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## Selected Psychological Characteristics of a Veterans Population Seeking Prosthetic Surgery for Sexual Dysfunction

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SELECTED PSYCHOLOGICAL CHARACTERISTICS OF A  
VETERANS POPULATION SEEKING PROSTHETIC  
SURGERY FOR SEXUAL DYSFUNCTION

by

Marilyn A. Mendoza

A Dissertation Submitted to the Faculty of the Graduate School  
of Loyola University of Chicago in Partial Fulfillment  
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Doctor of Philosophy

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## VITA

The author, Marilyn Allen Mendoza, is the daughter of Anna S. Allen and Jacob Allen (deceased). She was born December 26, 1947 in Elberton, Georgia.

She attended Elbert County High School through the eleventh grade in 1964 at which time she enrolled in Oxford College of Emory University. From there she transferred to the University of Georgia, Athens, Georgia, where she received her Bachelor of Arts degree with a major in Psychology in 1968. Her Masters of Science in General Experimental Psychology in 1973 was also obtained at the University of Georgia.

In 1973, the author moved to Chicago, Illinois and worked in a private psychiatric group practice. In 1979, she entered Loyola University of Chicago to pursue doctoral study in Counseling Psychology. After completing her course work, the author was a psychology intern at West Side Veterans Administration Hospital in Chicago, Illinois.

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## CHAPTER I

### INTRODUCTION

#### BACKGROUND OF THE STUDY

In the past 20 years, psychotherapy has evolved numerous subspecialty areas, one of which is the area of human sexuality. Since the publication of Masters' and Johnson's book on Human Sexual Inadequacy (1970), an ever increasing interest in sexuality has been expressed on a national and international level. Professionals report increasing demands concerning sexual difficulties. As a result, counseling services and clinics dealing with these problems are increasing in number. Entire issues of professional journals are focusing on this topic along with many new journals that deal specifically with sexuality being introduced to help the professional keep up with the increasing demands for help with sexual problems (Kirkpatrick, 1980).

Green (1975) contends that half of all married couples have some area of sexual incompatibility. In most instances these couples or individuals are either self referred or referred by a physician for sexual counseling. Most reputable clinics, hospitals or agencies engage in some form of a screening procedure to assess the suitability of these clients for treatment. A major focus of assessment in the past, particularly with erectile disturbances, has been on whether or not the sexual dysfunction was of a psychogenic or of an organic

nature. Relatively little attention, however, has been given to the formal investigation of the relationship or the dyadic personality interplay of the man and his sexual partner (Rosenheim and Neumann, 1981). This is somewhat surprising since it is now a generally accepted tenet that the way in which sexual partners interact is a major contributing factor to sexual dysfunction (Kaplan, 1974).

In the 1950's, the consensus from the literature seemed to be that 90% of impotence was of a functional or psychogenic nature and only 10% due to organic causes (Strauss, 1950). Although Strauss made this claim without any substantiating evidence, his contention held until the late 1970's when his statement began to be called into question by investigations which began to suggest that varying subtle organic causes were responsible in many cases of so-called psychogenic impotence. Bloom (1977) demonstrated that 50% of the patients with psychogenic impotence may have an underlying cause. Sparks (1980) found that 37% of his population had subtle hormonal abnormalities which in the absence of very specific endocrine testing would have gone undiagnosed and untreated. Schumacher and Lloyd (1980) report that 74% of their population of impotent men had some organic disease factors.

The physical causes of erectile dysfunction can be numerous and may result from anatomic, cardiovascular, genitourinary, hematologic, neurologic, vascular, endocrinological, or infectious disorders. Drug ingestion whether from alcohol, street or prescription drugs can also alter potency and performance. The interplay of the psychological and physiological concomitants of impotence is quite complex. Masters and

Johnson (1970) noted that in their comment that individuals with organic impotence almost always have an accompanying performance anxiety, a psychological complication that only compounds the problem. Levay, Sharpe and Kogle (1981) also refer to individuals with organic impairment from an illness such as diabetes which produces an organic impairment leading to partial dysfunction, which in turn produces psychological reactions causing full sexual dysfunction. This is a syndrome which they refer to as organo-psychogenic. It is therefore possible that many psychological symptoms and problems might coexist with the impotence or may be the result of rather than the cause of impotence.

Indeed, the fact that varying psychological characteristics, physical diseases and organic states can produce similar sexual dysfunction attests to the complexity and importance of the diagnostic/screening process and the necessity of varying treatment options (Beutler and Gleason, 1981). Traditionally, sexual dysfunctions have been treated with various forms of psychotherapy. Not all dysfunctions are amenable to this and in many instances medical or surgical procedures may be needed to restore functioning, as is often the case in the treatment of erectile dysfunctions.

Throughout history, man has been concerned about his potency and sought cures for impotence many of which were extreme in nature and potentially quite dangerous. The end result of many of these cures according to Gee (1975) was that many impotent men were "poorer, perhaps wiser but definitely no better." In the past decade, there have been three parallel developments in the area of penile surgery:

(1) corrective surgery on the arterial supply; (2) corrective surgery on drainage failures; and (3) the implantable penile prosthesis (Wagner, 1981). Surgical treatment of impotence dates back to the early 1900's. It was not, however, until 1952 when Goodwin and Scott used acrylic implants that many of the early problems with the prosthesis were overcome and the device began to be more widely used (Sotile, 1979). The acrylic implants, however, were often not tolerated well by the body and had to be removed. At present penile prostheses are made of silicone rubber which in addition to being tolerated well provide an added advantage of an erection which is relatively normal in appearance and feel (Brooks and Brooks, 1981). Currently, the most widely used prostheses are of two types: (1) paired silicon rods and (2) inflatable. According to Hales (1982) an estimated 15,000 men have already undergone the penile implant procedure with another 5,000 to 10,000 estimated to be recipients by the end of 1982. Certainly with the increasing numbers of men electing to have this more radical surgical intervention, the importance of developing a careful screening procedure for them as well as their sexual partner becomes most essential. The obtained information can then serve as an objective guideline to insure the ethical and appropriate application of this procedure.

Assessing the man's medical and psychological suitability for surgery and correcting his erectile dysfunction, however, are not the only aspects that need to be considered in this process. As mentioned earlier, the assessment of the man is typically done with little attention given to his sexual partner. Often, however, the impotence

has also significantly altered the marital relationship and an implant may serve to disrupt the balance of power within the couple system (Hales, 1982). Renshaw (1979) sees the wife as a full "50% of the penile implant equation" who must be considered for the overall success of the procedure. In a study of a group of wives of impotent men, Renshaw (1981) found that while 21% of the wives were angry at their husbands and did not want to be involved in treatment, 79% were not rejecting or blaming but were supportive, sensitive and concerned. She also found that the husband's impotence and the strain on the relationship led to the wives themselves developing physical symptoms. Once involved in treatment with their husbands, the wives quickly improved. Maddock (1980) and Krauss, Bogin and Culebras (1983) also contend that a successful penile implant requires that the man's partner be involved and assessed to help insure a healthy adjustment to the prosthesis. Failure to include the wife or to assess the impact of the impotence on the marital relationship is to risk personal disappointment and divorce, cases of which have already been cited in the literature (Gee, 1974; Steward & Gerson, 1976 and Krauss, et. al., 1983).

#### PURPOSE AND SIGNIFICANCE OF THE STUDY

In his review of the literature on the penile prostheses, Sotile (1979) claims that the studies done in this area have provided little, if any, baseline information on the men who receive this more radical surgical treatment for sexual dysfunction. In addition to a lack of

information about these men, there have been few systematic attempts to assess couples and their relationship while involved in treatment for sexual dysfunction. Although within the Veterans Administration Hospitals there has been an increasing involvement in the treatment of sexual problems, little is known or reported about what characterizes these individuals and couples. It is the major purpose of this dissertation to provide baseline psychological data on a sample of patients and their spouses seeking sexual dysfunction treatment at West Side Veteran's Administration Hospital (WSVA) in Chicago, Illinois. The rationale for collecting such data is to aid in the diagnostic, prognostic and evaluative process for the individuals undergoing penile prosthetic surgery. Hopefully, the results will encourage the use of psychological assessment screening procedures that will aid in ensuring the most effective treatment for the patient whether it be psychological, medical or a combination of both. Additionally, there would be an increased sensitivity and awareness to the marital relationship and involvement of the wife. In relation to the general purpose of this study, the following specific goals have been identified:

- (1) to develop an overall psychological and relationship assessment program that can be utilized on an ongoing basis at WSVA Hospital for screening and counseling of couples in which the male is a potential candidate for penile prosthetic surgery.

- (2) to examine and describe the psychological characteristics of the individual spouses as well as the nature of their relationship.

- (3) to establish normative baseline data for the Marital

Communication Inventory and Marital Satisfaction Questionnaire on the WSVA Family Program population who has sought out prosthetic surgery.

(4) to utilize the data from this study to generate and formulate hypothesis for further research in this area.

#### DEFINITION OF TERMS

There are several terms that have specific meaning in relation to this study.

##### Penile prosthesis

This is a device surgically implanted in the penis and used for the treatment of erectile impotence.

##### Biographical data

These are data obtained from interview material and medical records which provide historical and demographic detail about the subject and his or her family.

##### Medical data

These are data obtained from medical charts, physical examinations and laboratory tests which reflect the patient's present and past states of both mental and physical health.

##### Personality characteristics

These are specific scale scores on the Minnesota Multiphasic Personality Inventory.

##### Level of communication

This is the total score obtained on the Marital Communication Inventory test.



### Level of marital satisfaction

This is the total score obtained on the Multi-Modal Marital Satisfaction test.

### POPULATION OF THE STUDY

The population for the study was chosen from the WSWA Hospital's Family Mental Health Program. The sample of 12 couples consists of those men and their spouses who entered the Clinic seeking prosthetic surgery for sexual dysfunction.

### LIMITATIONS OF THE STUDY

Generalizability of the information obtained is a primary limitation of the study. The population is restricted to individuals seeking treatment at a Veterans hospital. It is further restricted in terms of sample size and on characteristics of race, education and socio-economic status.

### ORGANIZATION OF THE STUDY

The first chapter has provided an introduction to the study including background, purpose of study, definition of terms and limitations of the study. A review of the literature will be provided in Chapter Two and will explore four areas: marital satisfaction, the relationship between sexual and marital satisfaction, impotence and the penile prostheses. Chapter Three will be a detailed outline of

the design of the study which will include descriptions of the subjects and the evaluation procedures. The statistical analysis of the data and a discussion of the results will be presented in Chapter Four. Chapter Five will provide a summary of the study, conclusions, implications and recommendations for further research.

## CHAPTER II

### REVIEW OF RELATED LITERATURE

Chapter One included a rationale and brief outline of the study. Chapter Two will present a review of the literature relevant to this study and will cover four main areas: marital satisfaction, the relationship between sexual and marital satisfaction, impotence and the penile prosthesis. Since the literature on marital satisfaction and impotence is so extensive only an overview of these areas will be presented. In contrast, however, the relevant literature on sexual and marital satisfaction and the penile prosthesis is limited and will be presented in more detail.

### MARITAL SATISFACTION

The question of what constitutes marital satisfaction has been extensively researched. The methodology, however, has often been poor and the samples biased and limited in their generalizability. The findings from these studies have often been inconsistent and contradictory. An attempt to review all the variables investigated is beyond the scope of this work. There have, however, been certain trends and areas of investigation that have predominated through the years and these will be reported.

In their comprehensive review of the marital happiness and stability literature of the 1960's, Hicks and Platt (1970) comment on

the difficulties inherent in attempting to define and investigate such a personal and subjective experience as happiness. Indeed the literature over the past 20 years has been plagued by definitional ambiguity. Concepts such as quality, happiness and satisfaction are used interchangeably with little agreement on the meaning of the terms.

One of the more striking initial findings in the 1960's, and one that has proven durable over the years, is the finding that husbands tend to be happier in the marital relationship than wives. In the 1960's variables related to the husband seemed pivotal to the wives' happiness and to the level of adjustment of the marriage. High occupational level, status, prestige, income and educational level of the husband were all found to be positively related to high levels of marital satisfaction. A wife working outside the home, however, contributed to lower levels of satisfaction and adjustment in the relationship. Contrary to the widely held belief at that time, early research in the 1960's failed to support the idea that children made a marriage a happy one. However, confirmation of the widely held belief that a satisfactory marital relationship is associated with good verbal communication was found (Navran, 1967).

Also during the 1960's there began to be more studies that examined the marital relationship over time and specifically began to look at the family over its life cycle. The findings suggested that there were significant differences in satisfaction for husband and wife depending on the specific period investigated. The data of this era tends to be somewhat confusing in terms of the direction in which

the changes occur, but it does appear that there is not a linear decline over the whole life cycle. Rollins and Feldman (1970) found that the period of child bearing and child rearing was associated with the least amount of satisfaction for the wives while the most difficult period for the husbands was when they were anticipating retirement.

This concept of the differences between husbands' and wives' perception of the marriage was an intriguing one which investigators sought to explore more carefully in the 1970's. Jesse Bernard, in 1973, proposed that in every marriage there are actually two marriages, his and hers. According to her research, marriage for him proved to be most beneficial physically, psychologically and socially when compared to his unmarried male counterpart. Marriage for her, however, proved to be much worse as indicated by the poor mental and emotional health of married women as compared not only to that of married men but also to unmarried women.

