional traumas, norm violations and the possibility of psychological characteristics. They argue that economic resources, isolation from social networks and parental responsibilities contribute to differences in psychological functioning of the married and the unmarried. Their study (49) showed that the presently married were most free of depression, the formerly married were most burdened by it. These results remained the same even when sex, age and race were controlled for. The combination most productive of psychological distress was to be simultaneously single, isolated, experiencing parental obligations and, most seriously of all, poor. These findings suggest that marriage can function as a protective barrier against the distressing consequences of external threats. According to Pearlin & Johnson, it is to be noted that the links between marital status and depression are, in part, shaped by conditions rooted in broad social and economic structures and are not simple reflections of individual adjustments made on the basis of personality.

The premarital hypotheses tend to be favoured by biologically or psychoanalytically-oriented psychiatrists, and the postmarital hypotheses by social psychiatrists and social psychologists (41).

Summary

1. Unmarried people are more disposed to emotional problems than married people.

2. The divorced and separated are high risk groups for psychiatric hospitalization and outpatient treatment.

3. The presence of a child, especially of preschool age, has a much more seriously depressing effect on nonmarried than married people, although the parental strains are very much the same among married and unmarried people.

4. Employment for women in particular reduces the level of depression "caused" by young children.

5. It is most productive of psychological distress to be simultaneously single, isolated, experiencing heavy parental obligations and, most seriously of all, to be poor.

6. There are two main hypotheses concerning the relationship between marital status and psychological dysfunction; premarital and postmarital.

Sex differences in relationship to psychological dysfunction

There seems to be a widespread agreement that females are more likely to report more problems in a relationship than males (27); females desire more changes in their partners than do males (45); cohabiting females cite more problems in their living arrangement than cohabiting males (50); divorcing females have a greater number of complaints than divorcing males (51,52); divorced or separated females report having been more unhappy prior to the separation than divorced or separated males (23). There is also some evidence (45,53) that the degree of female dissatisfaction with a relationship is a better predictor than males' unhappiness of whether the relationship will end. These findings may indicate that females are more sensitive to and aware of relationship problems than are males (27).

Another possibility is that women and men come to the relationship with different expectations and desires and that, on average, present-day heterosexual relationships work better to fulfill the expectations and desires of men than of women (54). If so, Brehm (27) argues, it may be the case that women are sensitive to the failure of the relationship to fulfill their particular needs (for emotional support, responsiveness, intimacy), while men are equally sensitive to the success of the relationship in fulfilling theirs (for companionship, nurturance, sexual gratification).

In the United Kingdom, as in the USA, women are overrepresented among those receiving treatment for mental illness. Admissions for depressive psychosis account for a large part of the female excess. Women also predominate in the neurotic category. Various studies have shown that women have more psychological impairment than do men (55-57). It seems that the highest rates of depression in women occurred in their forties, corresponding with a time when marital satisfaction was lowest (58).

When we take into account marital status, we find that in the three unmarried categories (divorced, separated, widowed) men are at greater risk than women of inpatient treatment. Marriage is associated with a much lower risk of inpatient treatment for both sexes. However, married women have demonstrated more "pathology", including depression, than have either married men or unmarried women (54,59). Marriage thus affords women less protection than it does for men.

How do we explain these sex differences?

1. *Biological differences in susceptibility* However, this explanation is not sufficient to account for the large differences (60).

2. Another explanation is *the traditional gender role definitions of women and men* (38). Firstly, the "feminine" role, encompassing as it does dependence, passivity, and low self-esteem (the traditional perspective of the role) may make women less able to cope with life stress and hence more likely to respond pathologically. Second, girls may be more protected than boys during their upbringing and they may be taught to identify the opposite sex as instrumentally more effective than their own. One consequence of this type of upbringing might be that women who accept traditional gender role definitions will have only a relatively low ability to influence their environment. Women may also experience more discrimination in employment and more disruptive changes associated with marriage. All these factors may contribute to a condition of "learned helplessness" which, as suggested by Seligman (61), may lead to depression. Thirdly, women possibly find it easier to admit to symptoms and seek help from others than do men, for whom admitting to emotional problems may be taken as a sign of weakness and inadequacy.

This social gender role proposition is seriously weakened by its inability to account for the relationship between marital status and depression. As it is believed women need marriage more than men in order to gain identity, status and a role, a literal application of the proposition would predict that marriage should provide greater protection for women than men. It should also mean that women would be more affected by the loss of a spouse through divorce or death than would men. The opposite is true in both cases.

Clearly, a viable explanation for sex differences needs to take account of the differential effects of marital status for women and men. The most detailed theory to date has been developed by Gove et al. (55). They set a number of propositions about the relative satisfaction available to married women and men, which could account for the sex-related differences in rates of psychological disorder:

- Married women often have only one major social role - housewife - whereas men have two roles - head of household and participant in a career[a].

- The housewife role occupied by married women is relatively unskilled, undemanding, boring and of low status.

- The housewife role is unstructured and invisible:

---

[a] This condition has been dramatically changed in many countries during the last decade.

- Even if a married woman has a job, it is usually less satisfying than a man's.

However, various studies have produced no convincing support for the model. Fox (62) found that women in all marital status categories were more likely to be mentally ill than men. Warheit et al. (63) failed to find any meaningful interaction between sex, marital status and psychological wellbeing. In England, too, Cocharane & Stopes-Roe, (38) found that the marital status of respondents in a national community survey was not related to their psychological symptom levels, nor did marital status interact with sex in the way predicted by Gove.

What are the effects of female-paid employment on psychological status? Considerable research has focused on the beneficial effects of paid employment for women, in contrast to being a housewife (64-67). The beneficial influence of employment on health may simply be due to the income derived; on the other hand, better wellbeing may result from the increased self-esteem or social support that is provided by the job situation (68). Various studies (68,69) have found that employment protected women from depression. One of the more consistent findings in the literature to date, is that the psychological wellbeing of employed married women is poorer than that of employed married men - and not markedly better than that of married housewives (64,70). From a gender role perspective, these findings are not surprising. Whereas work is compatible with the family-role expectations of men, it is less compatible with the family roles of most women, thus resulting in role stress and the poorer psychological wellbeing of women (68).

One interesting finding (38) is that women with unemployed husbands were likely to report high levels of depression. There was, however, no reciprocal effect of wives' employment status on the psychological wellbeing of their husbands.

Rosenfield (71) found that women had higher levels of depressive symptoms in families with the traditional division of labour but that the position was reversed in the non-traditional families. This reversal was caused partly by the lower depression scores of working wives compared to housewives and partly by the higher depression scores of husbands with working wives compared with husbands whose wives did not work (68).

Summary

The findings indicate that there are differences between the sexes as well as within the sexes.

1. Women are more likely to report more problems in a relationship than males.

2. Women report more psychological symptoms than men and this is mostly marked for depression.

3. Unmarried women have fewer symptoms than unmarried men, whereas married women display more symptoms than their male counterparts.

4. Psychological wellbeing of employed married women is poorer than that of employed married men.

5. Unemployment of married men is related to high symptom levels in their wives but not vice versa.

6. Married, employed women have fewer symptoms than married men with working wives.

7. Women in employment have fewer symptoms than women not in employment.

8. Husbands report fewer symptoms in families where wives do not work, than where they do work.

Psychological dysfunction and marriage

Although there is an accumulation of studies showing that people with spouses are more likely to enjoy psychological wellbeing than those without (64, 72-74), numerous studies have reported a close relationship between indices of marital unhappiness and individual emotional distress (42, 75-81).

The impact of marital discord on mental health service utilization is, however, difficult to document, as the degree of marital discord in patients is not usually recorded by mental health services. The diagnostic categories do not really give any information, as most are individual diagnosis and do not reveal to what degree marital difficulties may have been a precipitating event.

However, there is indirect evidence to suggest that marital discord may contribute to the utilization of mental health services. In one study (82) 42 of the people who had sought

professional help in times of crisis, reported the crisis situation to be a marital problem. Sager et al. (83) found that in 50% of the cases, where the patient was in individual psychotherapy due to individual complaints, serious marital problems were later uncovered in the course of therapy. Considerable evidence suggests that marital discord is a frequent precipitating factor in suicide gestures and attempts (84,85).