The 1970's research also seemed to confirm the earlier conclusions about the effect of children on the general level of satisfaction with the marriage while dispelling other widely held beliefs about what constitutes satisfaction in a relationship. Houseknecht (1978) demonstrated that women who were voluntarily childless displayed higher levels of marital adjustment than women who were mothers. Glenn and Weaver (1978), examining data collected from national surveys across the country, found the strongest, most consistent variables effecting marital happiness to be the presence of young children and being middle aged for females. Both of these

variables lead to dissatisfaction. Their study interestingly failed to find or found only weak relationships for other variables that there had been a general consensus about over the years such as age at marriage, socioeconomic status, and wives' employment outside of the home.

Starting in the middle 1960's and into the 1970's there was an increased emphasis on communication and marital happiness. Navran (1967) was one of the early investigators to research the interrelationship between communication and adjustment in marriage. In his study he found that happily married couples had both better verbal and nonverbal communication than unhappily married couples. Good verbal communication was found to be more strongly associated with happiness than good nonverbal communication. Murphy and Mendelson (1973) also reported high correlations between adjustment and communication. These findings have been essentially substantiated over the years with investigators such as Snyder (1979) indicating that measures of communication are the best predictors of marital satisfaction.

Rhyme (1981) develops in her research a theme suggested earlier by others that it is not so much the demographics of the marriage that are so important to marital satisfaction but rather how each partner assesses the relationship. It is often difficult to predict subjective levels of satisfaction based on objective factors. It appears to be not so much what happens in the relationship but how each partner perceives it. Rhyme found although men are generally more satisfied with their marriages than women are, the same factors

are important to both in their assessment. These factors include love, affection, friendship, interests and sexual gratification. The greater the spouses' level of satisfaction in these areas, the higher the level of satisfaction with the marriage. In terms of satisfaction with sexual needs, women were found to be more satisfied with the extent to which their needs are met. She found that in the post parental stage, sexual gratification for women becomes primary.

#### THE RELATIONSHIP BETWEEN SEXUAL AND MARITAL SATISFACTION

Although the sexual component of the marital relationship is generally assumed to be an important contributing factor to marital satisfaction or happiness, there has been relatively little attention given to this in the literature. In one of the few longitudinal studies on marriage, Ard (1977) examines the role of sex in marriage over a 20 year period from 1935 to 1955. Essentially, the findings indicate that sex continues to be an important component of the marriage, but that there is a decrease in sexual activity over time with husbands reporting significantly greater enjoyment from sexual relations in the later years of marriage, a result somewhat discrepant from that found by Rhyme. The difference can perhaps be accounted for by the change in sexual attitudes and roles in the 30 years spanning the two studies.

Assessing the interface between sexual satisfaction and marital happiness has been of importance in the investigation of the effect sexual dysfunction has on the marriage. Sexual conflict is often seen

as a part of overall marital dissatisfaction (Hogan, 1975). It has been demonstrated (Frank, Anderson and Kupfer, 1976) that couples seeking sex therapy are also experiencing considerable marital discord. The aspect, however, which remains intriguing to clinicians and researchers is the causal impact of marital happiness on sexual satisfaction and vice versa. Hartman (1980a and 1980b) has addressed this issue and suggested that marital distress and sexual problems are not always interrelated. In general Hartman found that couples who report difficulty in sexual functioning without marital distress tend to be more similar to control subjects who are without any significant marital or sexual problems. These couples with sexual dysfunction alone tended to be more sensitive to and understanding of the spouse's feelings, more likely to share responsibility and to negotiate more effectively. Hartman concludes from his findings that a good sexual relationship is not always necessary nor sufficient to make a marriage satisfactory. Frank, Anderson and Rubenstein (1978) earlier found that it is not the absolute level of sexual functioning but the "affective tone" of the marriage that determines how couples perceive their sexual satisfaction. It appears that sexual difficulties can therefore occur in the context of a functional marital relationship or be an expression of the problem within the couple's relationship. Although a sexual problem may not have its roots in a conflictual marital relationship, the effects of the dysfunction can certainly affect both partners and potentially lead to other problems within the relationship. Regardless of which partner has the dysfunction both are affected. Masters and Johnson (1970) contend that there is no



such thing as an uninvolved sexual partner when some form of sexual problem exists.

Attempting to assess the interface between marital happiness and sexual dysfunction has very practical significance in terms of treatment and whether sexually dysfunctional couples need marital therapy in addition to or prior to sexual therapy. Hartman (1983) and Hartman and Daly (1983) have also addressed this question and have found that sex therapy helps both sexual and marital problems, while marital therapy helped only marital problems. Marital functioning, they suggest, may be improved by sex therapy as a result of the enforced communication in sex therapy, which in turn may improve general marital communication. Interestingly they did find a difference between men and women in the differential effects of sex and marital therapy. Generally, women seem to respond more to treatment which focuses specifically on sexual matters, while men seem to show greater improvement in response to marital therapy. Collapsing across sex, however, the main effects of treatment clearly favored sex therapy.

#### IMPOTENCE

Perhaps the most common sexual problem in men is impotence. There are many varying definitions of impotence and as with most sexual problems it tends to be difficult to define precisely. Malloy and Wein (1978), however, provide a rather succinct definition that addresses the dysfunction in the context of the relationship between

the man and his partner. Erectile impotence is defined "as the persistent inability to obtain and maintain an erection to complete the sex act to the satisfaction of both partners." A distinction is usually made in impotence between primary and secondary. Primary impotence refers to the man who has never been able to have intercourse. Secondary impotence refers to the man who at one time was able to function sexually. Occasional episodes of impotence may occur at all ages and be the result of any number of etiological factors. Federman (1982) contends that by age 65 one in four men have experienced erectile failure. By the age of 75, however, the number increases to one in every two men. This rather dramatic rise in the prevalence of impotence with age can be attributed to a number of factors. According to Levine (1977) among these are included diabetes, medication for various disorders, including hypertension, relationship deterioration and the idea that older men should not be sexual.

At any age, however, there are any number of variables that can contribute to the development of a dysfunction. Over the years impotence, for the most part, has been considered primarily a psychogenic disease. For example, Kaplan (1979) feels that sexual dysfunctions can be reduced to the simple factor of anxiety. Sexually related anxiety is considered the common pathway through which multiple psychopathogens may produce sexual dysfunction. Anxiety can have many origins and intensities and can play various roles in the personality structure of the individual and in his relationships. The individual may be entirely conscious about what causes his sexual

dysfunction or anxiety can operate on a deeply unconscious level and leave the individual confused and bewildered. The physiological concomitants of anxiety, however, are always the same no matter what the relationship to conscious experience and no matter what the level of insight.

In addition to anxiety, Renshaw (1975) identifies three other frequent underlying conscious or unconscious psychic factors in impotence. These are anger, depression and a traumatic reaction to the very first sexual episode. Levine (1976) would add guilt to this list, but states that any strong affect may interfere with the capacity to experience sexual satisfaction and induce temporary episodes of erectile dysfunction.

It is only more recently that the number of organic factors that can contribute to impotence have begun to receive attention. Organic causes, however, rarely operate alone and there is frequently an overlap of the physiological and psychological factors of impotence. Schumacher and Lloyd (1981) examined this issue with a population of couples referred for treatment of a sexual dysfunction in one of the partners. They found that 72.5% of the impotent men, in their sample, had evident organic disease which basically could be placed in five general categories: cardiovascular-respiratory disease, endocrine disease, metabolic disease, neurological disease and urogenital disease. Without exception all patients indicated psychological distress associated with their impotence. In examining treatment effects, in impotent men with organic disease there was a significantly higher rate of improvement in interaction with the

partner but not for sexual functioning. The authors feel that with treatment the pervasive anxiety and fear of failure experienced by all these men were decreased and improved their level of comfort and interaction with their partners. The authors suggest that to readily accept psychological symptoms as cause for most impotence may actually be unfair to the patient and result in mismanagement of the case. Psychological symptoms and problems may coexist with impotence or be the result of impotence and not necessarily its cause. The difficulty in the treatment of impotence seems to lie in the fact that regardless of etiology, once a lack of erectile security has been established, fears of performance become an integral part of the psychosocial influences of the man's daily life. That is why according to Milne and Hardy (1974) it is important in treatment to remember that it is really the whole man that is impotent. The man needs to be viewed as someone who lives his life as a whole and who has this impotence as a whole part of his life, not only in just his sexual life.

Traditionally, sexual dysfunctions have been attributed to psychological causes and as such have been subject to treatment with various forms of psychotherapy. There are a number of models for the treatment of sexual dysfunction. Included in these are the psychodynamically oriented approach which is based on the assumption that sexual dysfunction is a result of deep intrapsychic conflict generated during early psychosexual development and which is only amenable to long term individual treatment. Group therapy has also been utilized in the treatment of sexual dysfunction and has been particularly useful in the treatment of impotence and the development

of orgasmic responses in women. Behavior therapy is another model that has been used effectively, the basic assumption being that sexual behavior is learned and that if contingencies and consequences of the behavior are made explicit and altered, the behavior itself will change. Systematic desensitization is often stressed in these programs (Wright, et.al., 1977). There are also, however, some approaches that do not even deal with the sexual problem as the primary issue but tend to focus on the communication between the partners and in developing effective communication. Carl Rogers (1972) is one who advocates the necessity of communication in any significant continuing relationship.

Perhaps the most widely known and emulated program for brief sex therapy has been developed by Masters and Johnson. They conceive of sexual dysfunction as having easily defined etiological roots, i.e. sociocultural deprivation and ignorance of sexual physiology rather than any psychiatric illness. Their approach focuses on problem-centered procedures dealing with immediate causes of sexual dysfunction such as performance anxiety, spectator role and lack of communication and/or information about sexual matters in a couple. In their program certain steps are followed regardless of the presenting complaints with additional modifications added specific to the symptomatology. The couple is treated together for a two week period by a dual sex team. Extensive histories, individual interviews, medical histories and exams are all incorporated into the program. Discussions are used to process feelings and present information while sensate focus exercises are assigned as homework and discussed the

next day.

Although investigators have found flaws in Masters and Johnson's work, they readily state that criticisms are difficult to make against them because of their incomparable contributions to the development of sex therapy as a legitimate and respectable field. Murphy and Mibulas (1974), in reviewing Masters and Johnson's program from a behavioral therapy orientation, are critical of just providing a person with awareness or insight into their problems. They view that as an inefficient way of changing behavior and state that a more effective way would be to utilize a program that deals with the undesired behavior and builds in more desirable behavior. Zilbergeld and Evans (1980) have been sharply critical of Masters and Johnson. They fault them for their lack of clarity and specificity in their work. Specifically they claim that evaluation procedures are unclear as are the details of the screening process. They quote only a failure rate (20%) without being specific about what failure or nonfailure means. The greatest failing, as these authors view it, is Masters and Johnson's imprecision.

#### PENILE PROSTHESIS

In recent years the surgical treatment of impotence has been used more extensively as the procedure and prosthetic device itself has undergone refinement. The vast majority of the studies done in the area of the surgical treatment for impotence have primarily focused on the medical aspects of the procedure while leaving a large gap in the

investigation of the psychological concomitants. Sotile (1979) reviewed the articles in the area of penile prosthetics from 1952 to 1978 and found the literature to be greatly lacking in information regarding patient characteristics. Only two articles are referenced prior to 1979 that even obtained any form of psychiatric or psychological information on these men. The two articles are essentially case studies. Loeffler and Sayegh (1960) simply mention that the patient had a prior psychiatric admission because of an "acute emotional maladjustment" resulting from the cancellation of his proposed marriage, while Devita and Olsen (1975) provide psycho-social background for both the patient and his wife. Not only are the basic demographic characteristics absent from these early studies, but also rather conspicuous by their absence in the literature are follow-up reports of patient-partner satisfaction and what effect the procedure has on the sexual and nonsexual aspects of the relationship.

It was not until 1975 that studies began appearing in which psychological assessment was used in working with the organically impotent male. The primary purpose of these assessments, however, was to attempt to discriminate patients whose impotence was psychological in nature from those whose impotence was organic in nature (Beutler, et.al., 1975 and 1976). The primary test used for this purpose was the Minnesota Multiphasic Personality Inventory (MMPI). As part of the routine diagnostic procedure for men referred for inflatable prosthetic implants, Beutler, et.al. (1975) administered the MMPI and Male Impotence Test (MIT) to a sample of 32 men who were to undergo sleep studies. From the 24 men who completed at least two sleep

nights and the psychological tests, two criterion groups were chosen. One group whose nocturnal tumescence reflected a clear indication of organic disturbance and the other group in which the men evidenced no real insufficiency in their nocturnal erections. In examining the psychological tests of these groups, it was found that the MIT was essentially useless as a means of discriminating biologically based versus psychologically based impotence. They did find, however, that if two basic requirements were met on the MMPI, the diagnosis of organic impotence could be made with a 90% accuracy rate. Their two decision rules were as follows: (1) Scale 5 (Masculinity-Femininity) above a t score of 60 and (2) one other clinical scale above 70. If these were found, then in all likelihood the impotence was of a psychogenic nature. In 1976, Beutler, et.al. present a more detailed look at four specific cases in which MMPI profiles are combined with historical and medical data. The use of the decision rules was again confirmed, but in this study the role of the MMPI was expanded. In addition to its use as an initial device for differential diagnosis, its use as a prognostic tool for the patient's response to the surgery is also advanced.