Depression

There are several lines of evidence that link marital turmoil to clinically significant depression (86). Cammerer (87) suggests that therapists of depressed patients should assess more closely the level of marital support or stress among depressed individuals, and with marital maladjustment clinicians should be aware of potential depression (88).

As noted before, married women appear to display more depression than married men or unmarried women. Paykel (89) demonstrated that marital difficulties were the events most likely reported by depressed women prior to the onset of depression. An English study (90) found that depressed and neurotic women were five times as likely to have disturbed marriages than "normal" women. Another study (91) also identified a strong association between negative marital scores and the diagnosis of neurotic depression. In addition, findings of the same study indicated that a sample of female psychiatric patients with poor marriages experienced psychological breakdown earlier and the delay between marriage and first breakdown was shorter compared with patients who did not have poor marriages. Comparison between a female patient and a non-patient group characterized by poor marriages revealed that the patient group displayed more disturbances of the sexual relationship and also that their in-laws were more disapproving of the patient and the marriage than their non-patient counterparts.

Another study (92) showed that 38% of women without a close, intimate and confiding relationship with a husband or a boy-friend developed psychiatric symptoms of a predominantly depressive type when exposed to stressful life events or major difficulties. Working class women with children at home were much more vulnerable to the onset of disturbances when exposed to such stress.

In contrast, Coleman & Miller (88) found the correlation between depression and marital maladjustment to be stronger for men than for women. Women who were referred as patients seemed to be depressed irrespective of the presence or absence of marital conflict. There was also a low correlation between women's depression and their husbands' marriage ratings. Conversely, the greater the man's depression, the more both he and his wife rated

the marriage as in conflict (88). Barry (80) suggests in a review of family happiness, that the man's personality and instrumental functioning determines the level of marital happiness, regardless of the wife's disposition. Roy (93) identified poor marriage as one of many vulnerability factors associated with depressive male patients.

In other words, a poor marriage appears to be a risk factor associated with depression in both women and men. Other risk factors are parental loss before 17 years and unemployment (92-94).

Roy's study (94) found that both middle class and working class depressed women were more likely to have experienced parental loss before the age of 17 and poor marriage than their controls. Some of the women with a poor marital rating stated they were also unable to confide in their husbands. Among middle class depressive women more were unemployed than their controls. The middle class as well as the working class depressed women had more family history of depression. However, it should be noted that personality variables were not studied. In other words, we do not know to what extent personality problems or difficulties could have contributed to the results.

Ilfield (95) emphasizes that we must take into account social stressors as being equally important in affecting psychological functioning as past stressful changes or events. Social stressors are defined as circumstances or conditions of daily social roles which are generally considered to be problematic or undesirable. His research indicated that current marital stressors had the highest correlation with depression. Employed married fathers displayed a close relationship between stress of marriage and depressive symptoms. On the other hand, employed married mothers were equally affected by parental and marital stressors.

Three possible explanations of the association between marital discord and depression have been suggested by Birtchell & Kennard (91): the psychiatric symptoms may be generated by the marital disharmony; the marital disharmony may be a consequence of the woman suffering from neurotic depression; or the woman's personality may be such that she makes excessive demands upon her husband and becomes depressed if he is unable adequately to respond to them.

Rounsaville et al. (86) showed that the presence of marital disputes (defined in terms of situations in which the patient and the spouse had contradictory expectations of their own and their partner's marital roles) was an important determinant of treatment outcome for depressed women. Only a minority of women with marital disputes improved their marital relationship during the course of treatment. Those who did improve their marriage also experienced an

improvement in their depressive symptoms, while the majority of the women experienced less improvement or a worsening of symptoms. Bothwell & Weissman (96), on the other hand, found that even when the woman's depressive symptoms were no longer present, impairment of marital functioning persisted.

Sims (97) found that for women the poorest outcomes were among those who said on admission that their symptoms were precipitated by marital events.

Marital interaction - The results presented above are based on various global measurements of marital satisfaction/adjustment. In order to get a more complete picture of the relationship between marriage and depression, we need to focus on critical dimensions of marital interaction, such as emotional involvement, emotional expression, communication, conflict resolution, decision making, interpersonal control, role assignment (as to the roles the wife and the husband respectively should exhibit within the marriage) and role satisfaction (98).

With respect to emotional involvement, Henderson (99) found evidence that depressive states increased where emotional involvement was lacking.

Studies show there to be a reduction in expressions of emotion in marriages with depression. The evidence is quite consistent that there is increased criticism expressed between depressed patients and their spouses. Weissman reported in her study (100) that depressed women showed an increased amount of hostile behaviour towards their husbands. Hinchliffe (101) demonstrated increased negative emotional expression towards the spouse in "depressed" marriages. In another report (102) it was found that overt negative hostile behaviour was greater from depressed women than from depressed men.

McLean et al. (103) found a marked avoidance of communication among depressed patients. Weissman et al. (60) found that depressed women were reticent to discuss personal feelings and problems with their husbands. In contrast, the depressed men in Kreitman's study (104) were found to spend an increased time in face-to-face contact with their wives.

Theoretical views of depression as coerced and coercive behaviour suggest a considerable struggle for interpersonal control in these marriages. The increased criticism is one aspect of such a struggle. In Kreitman's study (104) it was found that among neurotic men there was an increased number of patterns of husband-domination and fewer cooperative marriages. Weissman's study (100) found increased submissiveness in marital relations by

depressed women. Among manic-depressive patients there was found to be a pattern where there was domination by the patient and greater passivity in the spouse. McLean et al. (103) found coercive communication patterns and an anarchic approach to domestic problem solving. Hinchliffe (101) found that in "depressed" marriages, there was substantially higher levels of control (indicated by interruptions and questions during a task assessing verbal interaction).

Studies have shown that marital intimacy influences emotional and physical wellbeing (105). Intimacy can be operationally defined as the dimension in the interpersonal relationship which most determines marital satisfaction. Facets of intimacy include: affection, cohesion, conflict resolution, compatibility, autonomy, identity, sexual life and expressiveness (105).

Various studies (106-108) have demonstrated an association between low ratings of marital intimacy and non-psychotic emotional illness and need for psychiatric help. Another study (109) found no relationship between intimacy and age, years of marriage, number of children, employment or religion. (It should be noted that no information is given as to the relationship between intimacy and sex). However, lower ratings of intimacy were found in less well-educated couples and couples with low income.

Summary

1. Several lines of evidence link marital discord to depression.

2. Working class women with children at home were much more vulnerable to the onset of depression when exposed to stress events.

3. The greater the man's depression, the more both he and his wife rate the marriage as in conflict.

4. The following characteristics have been identified in "depressed" marriages: a reduction in general emotional involvement; a reduction in expressions of affection; an increase in expressions of criticism (possibly greater among depressed women); a struggle for interpersonal control; a tendency towards less cooperation; an increase in husband-dominated patterns, occurring whether it is the husband or the wife who is depressed.

5. There is an assocition between low ratings of marital intimacy and non-psychotic illness and need for psychiatric help.

6. It must be kept in mind that any association between quality of marriage and depression could be as much to do with the effects of the symptoms upon the marriage as of the marriage upon the symptoms. It is also possible that only certain types of poor quality marriage give rise to psychological symptoms.

Sexual dysfunction

A survey of the psychological literature in the area of sexual dysfunction in the 1950's and early 1960's reveals, according to Roffe & Britt (110), that it centered primarily on an assessment of psychopathology and with a limited number of patients. Disturbances in sexual functioning were viewed as symptomatic of underlying pathology, accessible only to psychoanalytic treatment.

With the advent of the work of Masters & Johnson (111) there occurred a revolution in the focus of sex research. There was a shift in medical interest toward the physiology of normal sexual functioning of females and males, and clinical interest moved towards recognizing the variety of sexual experiences, categorizing the most common sexual dysfunctions and developing intensive short-term treatment programmes. This movement towards viewing sexual dysfunction as an etiological factor in the development of psychological distress has been of great importance to sex counsellors. Our comprehensive understanding of the specific role that a couple's sexual experience may play in the overall relationship has also increased.