Staples, et.al. (1980) attempted to replicate Beutler's (1975) procedure to evaluate the validity of these MMPI criteria. Their findings did not support those from the earlier study. Indeed the authors found that in using the two rule criterion a full two-thirds of their subjects would have been misdiagnosed when the physical findings from sleep studies were assessed. Marshall, et.al. (1980) also attempted to validate these results and found a large percentage



(75%) of misdiagnosis when the decision rules were applied. A rather interesting finding from this study, contrary to previous findings, was that the organic and not the psychogenic patients were the ones who displayed greater psychological disturbance as measured by the MMPI. In 1981, Marshall, et.al., once again were unable to establish the MMPI's use as a differential diagnostic tool for impotence. In none of these studies, however, were there any attempts made to explain the results or to describe the psychological characteristics of these men.

In still another attempt to validate the two decision rule of Beutler and associates, Robiner, et.al. (1982) used a larger sample than in previous studies. Their results, however, were consistent with those of Marshall, et.al., and not Beutler. The authors contend that while the MMPI may be poorly suited for use in the determination of etiology of impotence, it does have other important uses in the screening and treatment of these men. They also suggest that if the sexual partner is to be involved in treatment, a collateral MMPI would be useful in exploring the dynamics that might exist within the relationship.

In general, there has not only been scant information about the intrapsychic dynamics of these men, but their relationship with a marital partner and her perceptions have been only minimally addressed. Renshaw (1979) states that in large part the satisfaction for the male with the penile prosthesis comes from the sexual pleasure he is able to give his wife. Although the wife is, as Renshaw states, "a full 50% of the penile implant equation," she has generally been

neglected and avoided by surgeons. Psychologists and psychiatrists have also given relatively little attention to these women, unless it was to place them in an unflattering position in which they were essentially blamed for the male's impotence (Renshaw, 1981). This negative perception of women is quite evident in a 1981 study by Rosenheim and Neumann. In one of the few systematic research efforts that have attempted to examine the personality variables of both husband and wife, the authors interpret their findings as lending support to the psychoanalytic concept of these women as "castrating wives."

Only three articles appear in the literature at present that address patient-partner satisfaction and the results would appear to be highly discrepant. Gerstenberger (1979) reported an 89% patient-partner satisfaction rate, while Kramarsky-Brinkhorst (1978), who questioned only the sexual partners, found 42% of their sample to be satisfied with the results of the operation. Schlamowitz, Beutler, Scott, Karacan and Ware (1977) found that a third of the sexual partners indicated that they were mostly satisfied after the implantation with the remaining two-thirds stating they were totally sexually satisfied. Interestingly in this study, the men were more critical of the implant than were their partners, but expressed increased satisfaction in their relationships. These studies point to the importance of the wives' involvement in the process. Several studies (Beutler, 1978, and Maddock, 1980) have included the wife from the beginning in the entire assessment procedure, although neither study reports any specific findings about individual characteristics

or the nature of the couple's relationship.

#### SUMMARY

This chapter has reviewed the significant literature published to date in the areas of marital satisfaction, the relationship between sexual and marital satisfaction, impotence and the penile prosthesis. The trends in research in marital satisfaction over the past 20 years were explored and although certain variables were identified as predictive of satisfaction, it appears that it is really how one assesses the relationship that ultimately determines satisfaction. The limited literature addressing the interface between sexual and marital satisfaction seems to suggest that a good sexual relationship is not always necessary nor sufficient to make a marriage satisfactory. The review of impotence explored various psychological and organic causes of impotence as well as some of the more traditional forms of psychological treatment. The final section of this chapter examined the surgical treatment of impotence, the penile prosthesis. Chapter Three will describe the subjects involved in the study, the design of the study and the statistical procedures used for analysis. Chapter Three also provides validity and reliability data on the Marital Communication Inventory, Marital Satisfaction Questionnaire and the Minnesota Multiphasic Personality Inventory.

## CHAPTER III

### METHODOLOGY

This chapter will describe the subjects who participated in the study and the instruments used to assess their personality variables, level of communication and marital satisfaction. Information regarding test composition, validity and reliability will be presented. Other data gathering instruments used in the study will also be described. The procedure of data collection will be detailed, and the statistical analysis will be outlined.

### SUBJECTS

The subjects in this study consisted of 12 couples who had been referred to the Family Mental Health Program at WSWA Hospital for further assessment of the male partner's suitability for a penile prosthesis. The 12 men ranged in age from 47 to 65 years ( $\bar{x} = 54.9$  years). Five of the men were either the same age or younger than their wives. Their wives ranged in age from 40 to 68 years ( $\bar{x} = 52.7$  years). The frequency distribution for age is found in Table 1.

The sample was mixed racially with seven of the couples being Black and five White. Formal education for the husbands ranged from 9 to 16 years ( $\bar{x} = 11.5$  years) and for the wives from 8 to 13 years ( $\bar{x} = 11.3$  years). A frequency distribution for education is found in Table 2. Various occupations were represented. Among the husbands, two

Table 1

## Frequency Distribution of Subjects by Age

Age Category	<u>Husbands</u>		<u>Wives</u>	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
1. 40-47	1	.083	4	.333
2. 48-55	6	.500	4	.333
3. 56-63	3	.250	3	.250
4. 64-71	2	.167	1	.083

Table 2

## Frequency Distribution of Subjects by Education

Educational Level	<u>Husbands</u>		<u>Wives</u>	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
1. College/ Technical Training	2	.167	1	.083
2. High School Graduate	5	.417	7	.583
Did not complete High School	5	.417	4	.333

were butchers, two truck drivers, one teacher, one machinist, one postman, one television technician, one electronics technician and three were unemployed as a result of physical disabilities. Of the wives five were housewives, two machine operators, one cook, one LPN, one postal clerk, one crossing guard and one cashier.

The 12 couples had been married from 5 to 35 years ( $x = 19.8$  years). Of the husbands, 50% had at least one prior marriage while 33% of the wives had been married before. All of the couples had children who were now adults. Sixty-six percent of the couples had children together, while 50% of the couples had blended families with children from either one or both of their previous marriages.

Religious preference was predominantly Protestant. Eight (66%) of the husbands and seven (58%) of the wives were Protestant. Four husbands (33%) and four wives (33%) were Catholic. One wife (.08%) was Buddhist. Five couples (42%) had a mixed religious background. The frequency distribution for religion is found in Table 3.

All wives were without presenting primary sexual symptoms. The husbands had been experiencing difficulties from two to 28 years. Seventy-five percent of them had been having problems between two to four years.

#### INSTRUMENTS

Three instruments were used in this study. Level of communication was measured by Bienvenu's (1970) Marital Communication Inventory. Satisfaction within the marriage was assessed by Lazarus'

Table 3

## Frequency Distribution of Subjects by Religion

Religion	Husbands		Wives		Couples	
	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency	Absolute Frequency	Relative Frequency
1. Protestant	8	.667	7	.583		
2. Catholic	4	.333	4	.333		
3. Jewish	-		-			
4. Others Buddhist	-		1	.083		
Couples of Mixed Religious Background					5	.417



(1981) Multi-Modal Marital Satisfaction Questionnaire. Personality traits were measured by the Minnesota Multiphasic Personality Inventory.

#### Marital Communication Inventory

The Marital Communication Inventory (MCI) is a 46 item questionnaire that has been designed to provide an index of success or failure in marital communication. There are four responses to each question, each weighted from 0 to 3 with a favorable response, indicating good communication, being given the higher score. There are separate forms for husband and wife. The individual responds by simply checking one of the four answers to each question. The test is self administered and can be understood by anyone who can read at a seventh grade level.

Bienvenu (1970) evaluated the validity and reliability of the MCI using 344 middle class subjects (172 couples) from northern Louisiana. Forty five of the 46 questions discriminated at the .01 level of confidence. The remaining question discriminated at the .05 level of confidence. Bienvenu indicates that the MCI has a split-half reliability of .93 and that mean scores in his several groups of spouses ranged between 99 and 106.

The MCI has been used in the assessment of sexually dysfunctional couples previously. Chesney, Blakeney, Cole and Chan (1981a, b) studied couples experiencing sexual problems who seek sex therapy as opposed to those that do not seek treatment. The most significant finding of their investigation was that couples seeking treatment for sexual problems had greater communication problems than those who did

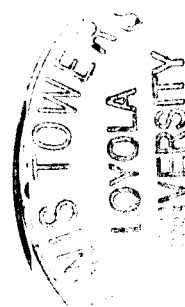
not seek treatment. They suggest that within couples that have sexual problems and do not seek treatment that a communication process exists that allows them to solve problems constructively whether the problems are of a sexual nature or not.

#### Marital Satisfaction Questionnaire

Lazarus' Multi-Modal Marital Satisfaction Questionnaire (MSQ) is a brief 12 item form in which the individual is asked to rate on a scale of 0 to 10 their present feelings about their marriage or spouse. A 0 response indicates that they are not pleased. In personal communication with Dr. Arnold Lazarus (October, 1981 and July, 1983), he indicated that to date there has been no systematic research done on the reliability or validity of this instrument. A small study in progress by one of his students has found a high correlation between the MSQ and the Locke-Wallace. The MSQ's main use has been clinical and according to Dr. Lazarus has been found to be an effective index of marital satisfaction. Some parameters for interpreting the scores have been established. A score of 60 or below indicates a poor level of marital satisfaction. A score between 72 and 83 reflects satisfactory to good feelings and interactions and a score of 84 or more indicates a very good marriage (Lazarus, 1981).

#### The Minnesota Multiphasic Personality Inventory

The Central Office of the Veterans Administration in Washington, D.C. has mandated that in all VA Hospitals, any individual being considered for prosthetic surgery, as part of the psychiatric evaluation, be administered the MMPI. The MMPI is a 566 item True-False statement test which measures a variety of personality



traits and psychopathologic behavior in order to permit comparison with statistically established norms based on traditional psychiatric classification. The test consists of three validity and 10 clinical scales (Dahlstrom and Welsh, 1960). The short form consisting of the first 400 items was used for the present study. This is the only short form recognized by the test authors and the publishers (Butcher and Tellegen, 1978).

Since its inception in the early 1940's, the MMPI has been extensively used in a variety of clinical and research investigations. Its validity and reliability have been demonstrated and its clinical use for assessing psychological adjustment in psychiatric as well as nonpsychiatric groups is widely recognized (Dahlstrom and Welsh, 1960). There is at least one area, however, in which the MMPI appears to have been used relatively little. There are few studies which appear in the literature in which the MMPI is used to study marital couples. Of these studies, some have attempted to use the MMPI to assess understanding and similarity in couples (Newmark, Woody, and Ziff, 1977). Others have used the MMPI to assess personality changes in couples as a result of counseling (Cookerly, 1974). Several attempts have also been made to identify common factors and characteristics of married couples (Arnold, 1970; Yom, Bradley, Wakefield, Kraft, Doughtie, and Cox, 1975; and Ollendick, Otto and Heider, 1983). The couples sampled in the above studies consisted of couples whose children were obtaining psychiatric services or couples who themselves were seeking marital counseling. Essentially absent from the literature are studies in which the MMPI is used to assess

couples seeking treatment for sexual dysfunction. An unpublished dissertation by Green (1978), however, did obtain MMPI scores of couples who were presenting for sex therapy. Although the range of the mean scores across the various groups for the husbands was small, she did find that the normal group had lower means than the symptom groups (premature ejaculators, secondary impotence) on the Hypochondriasis scale (1), Depression (2) and Psychoasthenia (7). The mean of Hypomania (9) was slightly higher for normal subjects. The profiles of the wives was somewhat less clear. Those wives complaining of sexual lack of interest were somewhat higher than the nonorgasmic group on Depression (scale 2), lower on Hypochondriasis (scale 1), Psychopathic Deviance (scale 4), Masculinity-Femininity (scale 5), Psychoasthenia (scale 7) and Schizoid mentation (scale 8). The mean for the normal group fell among the mean for the symptom groups.

#### Miscellaneous Forms

Consent Forms: Both husband and wife were asked to sign standard VA consent form 10-1086 which provided a written explanation of the study. It also stated that they were freely volunteering to participate in the study, had been informed of the nature of their participation and had been informed of their right to withdraw from the study.

Information Sheet: A short form was used to collect information such as name, age, sex, occupation, marital status, education, pertinent family and medical history and information about their sexual problems.

## PROCEDURE

### Subject Selection

The subjects were 12 couples in whom the men had been considered potential candidates for penile prosthetic surgery by their physicians. The men were initially evaluated physically in the Genitourinary (GU) clinic and referred to the Family Mental Health Program for further assessment of their suitability for surgery.

### Testing Procedure

Once referred for assessment the men were then assigned to one of two staff members for counseling, either a clinical nurse specialist or social worker, depending on the staff's availability for new cases. The husband was seen alone on the first visit and the wife alone on the second visit. After these sessions, they met as a couple for continued assessment and counseling. During the interviews, pertinent biographical, medical and family data was obtained and it was explained to the couples that they would be taking certain tests as part of the evaluation program and asked to sign the consent forms. Within the first three sessions, the tests were administered to the husband and wife by their counselor. The data was collected over a one year period from July, 1982 through July, 1983.

## ANALYSIS

Because of the small sample size, evaluation of the data was accomplished through the use of descriptive statistics, visual inspection, t tests and correlations. On the Marital Communication

Inventory and the Marital Satisfaction Questionnaire, means and standard deviations were calculated for both husbands and wives. Three correlation coefficient scores were obtained: (1) between the MCI and MSQ for the husbands (2) between the MCI and the MSQ for the wives and (3) between the MCI and MSQ for all subjects regardless of sex.

For the MMPI, mean, median and standard deviation scores for each scale were derived for both husbands and wives. For each scale on the MMPI, t tests were performed to assess any significant differences between the husbands' and wives' scores. The number of MMPI scales exceeding a t score of 70 were calculated for husbands and wives. A mean profile for husbands and wives was plotted as were individual couple profiles. Finally, the MMPI data on the husbands was evaluated according to Beutler's two point Decision Rule.

Chapter Three presented the methodology of the study. Included in this chapter was a description of the subjects, presentation of the demographic data, description of the psychometric instruments used in the study, the testing procedure employed and an outline of the statistical procedures.

The next chapter presents an analysis of the study and a discussion of the results.

## CHAPTER IV

### RESULTS OF THE STUDY

#### INTRODUCTION

This chapter reports the findings obtained through the use of descriptive statistics, visual inspection, t tests and Pearson Product Moment Correlation on the data from the Minnesota Multiphasic Personality Inventory (MMPI), Marital Communication Inventory (MCI) and the Marital Satisfaction Questionnaire (MSQ).

The MMPI scoring was done by computer through the MMPI Research Laboratory in Minneapolis, Minnesota under the direction of Dr. Harold Gilberstadt. All data were analyzed at the WSWA Medical Center utilizing the statistical package for the University of Illinois School of Pharmacy for descriptive statistics, frequency distributions, t test and correlations.

#### ANALYSIS OF THE MCI AND MSQ DATA

The means and standard deviations for both husbands and wives were calculated on the MCI and MSQ (Table 4). The mean score reported by Bienvenu on the MCI ranges between 99 and 106. The scores of 88.25 (husbands) and 85.92 (wives) are below these reported means. On the MSQ a score of 60 or below indicates a poor level of marital satisfaction. Between 72 and 83 reflects satisfactory to good

feelings and interactions and a score of 84 or more means a very good marriage. The present scores of 82.92 (husbands) and 85.30 (wives) falls within the range that would indicate a relatively high level of marital satisfaction.

Table 4

Means and Standard Deviations for the MCI and MSQ

	MCI		MSQ	
	$\bar{x}$	$\sigma$	$\bar{x}$	$\sigma$
Husbands	88.25	20.20	82.92	20.29
Wives	85.92	24.81	85.30	20.68

Correlation coefficient scores were obtained (1) between the MCI and MSQ for the husbands (2) between the MCI and MSQ for the wives and (3) between the MCI and MSQ for all subjects regardless of sex. All correlations were found significant ( $r = .67, .73, \text{ and } .70$  respectively) as tested by the  $t$  ratio described in Hays (1963).

These relationships are illustrated in Table 5.

Table 5

Correlations Between the MCI and MSQ

Husbands	.67*
Wives	.73**
All Individuals	.70**

\*Significant at the .05 level

\*\*Significant at the .01 level



## ANALYSIS OF THE MMPI DATA

The mean, median and standard deviation were calculated for the three validity and ten clinical scales of the MMPI for both husbands and wives (Table 6). Figures 1 and 2 illustrate the mean MMPI profile for both husbands and wives respectively. Four of the husbands had no t scores of 70 or above while the remaining eight had a total of 23 t scores of 70 or above. For the wives, five had no t scores of 70 or above while seven had a total of 21 t scores of 70 or above.

For each scale on the MMPI, t tests were performed to determine significant differences between the husbands' and wives' scores (Table 7). Statistical significance was found on scales 2 (Depression) and 5 (Masculinity-Femininity). A trend toward significance was evident on scales 1 (Hypochondriasis) and 7 (Psychoasthenia). Individual couple profiles are plotted for visual inspection (Figures 3 through 14).

Finally, the MMPI data for the husbands only was evaluated according to Beutler's 2-point Decision Rule. As cited previously, Beutler states that if two basic requirements are met on the MMPI, the diagnosis of organic impotence can be made with a 90% accuracy rate. The two decision rules are as follows: (1) scale 5 (Masculinity-Femininity) above a t score of 60 and (2) one other clinical scale above 70. If these are found, then in all likelihood, the impotence is said to be of a psychogenic nature. In the present study, based on medical assessment, only three of the men were without evident organic disease and whose impotence was felt to be strongly psychogenic in origin. Five of the profiles met the two point

Table 6

## MMPI Data on Husbands and Wives

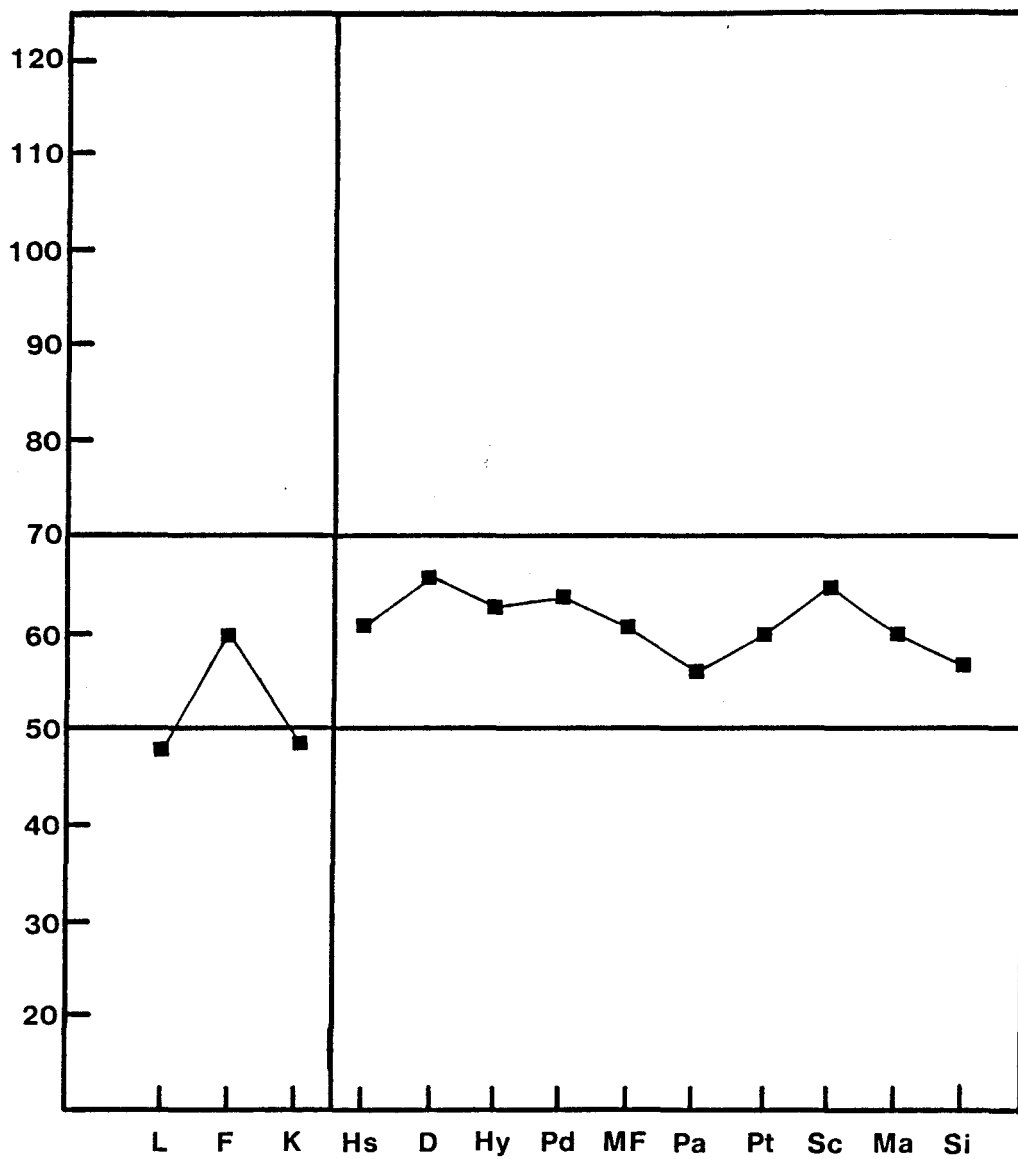
Scale	Husbands			Wives		
	x	Median	$\sigma$	x	Median	$\sigma$
L	48	50	5.08	50	49	9.96
F	60	61	6.54	59	62	9.89
K	49	50	8.73	50	48	9.09
1(Hs)	61	59	7.22	54	49	11.74
2(D)	66	62	13.91	54	51	10.56
3(Hy)	63	64	8.33	59	57	11.79
4(Pd)	64	63	9.86	59	56	9.97
5(MF)	61	60	9.58	54	56	6.67
6(Pa)	56	53	8.71	58	60	12.75
7(Pt)	60	58	15.08	51	49	11.19
8(Sc)	65	62	16.80	60	62	13.89
9(Ma)	60	60	7.30	63	60	11.41
0(Si)	57	54	8.35	54	51	7.52

Table 7

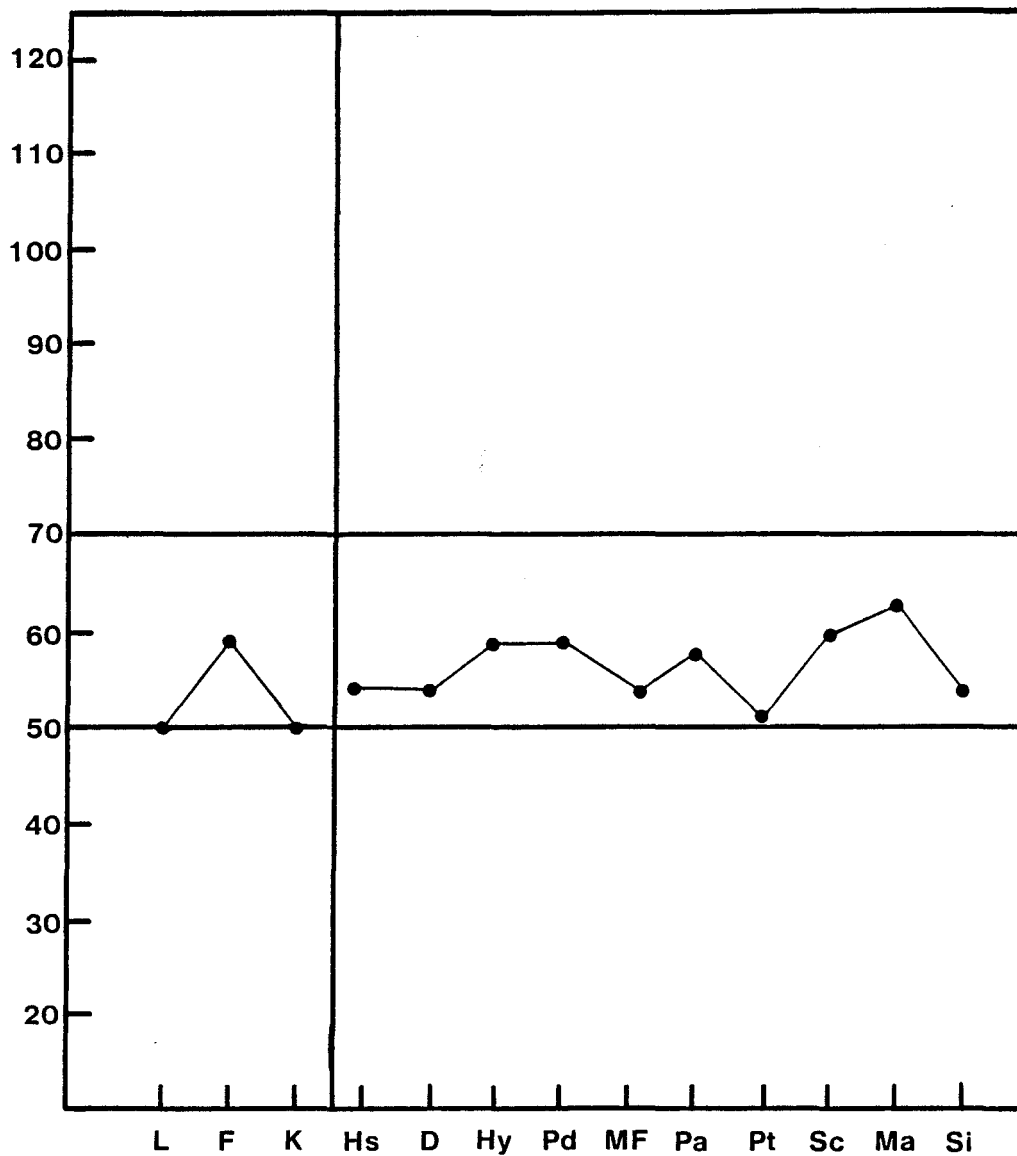
T Test Comparisons of Husbands' and Wives' MMPI Scale Scores