Both clinicians and researchers have considered relationship factors to be of major importance in the development and maintenance of sexual distress (112-115). Clinical impressions suggest that the following phenomena may be of special relevance for sexually distressed couples: problems with gender role flexibility, openness and trust in communication, communication competence, active intimacy, personal freedom and responsibility and conflicts of dominance and submission, power struggles and hostility (112, 115-120).

The importance of the quality of marital interaction for sexual desire and satisfaction has been suggested by several empirical studies using questionnaire data. In one study sex therapy clients reported less communication about sexual experiences than "normals" (121), whereas another (122) identified deficits in problem-solving communication. Zimmer's study (123) found that clients with sexual dysfunction and high scores on depression, had even worse ratings on influence strategies, self-acceptance, and non-verbal expression than both maritally distressed and "normal" couples.

Roffe & Britt (110) described three patterns of marital interaction in couples seeking help for sexual dysfunction - conflict-centered, passive-constrained and congenial-affectionate relationships. The data suggested that each couple pattern may make unique therapeutic demands on counsellors.

The transactional dynamics of the *conflict-centered couples* were characterized by an atmosphere of accusation and criticism from one partner, matched by demoralization and apology by the spouse. In its extreme form, one spouse may appear chronically angry, the other chronically depressed. Each spouse was anxious to keep distance in the relationship due to e.g. fears of emotional closeness.

Within the *passive-constrained relationship*, each spouse was careful to avoid an outward expression of disappointment, anger or dissatisfaction. Interactions were characterized by suppression of thoughts and feelings, and little personal information was exchanged. They exhibited a pattern of mutual withdrawal and limited involvement. The avoidance of assertiveness and minimization of differences by both partners tended to stifle individuality and were reflected in a facade of mutuality of interests and goals. One consequence of this pattern was the desexualizing of the relationship.

Couples in a *congenial-affectionate relationship* seemed to be more flexible in sharing intimacy, expressing affection, and empathizing with the spouse initially identified as the dysfunctional partner. This kind of relationship seemed to be relatively problem-free in terms of its general interactive qualities such as communication, emotional commitment and expression and role reciprocity. Sexual dysfunction was specific and circumscribed and the dysfunction was experienced with mutual disappointment, often accompanied by guilt and self-depreciation.

It has been suggested that symptom-focused sex therapies are not enough but that we need treatment approaches aimed at integrating changes in the couple's sexual system with changes in the character of the marital transactions that govern the couple's overall relationship (112, 124). This orientation regards sexual dysfunction as a multicausal phenomenon reflecting as much about the couple's relationship as the individual dysfunction. The marital couple is viewed as a functional, goal-directed unit in which each spouse is deeply invested and sexual dysfunction is one expression of their relationship predicament (110).

Frank et al. (125) reported that many couples seeking sex therapy also experienced considerable marital discord. In another study (118) a surprisingly high frequency of sexual problems were

identified in a group of happily married middle-class couples not seeking sex therapy and not voicing sexual complaints. Although erectile or ejaculatory difficulties were reported by 40% of the men and arousal or orgasm problems by 63% of the women, 85% of the couples reported that they were in general satisfied with their sexual relationship.

Hartman (126) found that couples reporting sexual dysfunction alone were more similar to symptom-free couples than to those experiencing marital conflict, with or without associated sexual dysfunction. Thus, it would appear as if sexual difficulties may in fact occur in a marriage that is functioning well. Interestingly, couples reporting both marital conflict and sexual dysfunction were rated as less disturbed on interpersonal variables than those with marital conflict alone. According to Hartman (126) these results suggest that sexual dysfunction and marital distress may operate independently of one another. This conclusion brings us to the question: How does one determine the impact of marital disharmony on sexual dysfunction?

The above-mentioned studies rely predominantly on correlational research which does not permit causal inferences to be drawn. From an etiological perspective, several alternatives are, however, possible. Sexual inadequacy may originate in relationship discord and therefore be viewed as a symptom of marital conflict. The opposite cause-effect relationship is also tenable. That is, the emergence of sexual difficulties in a marriage may generalize to other aspects of the relationship. It might also be the case that relationship factors and sexual function are totally independent of one another or finally, that the two have mutual causal impact (127).

It is possibe to illuminate causal channels indirectly through studies of treatment outcomes. McGovern et al. (128) reported that couples presenting for treatment with secondary female orgasmic dysfunction were found to enter treatment with more disturbed marital relationships than primary couples and to show less successful treatment results. Other studies have also found severe marital distress to indicate a poor prognosis in various forms of sex therapy (129, 130).

Everaerd & Dekker (131) attempted to determine whether the learning of communication skills and cooperation, without explicit sex therapy, would be sufficient to ensure more satisfactory sexual interaction. Findings indicated that both interventions resulted in improved sexual functioning, although sex therapy was more effective than communication therapy. Males especially showed significantly more improvement in sexual satisfaction with sex therapy. Communication therapy in fact resulted in a decrease in sexual

functioning for males. In order to increase total relationship satisfaction, women benefitted the most from sex therapy and males from communication therapy.

Hartman & Daly (132) found that about 25% of their sample displayed relationship distress concurrent with sexual dysfunction and required marital therapy as a necessary initial treatment to set the stage for sex therapy. Thus marital harmony may be necessary to treat sexual dysfunction but may not be sufficient in itself.

Hartman (127) evaluated the effects of sex and marital therapy on sexual satisfaction and marital happiness in couples seeking treatment for sexual problems. The results on measures of sexual interaction and marital happiness revealed a complex pattern of results according to sex. She found that sex therapy was more effective than marital therapy for both women and men in reducing their dissatisfaction with the frequency of sexual activity. For women, sex therapy produced greater improvement in their average level of sexual enjoyment, whereas men responded more to marital than sex therapy on this measure. Sex therapy was more effective in increasing self-acceptance of sexual enjoyment in women, while marital therapy proved more effective in this regard for men.

Summary

1. Relationship factors are of major importance in the development and maintenance of sexual distress.

2. Sexual dysfunction is a multicausal phenomenon.

3. Sexual dysfunction may occur in the context of a functional marital relationship, in other words, sexual dysfunction and marital distress may operate independently of one another.

4. Sex therapy is often more effective than communication therapy/marital therapy in improving sexual functioning.

5. Marital therapy is sometimes necessary as an initial treatment to set the stage for subsequent improvement in sexual satisfaction via sex therapy.

Marital conflict and problems in children

The impact of marital conflict on children has become the focus of an increasing and theoretically diverse professional literature (133). A number of investigations have found a relationship between discord in intact marriages and the severity or frequency of behaviour problems in children. This finding remains consistent across such countries as the USA (134,135), the United Kingdom (136) and India (137).

Several investigators have reported that parents whose children attend a psychiatric clinic are more often dissatisfied with their marriage than parents of children in the general population (140). Many family systems' theorists have suggested that children's disturbed behaviour is often a symptom of broader family conflicts (139). Behaviour therapists view marital conflict as a stress factor that can undermine treatment implemented by parents (140,141) and lead to inconsistent discipline practices (142). Psychodynamic therapists have been concerned that family conflict can produce psychological difficulties for children.

On the other hand, the relationship between the two variables is not simple. The child's behaviour may affect the parents' feelings about their marriage and be affected by them but these variables are also likely to interact with the parents' personalities, their mood and their self-esteem (143-146).

What is the empirical evidence concerning the relationship between marital and childhood problems? After reviewing the literature, Emery (142) concluded that a relationship between interparental conflict and children's psychological problems has been empirically demonstrated for both two-parent and divorced families. However, three methodological problems in the literature have consistently clouded estimates of the strength of the relationship:

- there has been a heavy reliance on sampling from child clinic populations;
- the same person has often evaluated both the marriage and the child, and
- measures that are of dubious reliability and validity have frequently been employed (142).

Stronger associations between marital discord and child adjustment seem to be found in clinic rather than in nonclinic samples. Christensen et al. (147) examined the intercorrelation between four family variables - marital disturbance, parental psychopathology, interactional dysfunction and parental perception of the child. In contrast to previous research (e.g. 148, 149) data

from fathers were included. The results suggested that parental perceptions of child behaviour problems were associated with marital discord and negative parental behaviour toward the child, but not with the behaviour of the target child. These results are consistent with the theory that the child is sometimes the scapegoat of parental marriage distress (150). In other studies (151,152) greater degrees of communication difficulty in parents of clinic children were found than in those of nonclinic control children. Lo (153) found that the emotional relationship between parents was a significant factor in differentiating neurotic from non-neurotic children.