Scale	d.f.	t-value	Significance
L	22	.514	.61
F	22	.194	.85
K	22	.113	.91
1(Hs)	22	1.655	.11
2(D)	22	2.231	.036*
3(Hy)	22	.939	.357
4(Pd)	22	1.174	.25
5(MF)	22	2.176	.04*
6(Pa)	22	.449	.66
7(Pt)	22	1.522	.14
8(Sc)	22	.82	.42
9(Ma)	22	.597	.56
0(Si)	22	.693	.49

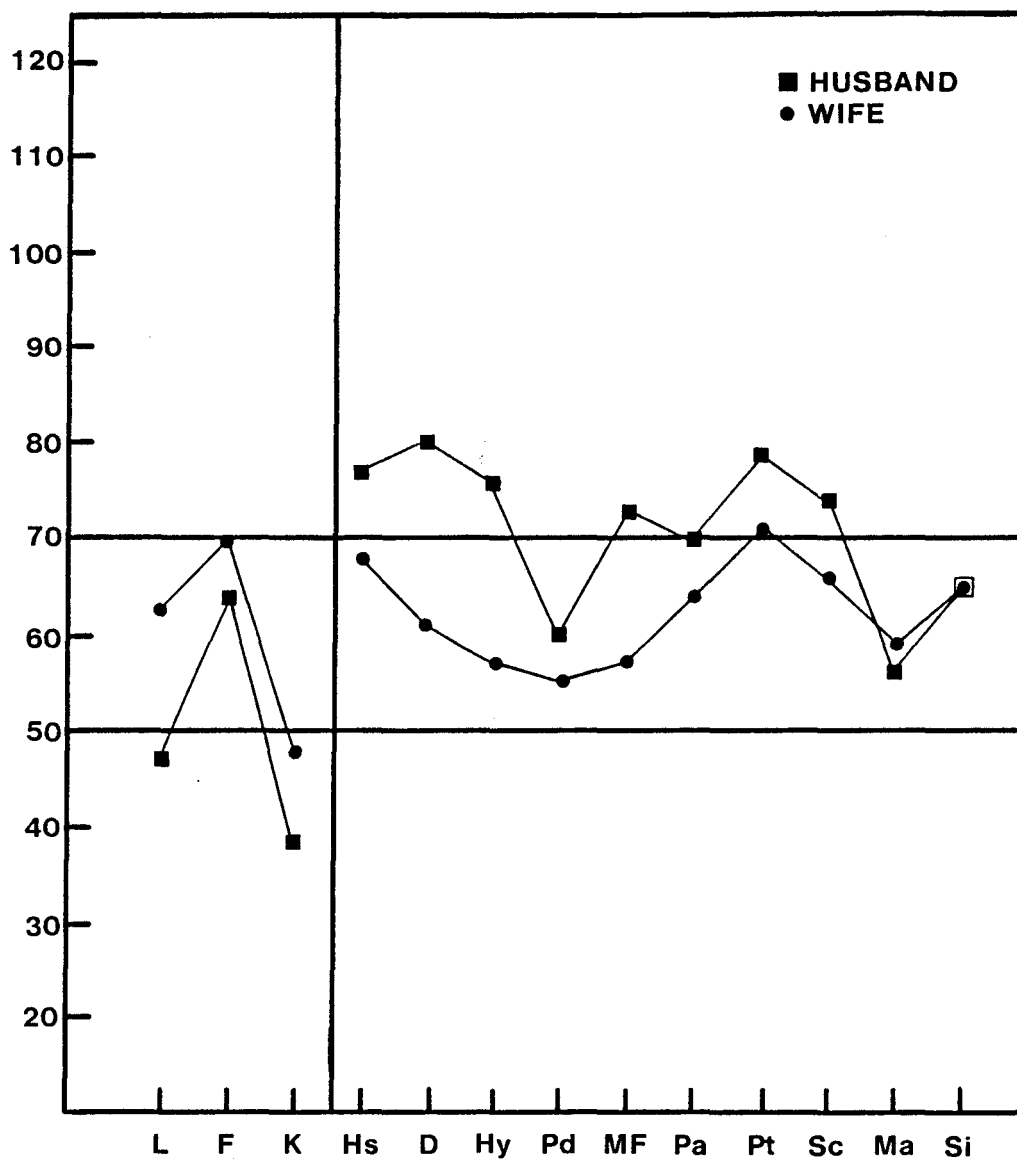
**FIGURE 1**  
**MEAN MMPI PROFILE FOR HUSBANDS**



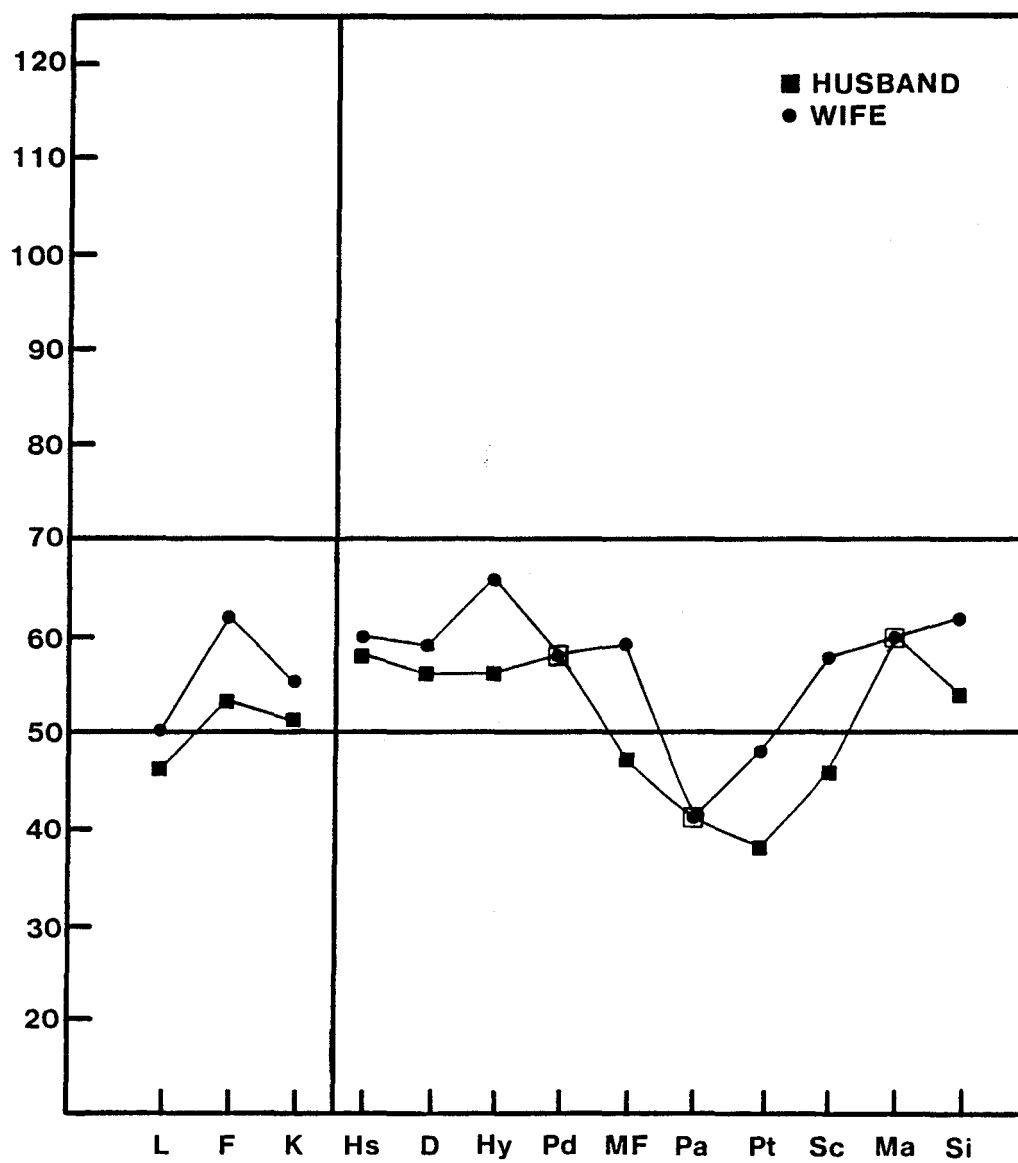
**FIGURE 2**  
**MEAN MMPI PROFILE FOR WIVES**



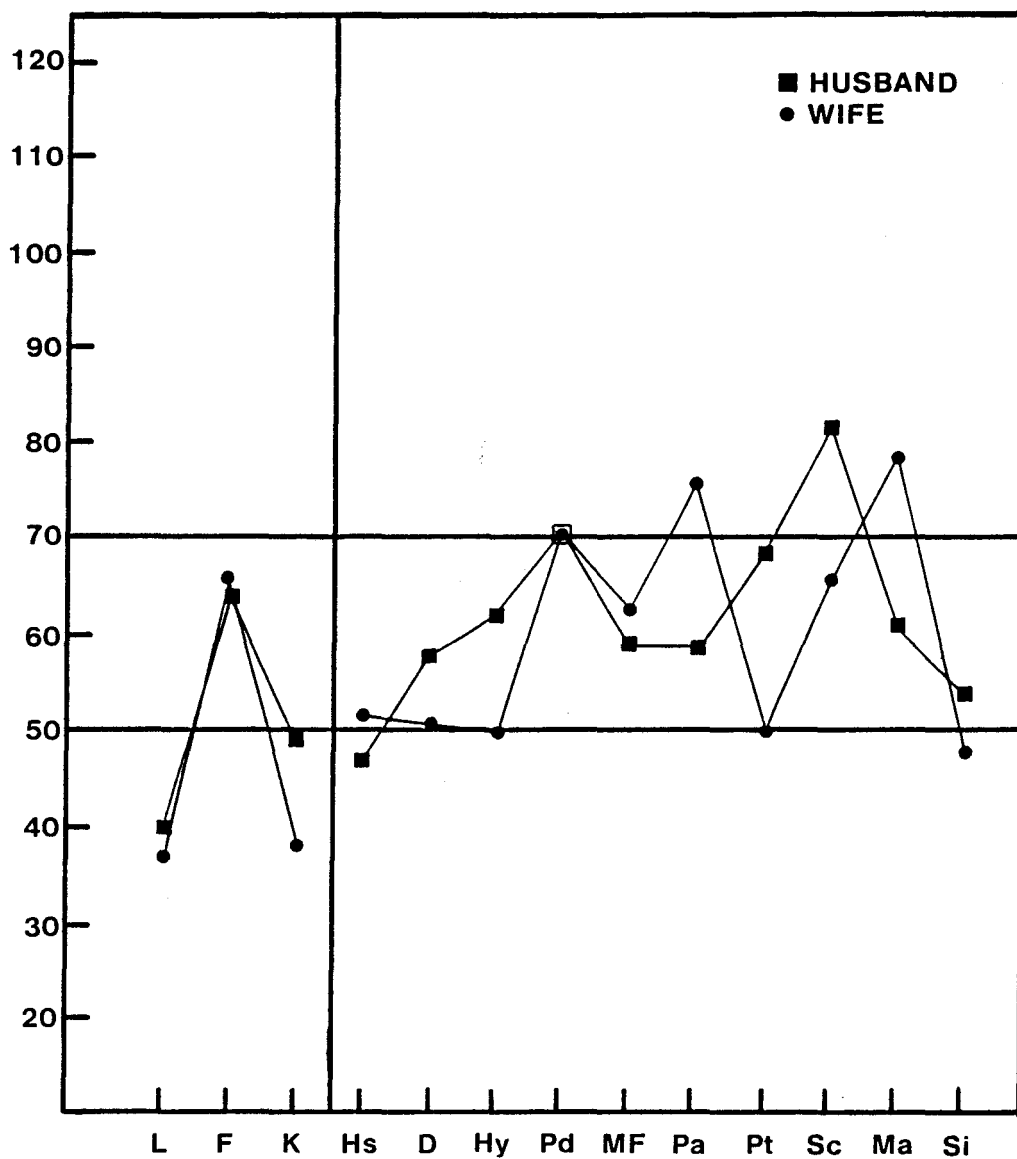
**FIGURE 3**  
**MMPI PROFILE OF COUPLE ONE**