Emery and O'Leary designed a study (133) to examine the relationship between marital discord in nonclinic, two-parent families and children's behaviour at home and in school. They used independent assessors as well as well established measures with respect to reliability and validity. One shortcoming of the study is, however, that data were collected only from the mothers. The most significant result was the low level of association found between marital discord and child behaviour problems. Comparable results have been reported in previous nonclinic sample studies (134,154,156).

Rutter (157,158) however, reported the opposite; strong associations between marital discord and childhood psychopathology in nonclinic samples. The relationship was, however, stronger between child problems and unhappy marriages characterized by quarrelsomeness than between child problems and unhappy marriages characterized by apathy. One explanation may be that the samples in the Rutter studies included a highly disproportionate number of children (50%) with adjustment difficulties (133).

It has been suggested that discord in intact families is related to disorders of undercontrol of children but not overcontrol (136). In studies of intact marriages, one nonclinic study (159) found that discord was related to feminine-aggressive behaviour, antisocial behaviour and sex anxiety but not abnormal fears in child. In a clinic group (160) it was found that marital discord was related to childhood aggression and encopresis but not to enuresis. Still another study (135) found that marital discord related to behaviour problems and anxiety in clinic children but two similar investigations found significant relationships only for behaviour problems (133,134). In direct conflict, Rutter (136,161) found significant relationships for behaviour problems but not for neurotic problems in nonclinic samples. The present data seem to indicate that interparental conflict appears to be related more strongly to the problems of undercontrol than of overcontrol of children.

It is well documented that children from families where a parent has a psychologica disturbance are at an increased risk of a variety of behavioural problems (162). In samples of nonclinic children in which one parent demonstrates serious individual psychopathology, moderate to strong correlations between marital and child problems have also been found (136,137).

Rutter (136) found that discord in intact marriages was related to antisocial behaviour in the children, both of normal parents and of parents with a personality disorder. On the other hand, when the marriage was harmonious there was no increased antisocial behaviour associated with parental disturbance.

It appears, thus, that marital discord is more strongly related to child behaviour problems in samples in which 1) nonclinic children with current adjustment problems are overrepresented; 2) one or both parents is psychologically disturbed; or 3) the children have been referred for psychological treatment.

Considerable recent evidence suggests that marital turmoil has a greater effect on boys than on girls, from both divorced and intact, discordant marriages (133,135,136,161,163). In clinic samples (133-135) considerably stronger associations have been found between marital discord and behaviour problems in boys than in girls. Porter & O'Leary (135) found in their clinic sample that marital hostility correlated with many behaviour problems in boys. Neither general marital unhappiness nor overt marital hostility related to problem behaviours in girls.

A series of studies looking for patterns have found that the interactive effects of parental conflict, sex of child, and relative parental dominance are predictive of later psychopathology (164). One study (151) found that parents of neurotic boys were characterized by maternal dominance, whereas the parents of neurotic girls were paternally dominated. In another study (165) sons exhibited fewer problems when the father was dominant, and daughters exhibited fewer problems when the mother was dominant. A further study (166) established that families of neurotic delinquent boys were characterized by verbal aggression between the parents and by maternal dominance. These studies appear to provide strong support for Schwarz's (164) triple interaction model of psychopathology. That is, parental conflict and cross-sex dominance may lead to psychopathology in children. Schwarz has elaborated the model by adding changeable parental love to predict depression. The triple interaction model was supported in a study (164) where inconsistent love from father in high-conflict, paternally-dominated families associated with the greatest vulnerability to depression in girls. Consistent parental love, low conflict, and paternal dominance were, on the other hand, associated with the least vulnerability to depression.

In nonclinic samples of intact marriages, problems in both boys and girls have been found to be related to marital discord (163,167). However, marital turmoil was found to be related directly to undercontrol only for boys, whereas those weaker associations that were found for girls were with overcontrolled behaviour. In contrast, Emery & O'Leary (133) found no difference in the association between marital discord and childhood problems for boys and girls.

In sum, it can be concluded that in several studies with adequate methodology, marital turmoil is more strongly related to behaviour that is obviously maladaptive in boys than in girls. However, it is possible that the effects on girls may be delayed. Girls are likely to be just as troubled by marital turmoil as boys but may demonstrate their feelings in a manner that is more "appropriate" to their gender role, namely by becoming anxious, withdrawn, or perhaps very well behaved.

The parent-child relationship deteriorates as a result of marital turmoil. However, there is emerging evidence that a particularly warm relationship with at least one parent can mitigate, but not eliminate, the effects of marital turmoil on children. It should be noted though, that boys from discordant marriages still had more problems than did boys from happy marriages despite the good parent-child relationship (142).

There are various hypotheses that aim at explaining how marital turmoil may produce childhood disorders: for example disruption of attachment bonds, modeling, altered discipline practices. It is unlikely that any single hypothesis fully explains the relationship between marital and child problems, yet each may prove to have merit. Parents involved in conflicts are probably poorer models, are more inconsistent in their discipline, and place more stress on their children.

Summary

1. Openly hostile and continued conflict has a great effect on children.

2. The most prominent childhood problem is of undercontrol.

3. Boys demonstrate a greater observable response than do girls.

4. Increased interparental conflict may explain many of the negative effects found among children of parents with individual psychopathology.

5. A good relationship with at least one parent can partially buffer negative effects.

6. So far, there is a gap in our understanding of the forms of family conflict that are related to the types of behaviour problems.

7. The results presented here clearly suggest a focus on marital adjustment and parent-child interaction, rather than individual child therapy when treating families with child behaviour problems.

8. In order to answer questions of etiology, we need prospective, longitudinal investigations with both clinic and nonclinic samples of children and to obtain data from multiple sources.

General conclusions

On the basis of the research results presented in this literature study, the following general conclusions can be made.

Generally speaking, women report more psychological symptoms, in particular depression, than do men. Marriage, in comparison to not being married, appears to be protective of both sexes, but less so for women. While employment for married women has a beneficial effect on their psychological wellbeing, employed married men are still better off psychologically than their female counterparts.

Another interesting finding is that the husband's personality and functioning appear to determine the level of marital satisfaction, whereas the wife's disposition does not play any crucial role.

Although there is clear evidence of a link between relationship factors and development of sexual dysfunction, there is still a gap in our knowledge concerning cause and effect. Some findings indicate for example that sexual dysfunction and marital distress may operate independently of one another.

Research findings also indicate that there is a relationship between marital discord and children's problems. In particular, openly hostile and continued conflicts have a great effect on children, particularly on boys, who usually react by means of undercontrolled behaviour. The association between marital distress and childhood problems seems to be stronger among children who attend psychiatric clinic or where one or both parents are psychologically disturbed.

Considering the model of sexuality (p.7) it would appear reasonable to argue that there exists a relationship between psychological dysfunction and sexuality. However, it is not possible to state anything about cause inferences. Symptoms such as depression and sexual dysfunction may originate in difficulties within the intimacy sphere, but on the other hand depression may affect intimacy and sexual expression in an obstructive way.

The studies presented here have some significant flaws that need to be highlighted. Generally speaking, it should be noted that there is a tendency within marital research to focus on quantitative studies, in spite of the fact that emphasis is put upon understanding the dynamics of the family. In other words, there is a lack of studies illuminating the dynamics within a couple. Another general limitation is the cross sectional character of projects.

The researchers cited in this study have usually used global measurements of marital satisfaction. There are actually few studies that have been concerned with identifying various patterns and dimensions of intimacy that may contribute to marital conflict and/or psychological distress. The same argument holds for inner personality factors. By taking into account a dimensional perspective we would get a more diversified picture of marital interaction.

Whereas gender role behaviour has been quite extensively studied, there is still a gap in our understanding of gender role identity per se as well as various constellations of gender role identity within couples and their meaning to marital satisfaction. It was found, for example, in one study (168) that androgynous women and men were more likely to be satisfied on both a global measurement of marital satisfaction as well as on various dimensions of intimacy than the "masculine" wives in particular. Findings also indicated that those couples characterized as non-traditional (where one or both of the spouses displayed an "atypical" gender role identity, for example where the wife showed a "masculine" or the husband a "feminine" gender role identity) were more likely to be characterized as "two marriages within one" than the traditional or androgynous marriages.