**FIGURE 4**  
**MMPI PROFILE OF COUPLE TWO**

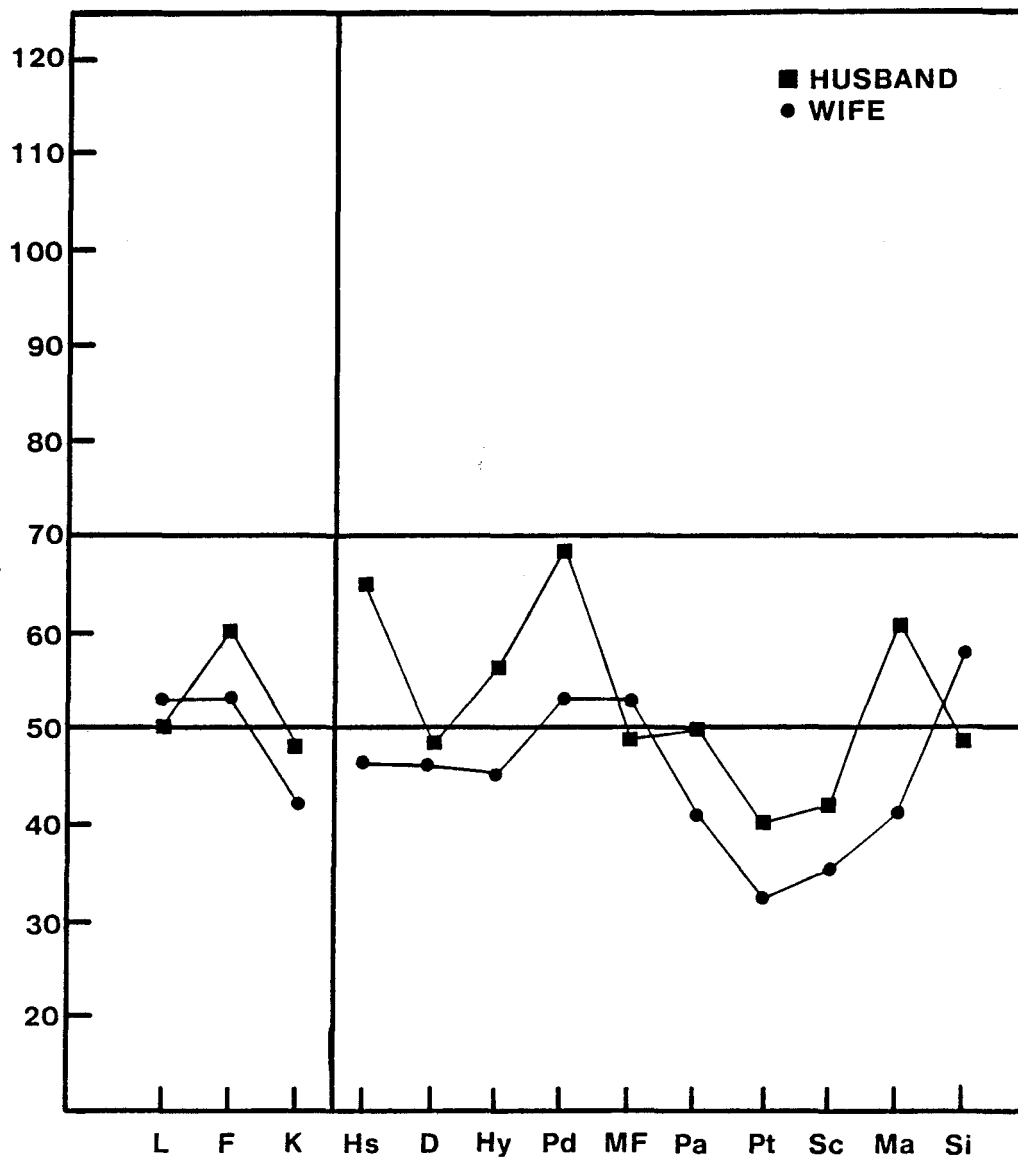


**FIGURE 5**  
**MMPI PROFILE OF COUPLE THREE**

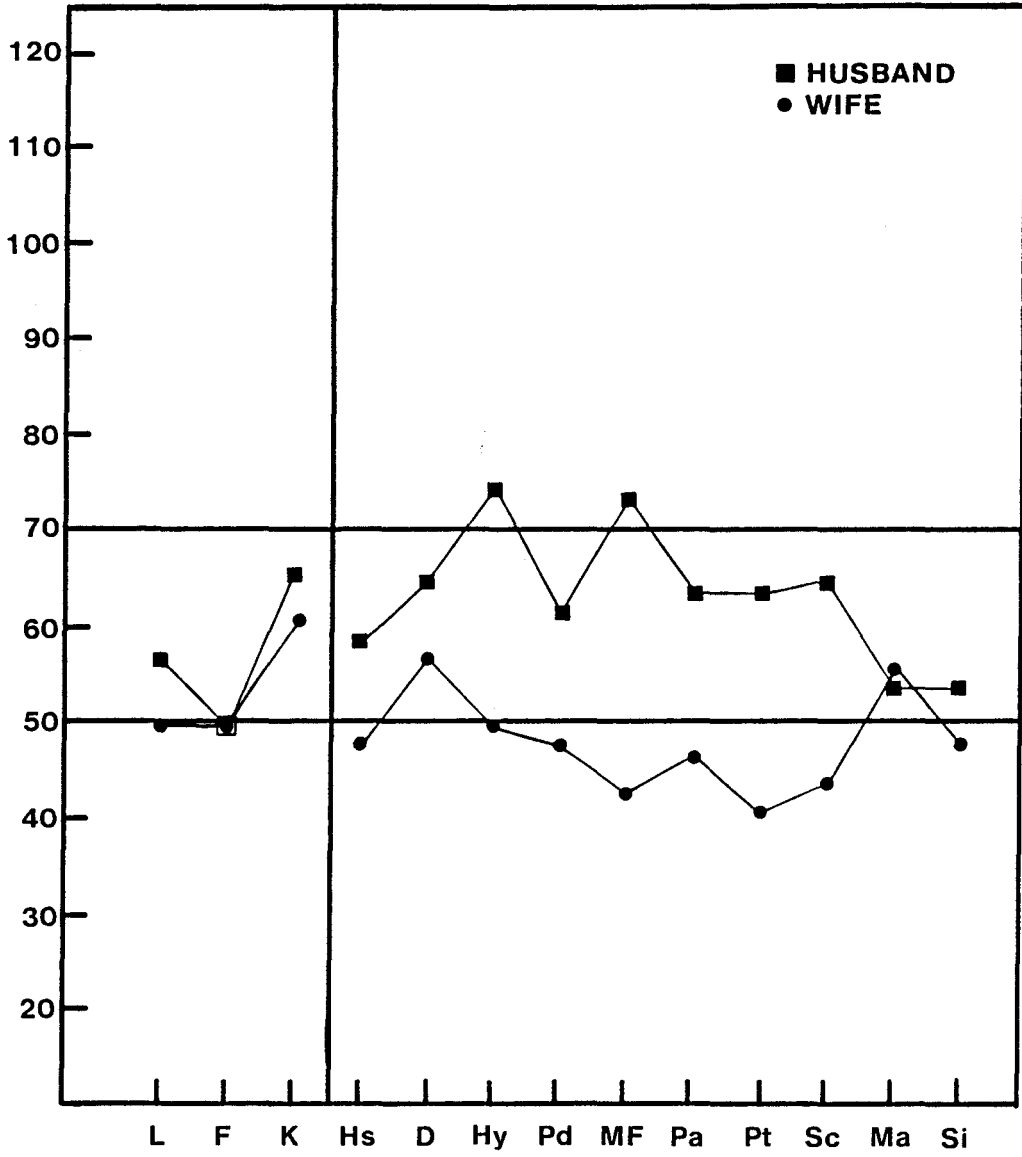




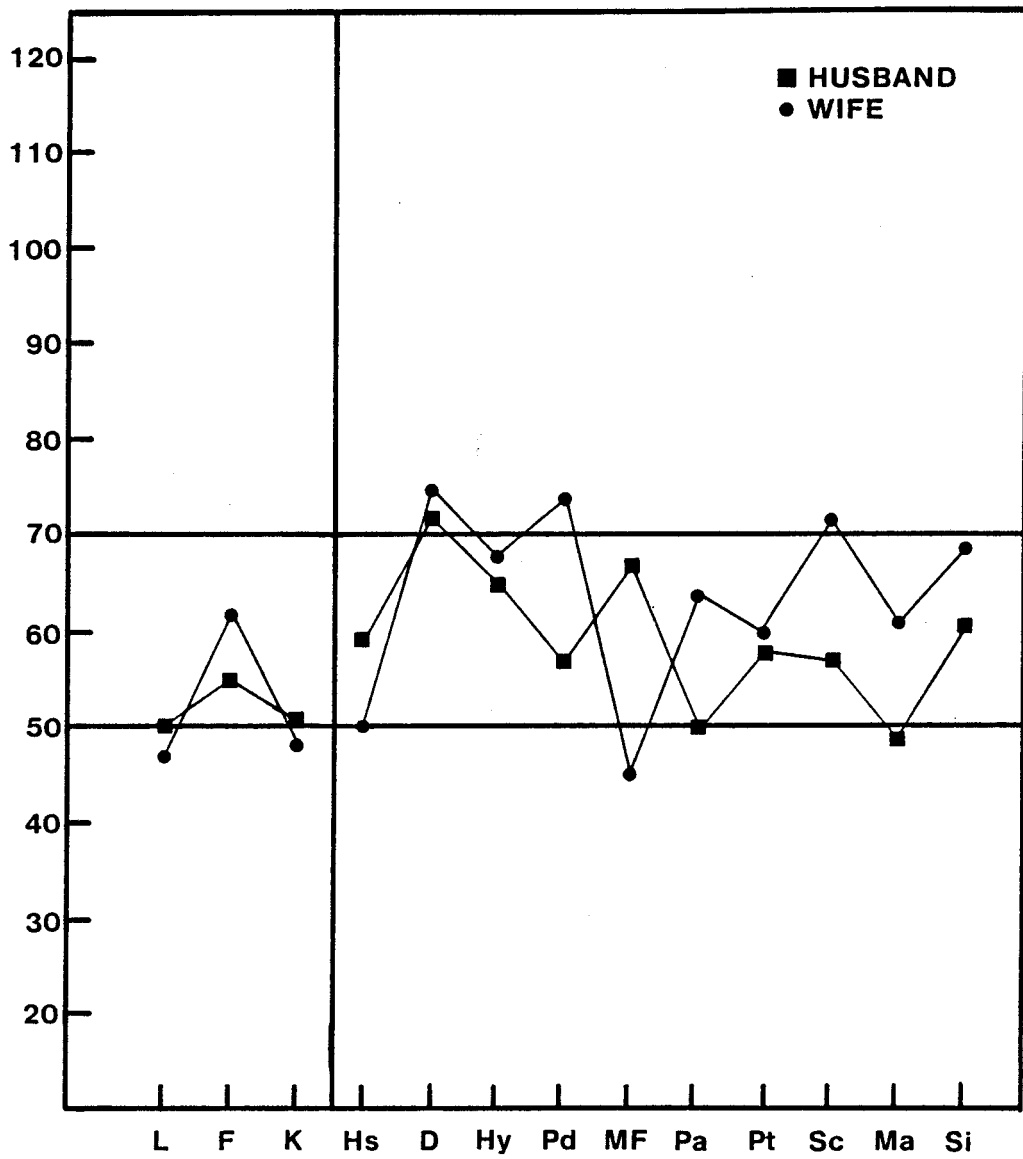
**FIGURE 6**  
**MMPI PROFILE OF COUPLE FOUR**



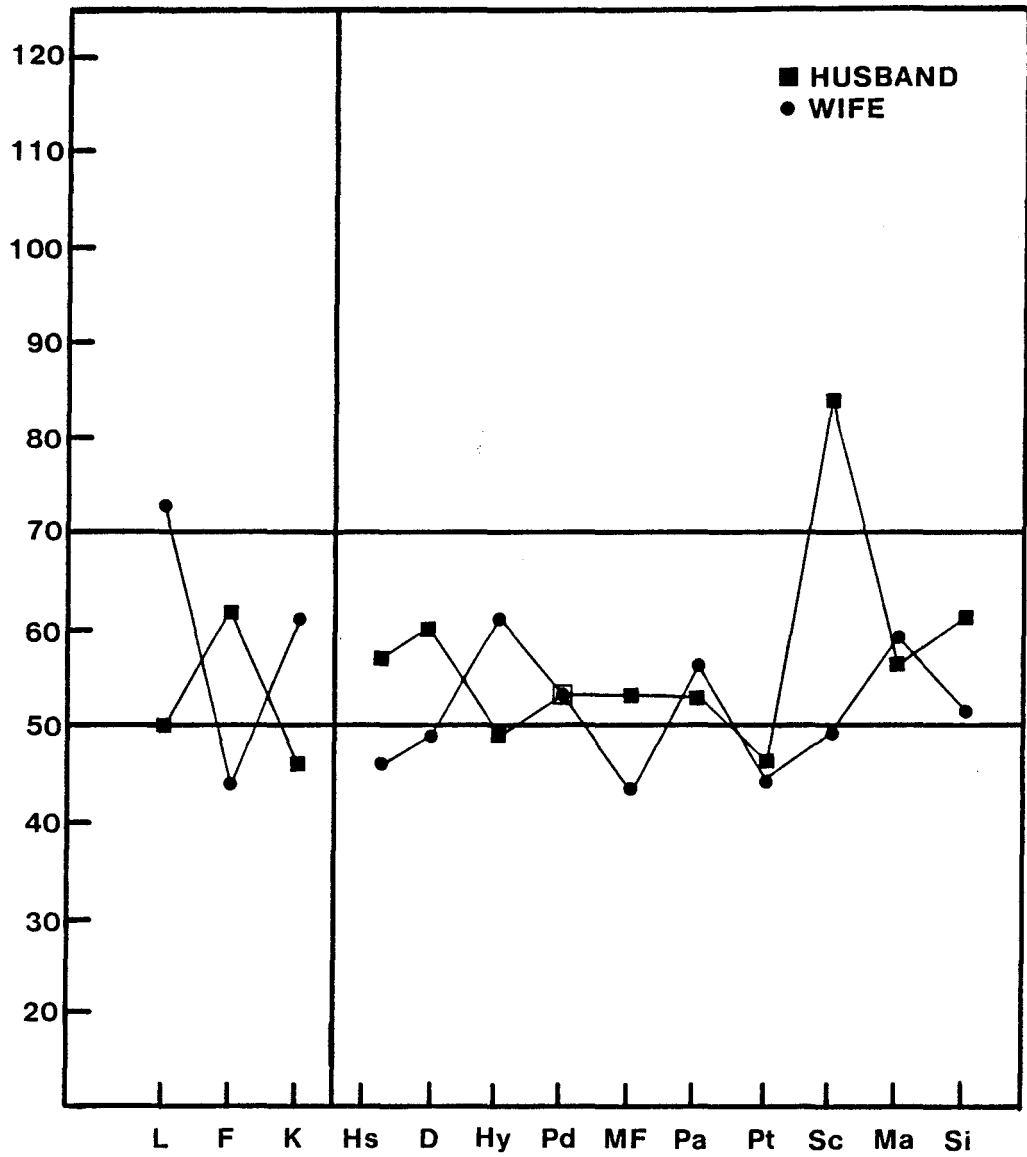
### FIGURE 7 MMPI PROFILE OF COUPLE FIVE



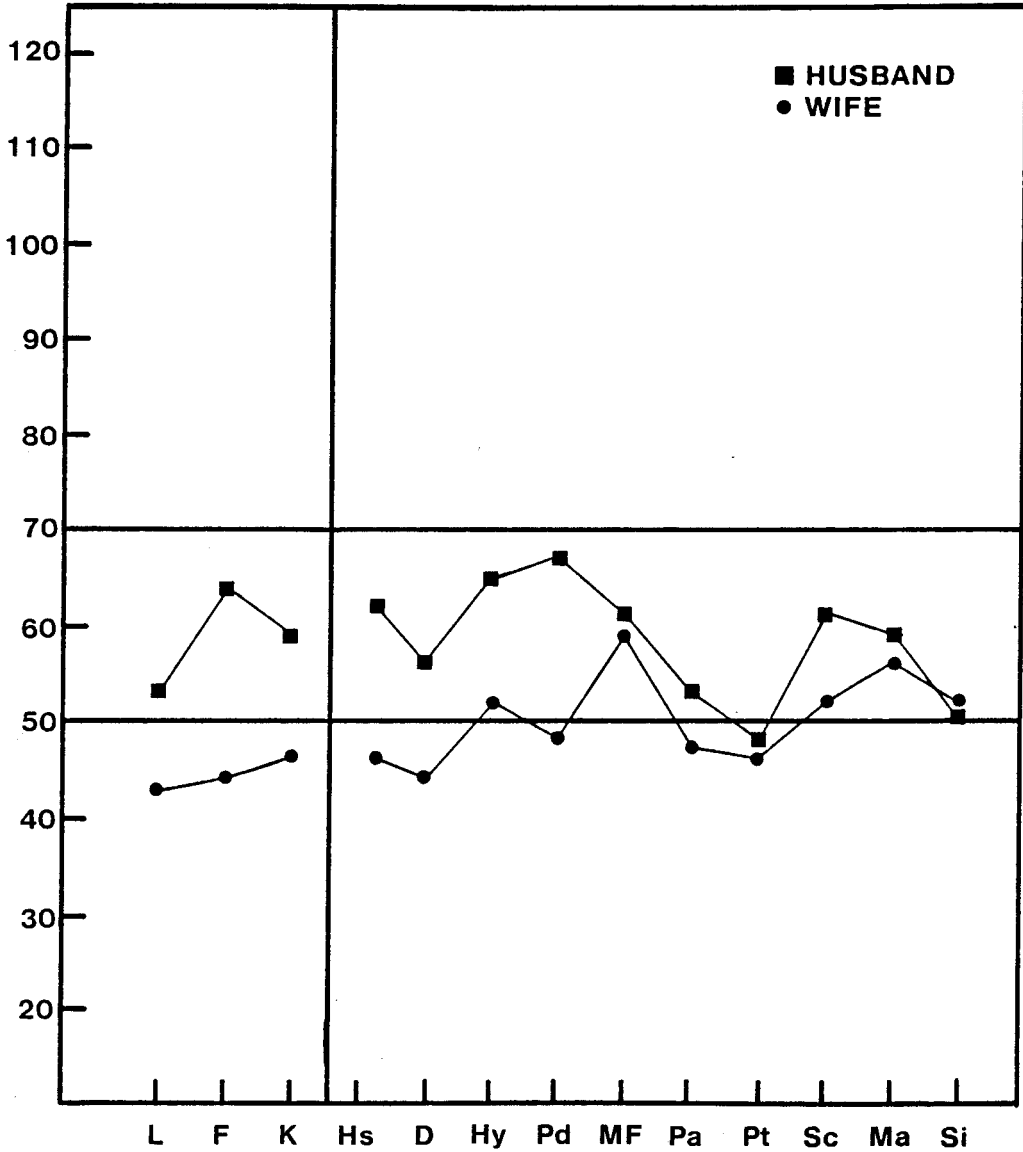
**FIGURE 8**  
**MMPI PROFILE OF COUPLE SIX**



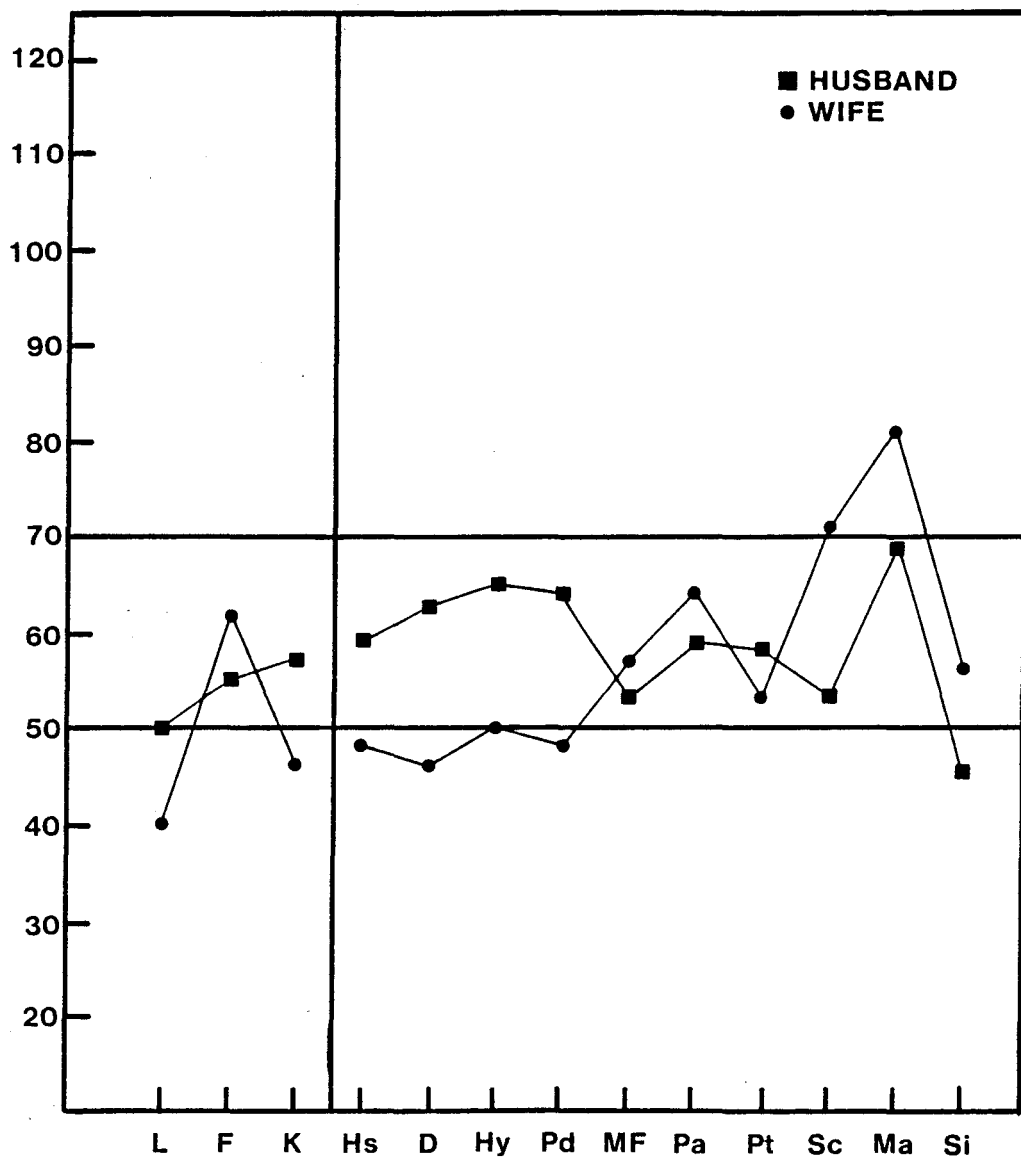
**FIGURE 9**  
**MMPI PROFILE OF COUPLE SEVEN**



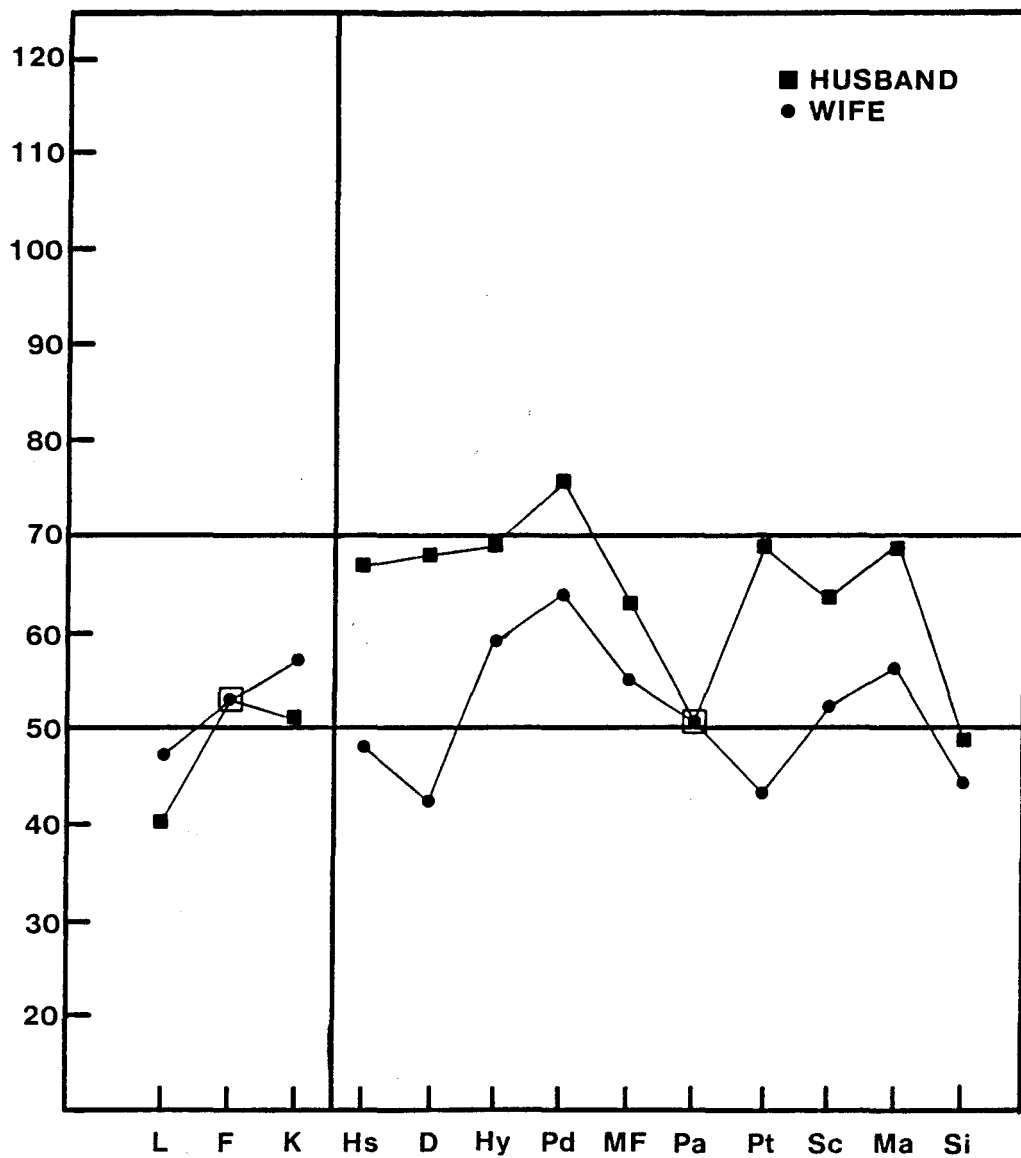
### FIGURE 10 MMPI PROFILE OF COUPLE EIGHT