As the number of cohabiting couples is increasing in many European countries, it would be valuable to conduct comparable studies (married - cohabiting - non-steady relationships) and cohabitation studies per se. It also appears to be very difficult to find studies that focus on mixed relationships, for example different cultures or nationalities.

Many research projects make use of "control" groups, i.e. "non-married". However, it is often impossible to decide whether "non-married" refers to cohabiting individuals or people who are not involved in any steady relationship at all. This is a vital criticism, as interpretations and explanations of the findings will be of different character, depending upon the "status" of the individuals.

The findings presented in this literature study are mainly of a descriptive nature. Many of the results are, however, left without any interpretation and/or explanation. Others present interpretations but they are solely on a social level and do not pay attention to psychological aspects. To give some examples: in one study (38) it was found that married women with unemployed husbands were likely to report high levels of depression but not vice versa. The author's interpretation is "women would be affected by unemployment of their spouses, as this is likely to lead to material hardship and status decline even if the woman herself has a job". From a psychological perspective the result could be understood in terms of projection. Many men may be afraid of depressive feelings and not "know" how to handle and cope with them. This emotional state might recall memories from the early mother-child relationship that very much was characterized by chaotic emotions. Hence, these feelings are projected on the wife and displayed by her.

Another study (88) found that married women seemed to be depressed irrespective of the presence or absence of marital conflict, if they were referred patients. The author does not discuss the possibility that there might exist latent marital conflicts, such as power-struggles. Due to difficulties in expressing and dealing with controversies, it is kept invisible. On the surface the marriage may come across as nice, peaceful and harmonious, but the wife is depressed.

Finally, and maybe the most important flaw is that it appears as though most of the researchers have not really considered the importance of bringing into consideration the concept of gender and its meaning for intimate relationships (the gender system). In some cases the researchers have not even separated the sexes in their analyses which might be a manifestation of the monosexual tradition in western thought or an androcentric viewpoint (reality is only considered from a male perspective).

In contrast to the traditional model of the family, the basic assumption behind the gender system is that women and men do not have the same position within the family and that there are controversies and conflicts of interests between the sexes. These conflicts are of material and psychological character and related to different societal conditions for women and men. There is, for

example, an invisible assumption within the family that the conditions that are of importance to the wife should be subordinated to the conditions important to the husband (169,170).

From a "marital perspective", where harmony is the basic assumption, conflicts are looked upon as negative. However, conflicts, if resolved in a constructive way, can bring something positive to the relationship as well as to the individual. It is of interest and importance to study the way in which concurrence between consequences for the couple and for the wife and the husband respectively are moulded. An employed wife could, for example, perceive her job as positive and increasing her self-esteem. The husband, on the other hand, might see her job as a threat to their relationship and/or as a demasculization of him. The contradictory perspective may contribute to conflicts between the spouses and even psychological dysfunction.

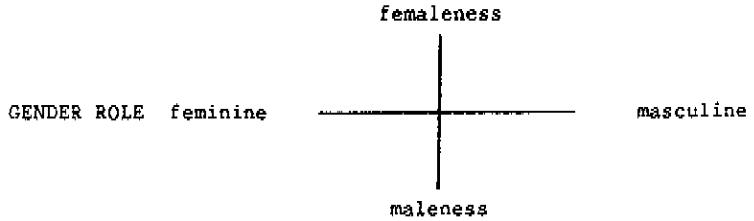
Gender system is a link in the development of a theoretical framework to describe and understand the intimate relationship. Hierarchies or oppression are aspects of this systme and another manifestation is its complementary or polarizing aspect. The interaction between the sexes has to be understood as a number of continual negotiations within the individual, as well as between the spouses, about the meaning of gender for the relationship. The one who decides the rules and norms in these negotiations is the most powerful person.

What then is the meaning of gender in marital interaction? The main idea is that loving another person can give that person power over oneself. This process is simplified by the societal balance of power, i.e. men's societally condoned power over women (170).

Some of the earier analyses of intimate couples focused upon gender roles. Today we have to expand that perspective and consider the continuous negotiations that go on between women and men as to the significance of gender for the intimate couple.

However, when an individual perspective is applied to gender, it is necessary to use a two-dimensional explanatory model. The traditional model describes core gender identity as parallel to gender role identity. Such a theoretical model keeps both sexes in an insoluble conflict, where men and women cannot display optimal behaviour. The two-dimensional model, on the other hand, describes the two concepts as two separate lines (171). This model provides a perspective, where women are viewed as thinking, active and problem-solving individuals and men as emotional, nurturant and caring.

CORE GENDER IDENTITY



Another aspect that appears to be missing or ignored in the studies is the fact that women in patriarchial societies must put more restraint on their personality than do men. This condition may have a negative impact on women's psychological wellbeing. Girls and boys both incorporate at an early age - although on a diffuse and abstract level - the understanding that men have higher status and power in society than women. This kind of insight leads to various consequences for the girl, such as feelings of confusion and violation. She has to find an intellectual as well as an emotional solution to this dilemma. According to a Danish psychologist (172), the girl has to "choose" one of the following "routes" as a basis for her further personality development:

- she is good enough and hence male dominance does not exist, or
- male dominance does exist and hence she is not good enough, or in some cases
- both aspects can be accurate at the same time: "I am good enough and male dominance is part of reality".

Ethelberg (171) calls these three "solutions" personality strategies. The *first strategy* is based upon suppression of male dominance. A woman characterized by this personality strategy relates to men in such a way that the power relationship is made invisible. The *second strategy* is based upon an over-adaptation to the traditional female ideal with low self-esteem as one consequence. "It implies passivity and dependence which makes male dominance visible, but it is brought back by the woman on her own insufficiency". The *third personality strategy* is based upon protest. Women characterized by this strategy often make male dominance visible through protesting or being dominant themselves. The third strategy is often perceived as troublesome and many women give in due to pressure.

It could be hypothesized that married women who have developed the second strategy are more likely to react in a depressive way when marital discord appears. One plausible explanation could be that due to their low self-esteem and lack of self-confidence, feelings of resentment and anger are suppressed and turned into depression and feelings of guilt.

The "protesting" women (the third strategy) may develop depressive mood due to environmental pressures and lack of support. It is plausible that third-strategy women, in contrast to those employing the second, are more likely to initiate separation or divorce.

To summarize, it is suggested that future research that seeks to increase understanding and to find explanatory models of the complexity of the links between marital discord, psychological dysfunction and sexuality, should attend to:

- various dimensions of intimacy and their relationship to marital discord and psychological dysfunction;
- various personality factors, for example gender role identity and their links to intimacy, marital discord and psychological dysfunction;
- qualitative studies of couples characterized by marital conflicts and/or psychological dysfunction;
- cohabiting couples and mixed intimate relationships;
- the concept of gender, not only with an individual perspective (gender identity) but also paying attention to the way in which gender system influences intimate relationships.

Finally, researchers should be aware of sex as a social variable and attempt a non-biased treatment of the sexes.

There are also implications for medicine. Several important questions can be raised as to issues of marriage in medical practice. Are specialists or family doctors equipped to recognize marital problems that are presented covertly? Do they have the understanding and skills to respond adequately? Do they make use of resources when referral is necessary? Traditional medical education is poorly suited to equip physicians to recognize marital discord (105).

According to Segraves (41) the study of marriage in relationship to psychological dysfunction and the provision of treatment for marital discord have received relatively little emphasis within the psychiatric community. There appears, at least in the US, to be few accredited training programmes including training in the treatment of marital discord.

Although the current evidence does not permit definitive conclusions as to the relationships between marital status and psychological wellbeing, it does suggest that mental health training and service facilities should reconsider their relative lack of emphasis on marital and family therapy interventions. It is possible that psychiatric interventions to decrease the emotional turmoil associated with severe marital discord and separation might be cost-effective and serve a preventative function. Such interventions might include provision of support systems for individuals at the time of separation as well as marital and sexual counselling services for disturbed marriages (41, p.195).

References

1. Bowen, G. & Orthner, D. Sex role congruency and marital quality. Journal of Marriage and the Family, 45: 223-230 (1983).

2. Blood, R. Jr & Wolfe, D. Husbands and wives: The dynamics of married living. Illinois, Free Press, 1960.

3. Centers, R. et al. Conjugal power structure: A re-examination. American Sociological Review, 36: 264-278 (1971).

4. Olson, D. et al. Circumplex model of marital and family systems: cohesion and adaptability, dimensions, family types and clinical applications. Family Process, 18: 3-28 (1979).

5. Nye, F. Role structure and analysis of the family. Beverly Hills Ca, Sage, 1976.

6. Araij, S. Husbands' and wives' attitude behaviour congruence on family roles. Journal of Marriage and the Family, 39: 302-322 (1977).

7. Seyfried, B. & Hendrick, C. When do opposites attract? Journal of Personality and Social Psychology, 25: 15-20 (1973).

8. Boss, P. The relationship of psychological father presence, wife's personal qualities and family dysfunctions in families of missing fathers. Journal of Marriage and the Family, 42: 541-549 (1980).

9. Clark, R. et al. Work involvement and marital role performance. Journal of Marriage and the Family, 40: 9-21 (1978).

10. Scanzoni, J. Contemporary marriage types. Journal of Family Issues, 1: 125-140 (1980).

11. Scanzoni, J. Sex roles, economic factors and marital solidarity in black and white marriages. Journal of Marriage and the Family, 37: 130-144 (1975).

12. Snyder, D. Multidimensional assessment of marital satisfaction. Journal of Marriage and the Family, 41: 813-823 (1979).

13. Wilson, G. Feminism and marital satisfaction. Personality and Individual Differences, 3: 345-347 (1982).

14. Keith, P. & Schafer, R. A comparison of depression among employed single-parent and married women. The Journal of Psychology, 110: 239-247 (1982).

15. Nettles, E. & Loevinger, J. Sex role expectation and ego level in relation to problem marriages. Journal of Personality and Social Psychology, 45: 676-687 (1983).

16. Fogarty, M. et al. Sex careers and family. Beverly Hills Ca, Sage, 1971.

17. Pleck, J. The work family role-system. Social Problems, 24: 417-427 (1977).

18. Weingarten, K. The employment pattern of professional couples and their distribution of involvement in the family. Psychology of Women Quarterly, 3: 43-52 (1978).

19. Kvinnors arbete [Women's work]. SOU [Swedish Government official report], 89 (1979).

20. Strober, M. Women and men in the world of work: Present and future. In Cater, L. et al., ed. Women and men: Changing roles, relationships, and perceptions. New York, Praeger, 1977.

21. Hill, C. & Stafford, F. Parental care of children time diary estimates of quantity, predictability and variety. Journal of Human Resources, 219-239 (1980).

22. Atkinson, J. & Huston, T. Sex role orientation and division of labor early in marriage. Journal of Personality and Social Psychology, 46: 330-345 (1984).

23. Jacobson, N. et al. Reactivity to positive and negative behavior in distressed and nondistressed married couples. Journal of Consulting and Clinical Psychology, 50: 706-714 (1982).

24. Burr, W. Satisfaction with various aspects of marriage over the life cycle: A random middle class sample. Journal of Marriage and the Family, 32: 29-37 (1970).

25. Rollins, B. & Cannon, K. Marital satisfaction over the family life cycle: A re-evaluation. Journal of Marriage and the Family, 36: 271-282 (1974).

26. Rollins, B. & Galligan, R. The developing child and marital satisfaction of parents. In: Lerner, R. & Spanier, G., ed. Child influences on marital and family interaction. New York, Academic Press, 1978.

27. Brehms, S. Intimate relationships. New York, Random House, 1985.

28. Ryder, R. Longitudinal data relating marriage satisfaction to having a child. Journal of Marriage and the Family, 35: 604-606 (1973).

29. Houseknecht, S. Childlessness and marital adjustment. Journal of Marriage and the Family, 41: 259-265 (1979).

30. Vernoff, J. et al. The inner American: A self-portrait from 1957 to 1976. New York, Basic Books, 1981.

31. Glenn, N. & McLanahan, S. Children and marital happiness: A further specification of the relationship. Journal of Marriage and the Family, 44: 63-72 (1982).

32. Berscheid, E. & Peplau, L. The emerging science of relationships. In: Kelly, N. et al., ed. Close relationships. New York, Freeman, 1983.

33. Weiss, R. The fund of sociability. Transaction, 7: 36-43 (1963).

34. Kelly, H. et al., ed. Close Relationships. New York, Freeman, 1983.

35. Lynch, J. The broken heart: The medical consequences of loneliness, New York, Basic Books, 1977.

36. Berkman, L. & Syme, S. Social networks, host resistance, and morality: A nine year follow-up study of Alameda County residents. American Journal of Epidemiology, 109: 186-204 (1979).

37. Campbell, A The sense of wellbeing in America: Patterns and trends, New York, McGraw-Hill, 1981.

38. Cocharane, R. & Stopes-Roe M. Women, marriage, employment and mental health. British Journal of Psychiatry, 139: 373-381 (1981).

39. Renne, K. Health and marital experience in an urban population. Journal of Marriage and the Family, 33: 338-350 (1971).

40. Kessler, R. & Essex, M. Marital status and depression: The importance of coping resources. Social Forces, 61: 484-505 (1982).

41. Segraves, R. Marriage and mental health. Journal of Sex and Marital Therapy, 6: 187-198 (1980).

42. Kelly, E. Concerning the validity of Terman's weights for predicting marital happiness. Psychological Bulletin, 139: 202-203 (1939).

43. Tenman, L. Prediction data: predicting marriage failure from test scores. Marriage and Family Living, 12: 51-54 (1950).

44. Adams, C. The prediction of adjustment in marriage. Education and Psychological Measurement, 6: 185-193 (1946).

45. Burger, E. & Wallin, P. Engagement and marriage. Chicago, JB Lippencott, 1953.

46. Bentler, P. & Newcomb, M. Longitudinal study of marital success and failure. Journal of Consulting and Clinical Psychology, 46: 1053-1070 (1978).

47. Lee, G. Marriage and anomie: a causal argument. Journal of Marriage and the Family, 36: 523-532 (1974).

48. Udry, J. The social context of marriage (3rd ed.). Philadelphia Pa, Lippincott, 1974.

49. Pearlin, L. & Johnson J. marital status, life-strains and depression. American Sociological Review, 42: 704-715 (1977).

50. Macklin, E. Review of research on nonmarital cohabitation in the United States. In Murstein, B., ed. Exploring intimate lifestyles. New York, Springer, 1978.

51. Levinger, G. Sources of marital dissatisfaction among applicants for divorce. American Journal of Orthopsychiatry, 36: 803-807 (1966).

52. Levinger, G. Marital cohesiveness at the brink. The fate of applications for divorce. In Levinger, G. & Moles, O., ed. Divorce and separation. New York, Basic Books, 1979.

53. Rubin, Z. et al. Loving and leaving: Sex differences in romantic attachments. Sex Roles, 7: 821-835 (1981).

54. Bernard, J. The future of marriage. New York, World, 1972.

55. Gove, W. & Tudor, J. Adult sex roles and mental illness. American Journal of Sociology, 78: 812-835 (1973).

56. Dohrenwend, B. & Dohrenwend B. Sex differences and psychiatric disorders American Journal of Sociology, 81: 1447-1564 (1976).

57. Goldman, N. & Ravid, R. Community surveys: sex differences in mental illness. In: Guttentag, M. et al. ed. The mental health of women. New York, Academic Press, 1980.

58. Heins, T. Marital interaction in depression. Australian and New Zealand Journal of Psychiatry, 12: 269-275 (1978).

59. Knupfer, G. et al. The mental health of the unmarried. American Journal of Psychiatry, 122 : 841-851 (1966).

60. Weissman, M. & Klerman, G. Sex differences and the epidemiology of depression. Archives of General Psychiatry, 34: 98-111 (1977).

61. Seligman, M. Helplessness: On depression, development, and death. San Francisco, Freeman, 1975.

62. Fox, J. Gove's specific sex-role theory of mental illness: a research note. Journal of Health and Social Behavior, 21: 260-267 (1980).

63. Warheit, G. et al. Sex, marital status and mental health. Social Forces, 55: 459-470 (1976).

64. Radloff, L. Sex differences in depression: the effects of occupation and marital status. Sex Roles, 1: 249-265 (1975).

65. Gove, W. & Geerken, M. The effect of children and employment on the mental health of married men and women. Social Forces, 55: 66-76 (1977).

66. Kessler, R. & McRae, J. Trends in the relationship between sex and psychological distress. American Sociological Review, 46: 443-452 (1981).

67. Kessler, R. & McRae, J. The effect of wives' employment on the mental health of married men and women. American Sociological Review, 47: 216-227 (1982).

68. Gore, S. & Mangione, T. Social roles, sex roles and psychological distress: Additive and interactive models of sex differences. Journal of Health and Social Behavior, 24: 300-312 (1983).

69. Brown, G. & Harris, T. Social origins of depression: A study of psychiatric disorder in women. New York, Free Press, 1978.

70. Aneshensel, C. et al. Family roles and sex differences in depression. Journal of Health and Social Behavior, 22: 379-393 (1981).

71. Rosenfield, S. Sex differences in depression: Do women always have higher rates? Journal of Health and Social Behavior, 21: 33-42 (1980).

72. Blumenthal, M. Mental health among the divorced. Archives of General Psychiatry, 16: 603-608 (1967).

73. Bradburn, N. The structure of psychological well-being. Chicago, Aldine, 1969.

74. Briscoe, C. & Smith, J. Psychiatric illness, marital units and divorce. Journal of Nerv Ment Dis, 158: 440-445 (1974).

75. Karlsson, G. Adaptability and communication in marriage. Uppsala, Almquist & Wiksell, 1951.

76. Loche, J. & Karlsson, G. Marital adjustment and prediction in Sweden and the United States. American Sociological Review, 17: 10-17 (1952).

77. Burchinal, L. et al. Personality characteristics and marital satisfaction. Social Forces, 35: 218-222 (1957).

78. Dean, D. Emotional maturity and marital adjustment. Journal of Marriage and the Family, 28: 454-457 (1966).

79. Murstein, B. & Glaudin, V. The use of the MMPI in the determination of marital adjustment. Journal of Marriage and the Family, 30: 651-655 (1968).

80. Barry, W. Marriage research and conflict. Psychological Bulletin, 73: 41-54 (1970).

81. Bloom, B. et al. Marital separation: a community survey. Journal of Divorce, 11: 7-19 (1977).

82. Gurin, G. et al. Americans view their mental health. New York, Basic Books, 1960.

83. Sager, C. et al. The married in treatment. Archives of General Psychiatry, 19: 206-215 (1968).

84. Kessel, N. Self Poisoning. Part 2. British Medical Journal, 2: 1336-1340 (1965).

85. Sclare, A. & Hamilton, C. Attempted suicide in Glasgow. British Journal of Psychiatry, 109: 609-615 (1963).

86. Rounsaville B. et al. Marital disputes and treatment outcome in depressed women. Comprehensive Psychiatry, 20: 483-490 (1979).

87. Cammerer, L. Family feedback in depressive illnesses. Psychosomatics, 12: 127-132 (1971).

88. Coleman, R. & Miller, A. The relationship between depression and marital maladjustment in a clinic population: A multitrait-multimethod study. Journal of Consulting and Clinical Psychology, 43: 647-651 (1975).

89. Paykel, E. et al. Life events and depression. Archives of General Psychiatry, 31: 753-760 (1969).

90. Rutter, M. & Quinton, D. Psychiatric disorder: ecological factors and concepts of causation. In: McGurk H., ed. Ecological factors in human development. Amsterdam, North Holland, 1977.

91. Birtchnell, J. & Kennard, J. Marriage and mental illness. British Journal of Psychiatry, 142: 193-198 (1983).

92. Brown, G. et al. Social class and psychiatric disturbance among women in an urban population. Sociology, 9: 225-254 (1975).

93. Roy, A. Vulnerability factors and depression in men. British Journal of Psychiatry, 138: 75-77 (1981).

94. Roy, A. Risk factors and depression in Canadian women. Journal of Affective Disorders, 3: 65-70 (1981).

95. Ilfield, F. Current social stressors and symptoms of depression. American Journal of Psychiatry, 132: 161-166 (1977).

96. Bothwell, S. & Weissman, M. Social impairments four years after an acute depressive episode. American Journal of Orthopsychiatry, 47: 231-237 (1977).

97. Sims, A. Prognosis in the neuroses. American Journal of Psychoanalysis, 37: 155 (1977).

98. Riskin, J. & Faunce, E. An evaluative review of family interaction research. Family Process, 11: 365 (1972).

99. Henderson, S. The social network, support and neurosis: the function of attachment in adult life. British Journal of Psychiatry, 131: 37 (1977).

100. Weissman, M. et al. The social role performance of depressed women: comparisons with a normal group. American Journal of Orthopsychiatry, 41: 390 (1971).

101. Hinchliffe, M. et al. A study of the interaction between depressed patients and their spouses. British Journal of Psychiatry, 126: 164 (1975).

102. Hinchliffe, M. et al. The melancholy marriage: An inquiry into the interaction of depression. II Expressiveness. British Journal of Medical Psychology, 50: 125 (1977).

103. McLean, P. et al. A behavioral approach to the treatment of depression. Journal of Behavior Therapy and Experimental Psychiatry, 4: 323 (1973).

104. Nelson, B. et al. Neurosis and marital interaction. British Journal of Psychiatry, 117: 47 (1970).

105. Waring, E. Marital intimacy and medical practice. International Journal of Psychiatry in Medicine, 12: 59-66 (1982).

106. Finlay-Jones, R. & Burvill, P. The prevalence of minor psychiatric morbidity in the community. Psychological Medicine, 7: 475-489 (1977).

107. Hames, J. & Waring E. Marital intimacy and non-psychotic emotional illness. Psychiatric Forum, 9: 13-19 (1980).

108. Waring, E. et al. Intimacy and emotional illness in the general population. Canadian Journal of Psychiatry, 26: 167-172 (1981).

109. Waring, E. et al. Dimensions of intimacy in marriage. The International Journal of Psychiatry, 44: 169-175 (1981).

110. Roffe, M. & Britt, B. A typology of marital interaction for sexually dysfunctional couples. Journal of Sex and Marital Therapy, 7: 207-222 (1981).

111. Masters, W. & Johnson, V. Human sexual response. Boston, Little, Brown, 1966.

112. Kaplan, H. The new sex therapy. Active treatment of sexual dysfunction. New York, Brunner/Mazel, 1974.

113. LoPiccolo, J. & LoPiccolo, L., ed. Handbook of sex therapy. New York, Plenum, 1978.

114. Masters, W. & Johnson, V. Human sexual inadequacy. Boston, Little, Brown, 1970.

115. Arentewitcz, G. & Schmidt, G. Sexuell gestörte Beziehungen. Berlin & New York, Springer, 1980.

116. Harbin, H. & Gamble, B. Sexual conflicts related to dominance and submission. Medical Aspects of Human Sexuality, 11: 84-89 (1977).

117. Jehu, D. Sexual dysfunction. New York, Wiley, 1979.

118. Frank, E. et al. Frequency of sexual dysfunction in normal couples. English Journal of Medicine, 299: 111-115 (1978).

119. Heiman, J. et al. The treatment of sexual dysfunctions. In: Gurman, A. & Kniskern, D., ed. Handbook of family therapy. New York, Brunner/Mazel, 1981.

120. Jayne, C. A two dimensional model for female sexual response. Journal of Sex and Marital Therapy, 7: 3-30 (1981).

121. Chesney, A. et al. A comparison of couples who have sought sex therapy with couples who have not. Journal of sex and Marital Therapy, 7: 131-140 (1981).

122. Berg, P. & Snyder, D. Differential diagnosis of marital and sexual distress: A multidimensional approach. Journal of Sex and Marital Therapy, 7: 290-295 (1981).

123. Zimmer, D. Interaction patterns and communication skills in sexually distressed, maritally distressed and normal couples: Two experimental studies. Journal of Sex and Marital Therapy, 9: 251-265 (1983).

124. Messersmith, C. Sex therapy and the marital system. In: Olsen, D., ed. Treating relationships. Lake Hills, Ia, Graphic, 1976.

125. Frank, E. et al. Profiles of couples seeking sex therapy and marital therapy. American Journal of Psychiatry, 133: 559-561 (1976).

126. Hartman, L. The interface between sexual dysfunction and marital conflict. American Journal of Psychiatry, 137: 576-579 (1980).

127. Hartman, L. Effects of sex and marital therapy on sexual interaction and marital happiness. Journal of Sex and Marital Therapy, 9: 137-151 (1983).

128. McGovern, L. et al. Secondary orgasmic dysfunction. Archives of Sexual Behavior, 4: 265-275 (1975).

129. Leiblum, S. et al. Group treatment format. Mixed sexual dysfunctions. Archives of Sexual Behavior, 5: 312-322 (1976).

130. Crowe, M. et al. Form and content in the conjoint treatment of sexual dysfunction. Behavioral Research Therapy, 19: 47-54 (1981).

131. Everaerd, W. & Dekker, J. A comparison of sex therapy and communication therapy. Journal of Sex and Marital Therapy, 2: 278-289 (1981).

132. Hartman, L. & Daly, E. Relationship factors in the treatment of sexual dysfunction. Behavioral Research Therapy, 21: 153-160 (1963).

133. Emery, R. & O'Leary, D. Marital discord and child problems in a non-clinic sample. Journal of Abnormal Child Psychology, 12: 411-420 (1984).

134. Oltmanns, T. et al. Marital adjustment and the efficacy of behavior therapy with children. Journal of Consulting and Clinical Psychology, 45: 724-729 (1977).

135. Porter, B. & O'Leary, D. Marital discord and childhood behavior problems. Journal of Abnormal Psychology, 80: 287-295 (1980).

136. Rutter, M. Parent-child separation: Psychological effects on the children. Journal of Child Psychology and Psychiatry and Allied Disciplines, 12: 233-260 (1971).

137. Chawla, P. & Gupt, K. A comparative study of parents and emotionally disturbed and normal children. British Journal of Psychiatry, 134: 406-411 (1979).

138. Kelso, J. et al. The Measure of marital satisfaction: A questionnaire to screen parents for marital problems. Child Psychiatry and Human Development, 15: 86-103 (1984).

139. Gurman, A. & Kniskern, D. Handbook of family therapy. New York, Brunner/Mazel, 1981.

140. Kent, R. & O'Leary, D. A controlled evaluation of behavior modification with conduct-problem children. Journal of Consulting and Clinical Psychology, 44: 586-596 (1976).

141. Margolin, G. & Christensen, A. The treatment of families with marital and child problems. Paper presented at the meeting of the Association for the Advancement of Behavior Therapy, Toronto 1981. The paper is cited in (133).

142. Emery, R. Interparental conflict and the children of discord and divorce. Psychological Bulletin, 92: 310-330 (1982).

143. Cummings, S. et al. Effects of the child's deficiency on the mother: A study of mothers of mentally retarded, chronically ill and neurotic children. American Journal of Orthopsychiatry, 36: 559-608 (1966).

144. Johnson, S. & Lobitz, G. The personal and marital adjustment of parents as related to observed child deviance and parenting behaviors. Journal of Abnormal Child Psychology, 2: 193-207 (1974).

145. Cooper, S. et al. The children of psychiatric patients: Clinical findings. British Journal of Psychiatry, 132: 514-522 (1977).

146. Patterson, G. Coercive family process: A social learning approach, Vol.3. Eugene, Oregon, Castalia, 1982.

147. Christensen, A. et al. Parental characteristics and interactional dysfunction in families with child behavior problems: A preliminary investigation. Journal of Abnormal Child Psychology, 11: 153-166 (1983).

148. Forehand, R. et al. Mother-child interactions: Comparisons of a non-compliant clinic group and a non-clinical group. Behavioral Research and Therapy, 13: 79-84 (1975).

149. Griest, D. et al. An examination of differences between non-clinic and behavior-problem clinic-referred children and their mothers. Journal of Abnormal Psychology, 89: 497-500 (1980).

150. Boszormenyi-Nagy, I. & Ulrich, D. Contextual family therapy. In: Gurman, A. & Kniskern, D., ed. Handbook of family therapy, New York, Brunner/Mazel, 1981.

151. Gassner, S. & Murray, E. Dominance and conflict in the interactions between parents of normal and neurotic children. Journal of Abnormal and Social Psychology, 74: 33-41 (1969).

152. Leighton, L. et al. Patterns of communication in normal and clinic families. Journal of Consulting and Clinical Psychology, 36: 252-256 (1971).

153. Lo, H. Aetiological factors in childhood neurosis. British Journal of Psychiatry, 115: 889-894 (1969).

154. Ferguson, L. & Allen, D. Congruence of parent perception, marital satisfaction, and child adjustment. Journal of Consulting and Clinical Psychology, 46: 345-346 (1978).

155. Robinson, E. & Anderson, L. Family adjustment, parental attitudes and social desirability. Paper presented at the meeting of the American Psychological Association, Los Angeles, 1981. Cited in (133).

156. Emery, R. et al. Effect of marital discord on the school behavior of children of schizofrenic, affectively disordered, and normal parents. Journal of Abnormal Child Psychology, 10: 215-228 (1982).

157. Rutter, M. et al. Attainment and adjustment in two geographic areas. Some factors accounting for area differences. British Journal of Psychiatry, 126: 520-533 (1975).

158. Rutter, M. et al. Adolescent turmoil: Fact and fiction. Journal of Child Psychology and Psychiatry, 17: 35-36 (1976).

159. McCord, J. et al. Some effects of paternal absence on male children. Journal of Abnormal and Social Psychology, 64: 361-369 (1962).

160. Pemberton, D. & Benady, D. Consciously rejected children. British Journal of Psychiatry, 123: 575-578 (1973).

161. Wolkind, S. & Rutter, M. Children who have been "in care" - An epidemiological study. Journal of Child Psychology and Psychiatry, 14: 97-105 (1973).

162. Mednick, S. & McNeil, T. Current methodology in research on the etiology of schizofrenia: Serious difficulties which suggest the use of high-risk group method. Psychological Bulletin, 70: 681-693 (1968).

163. Block, J. et al. Parental agreement-disagreement on child-rearing orientations and gender-related personality correlates in children. Child Development, 52: 965-974 (1981).

164. Schwarz, C. & Zuroff, D. Family structure and depression in female college students: Effects of parental conflict, decision-making power, and inconsistency of love. Journal of Abnormal Psychology, 88: 398-406 (1979).

165. Klein, M. et al. Parental dominance-passivity and behavior problems of children. Journal of Consulting and Clinical Psychology, 40: 416-419 (1973).

166. Hetherington, E. et al. Patterns of family interaction and child-rearing attitudes related to three dimensions of juvenile delinquency. Journal of Abnormal Psychology, 78: 160-176 (1971).

167. Whitehead, L. Sex difference in children's responses to family stress: A re-evaluation. Journal of Child Psychology and Psychiatry, 20: 247-254 (1979).

168. Nilsson Schönnesson, L. Det sociala könet: Könsrollsidentitetens betydelse för upplevelsen av äktenskapet [Gender role identity and its impact on marriage]. Rapport nr 2 från projektet Parrelationer i barnfamiljer, Stockholm, Jämfo, 1986.

169. Gullvag-Holter, O. Skisse av en teori om kjonn og patriarkat [A theoretical model of gender and patriarchy] Arbeidsnotat, Oslo Work Institute, 1986.

170. Haavind, H. Magt og Kjaerlighet i ekteskapet [Power and love within the marriage]. In: Haukaamte, R. Kvinneforskning: Bidrag til samfunnsteori. Oslo, Universitetsforlaget, 1982.

171. Christensen, E. & Hvidtfeldt, K. Den traditionelle kvinderolle som ideologi [The traditional female role as ideology]. Kvindeforskning omkring alkohol og droger. Copenhagen, NAD-publikation nr 8, 1983.

172. Ethelberg, E. Tre kvinnliga personlighetsstrategier [Three female strategies of personality]. Kvinnovetenskaplig Tidskrift, 1 (1985).