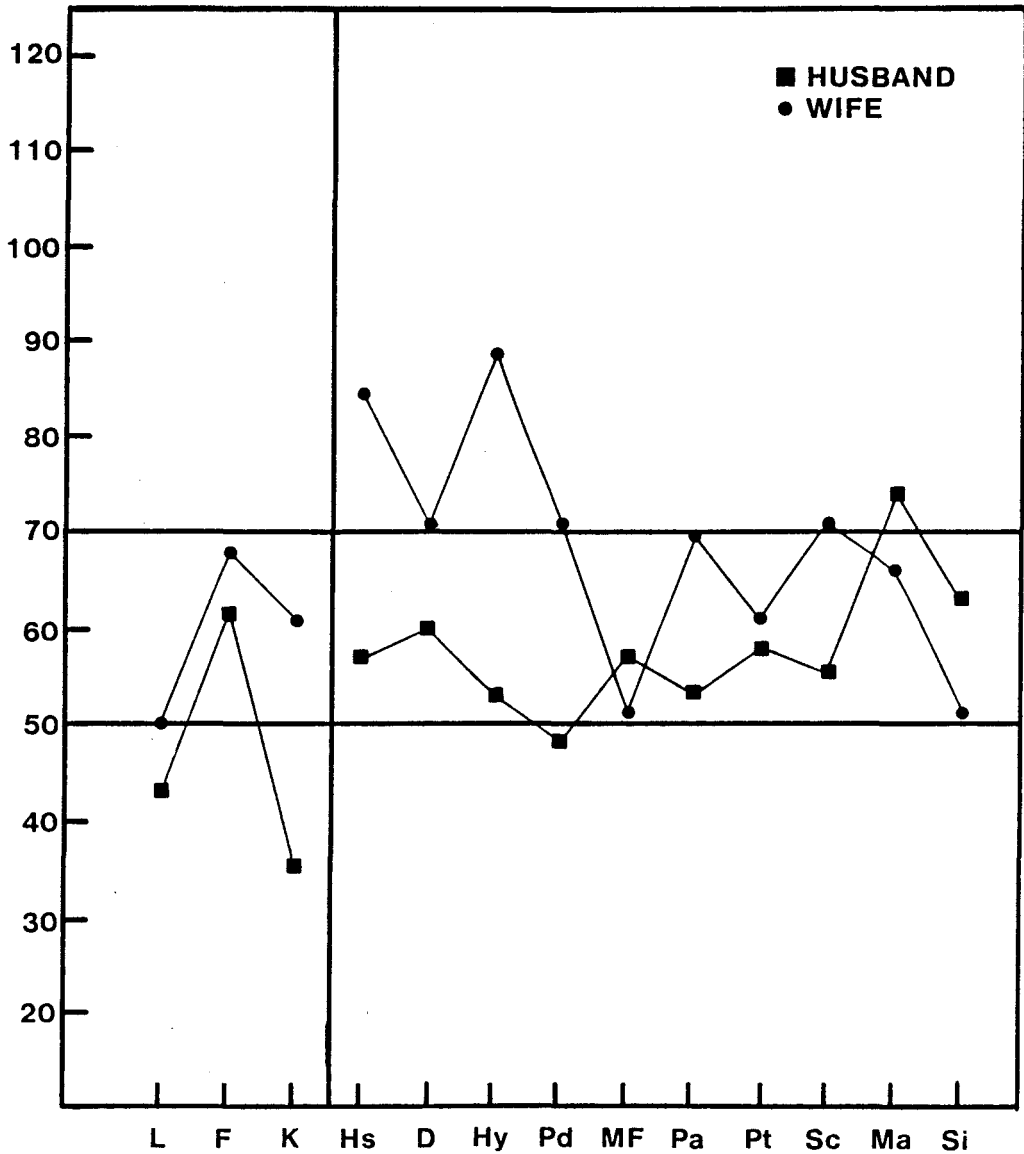
**FIGURE 11**  
**MMPI PROFILE OF COUPLE NINE**



**FIGURE 12**  
**MMPI PROFILE OF COUPLE TEN**

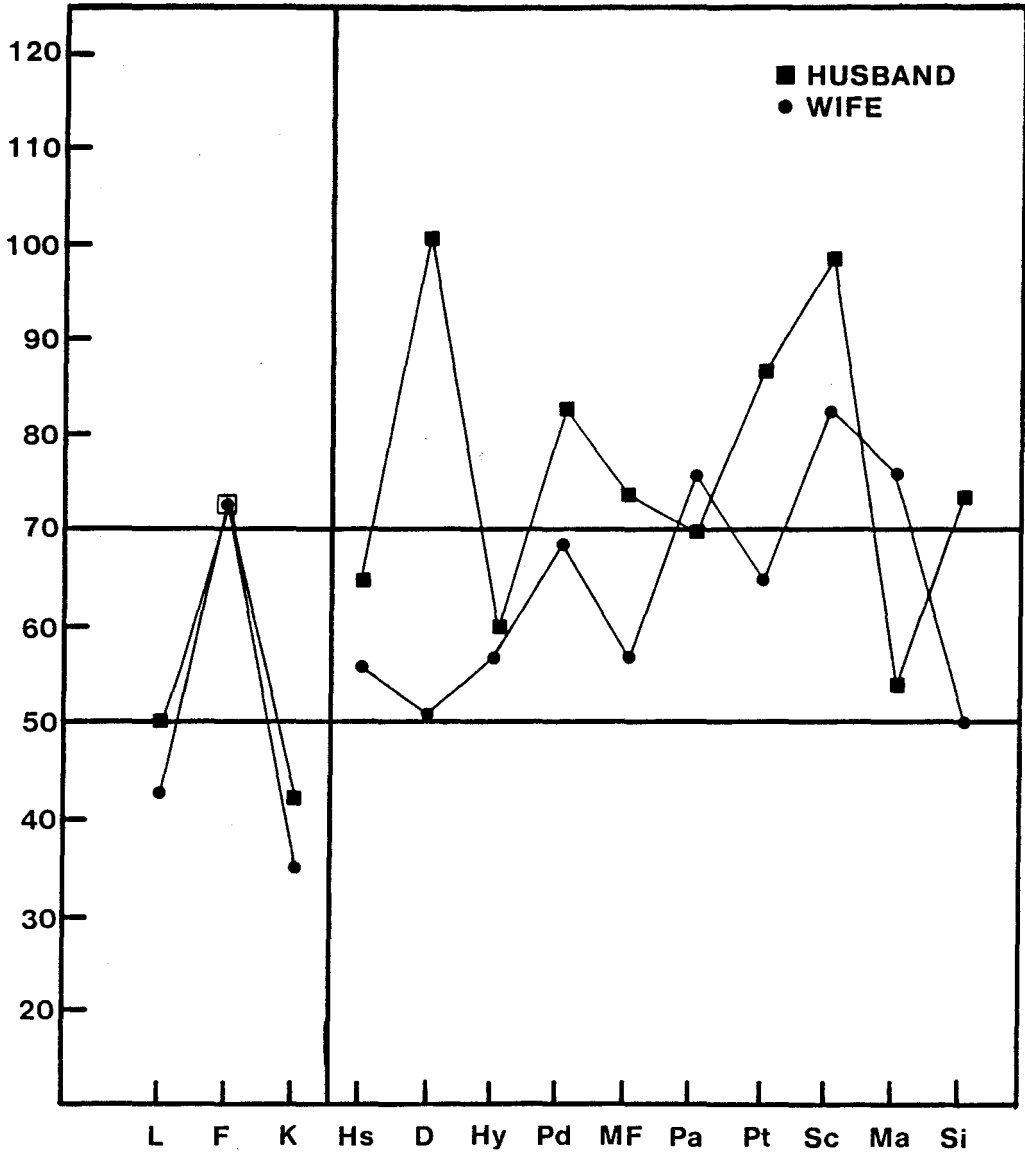


**FIGURE 13**  
**MMPI PROFILE OF COUPLE ELEVEN**





**FIGURE 14**  
**MMPI PROFILE OF COUPLE TWELVE**



criterion. Of these five, however, four were organic and only one psychogenic. Thus, with the present data, the two point decision rule is unsubstantiated.

#### DISCUSSION OF RESULTS

The present mean communication scores on the MCI are lower than those reported in Bienvenu's (1970) normative work. While there are differences in the populations which might be a consideration in interpreting these scores, the differences might well be reflecting a characteristic that has been found in couples with sexual dysfunction. This characteristic is one of reduced or impaired communication. In 1978, Green found that in couples undergoing treatment for sexual dysfunction, communication differentiated those who improved from those who did not. Communication was a key factor in their improvement. The type of communication was not of as much importance as was the fact that communication occurred.

Chesney and associates in 1981 published two articles in which communication, as measured by the MCI, was assessed as part of a battery of tests given to couples at a sex therapy workshop. In the first study, couples were given before and after measures of four variables included among them was marital communication. The mean marital communication score before treatment was 84.78 and after treatment was 90.40. This increase after treatment was found significant at the .002 level (Chesney, Blakeney, Chan, and Cole, 1981a).

The second study sought to examine couples who seek therapy for their sexual difficulties with those who do not. A number of measures were again used along with the MCI. Significant differences were found between the groups in terms of their level of marital communication. The group not seeking treatment had fewer communication problems than did the couples who were involved in the sex workshop. The reported means on the MCI for the sexual workshop group was 84.64 while the comparison group achieved a mean of 100.44 (Chesney, Blakeney, Cole, and Chan, 1981b). The mean MCI scores of the present study for the husbands (88.25) and the wives (85.92) are consistent with those found by Chesney and associates. Indeed, it would seem that these consistent findings with two rather variant populations lend additional support to the idea that couples with sexual dysfunction can be characterized as experiencing impaired communication. Another implication of this finding underlies the importance of assessing the nonsexual aspects of the relationship of sexually dysfunctional couples. Although, as Kaplan (1974) states, a lack of communication may not be the cause of dysfunction, but it can certainly serve to perpetuate and escalate the problem.

The current findings from the MSQ indicate that these 12 couples have a moderately high level of satisfaction with their marriage based on the parameters established by Lazarus (1981). As previously discussed in Chapter Two, because a couple experiences a sexual problem or dysfunction, it does not necessarily follow that they will be unhappy or dissatisfied with their marital relationship.

The correlations between the MCI and MSQ for the husbands, wives

and for all individuals regardless of sex were found to be significant ( $r = .67, .73, \text{ and } .70$  respectively). The scores indicate that the two scales retain a linear correlation regardless of their relative level and suggest a strong, positive relationship between communication and marital satisfaction.

The MSQ is a recently developed test which is just beginning to be used in systematic research. This present study is the first to use it with sexually dysfunctional couples. Although the number of individuals used in the present sample is small, the data can be used in the growing base of information about the test itself and its relationship to other measures.

In examining the MMPI profiles of the husbands and wives, it is apparent that there is not one profile configuration that could be considered characteristic of either group. The mean profile for both the husbands and the wives are well within the normal range. The mean profiles were examined in comparison to the normative MMPI interpretations as found in Dahlstrom and Welsh (1960). From the mean MMPI profile, the husbands as a group might be described as having somewhat more than the usual concerns with their body, to be experiencing some subjective discomfort that might be expressed in terms of some degree of depressive affect, anxiety, to be somewhat moody, passive and feeling somewhat uncomfortable and estranged in their dealings with other people. They are not, however, withdrawn in social situations or likely to experience any significant paranoid feelings.

A similarly based description of the wives as a group might

describe them as lacking in any significant anxiety, depression, concern over their bodies or their femininity. They do seem to evidence somewhat more than the usual degree of feelings of personal sensitivity, guardedness and tension.

Again, to reemphasize, these descriptions reflect normal variations in functioning that any individual might experience. Multiple t tests performed on each scale of the MMPI indicate statistically significant differences on scales 2 (Depression) and 5 (Masculinity-Femininity). A trend toward significance was evident on scales 1 (Hypochondriasis) and 7 (Psychoasthenia). This suggests that in comparison to the wives, the husbands are significantly more dysphoric in mood and passive as well as evidencing more physical concerns and anxiety. There is research in the literature to indicate that these particular scales do tend to be somewhat elevated in a population of sexually dysfunctional males. In 1978, Green studied 77 couples at the sex therapy program in Loyola University Hospital. The MMPI was administered as part of a battery of tests. It was found that for the symptomatic males (premature ejaculators and erectile dysfunctions) three scales were greater than for the control group: scales 1, 2, and 7. The mean for scale 5 was also higher in the symptomatic group. Her findings for the wives were not as clear. The scores for the asymptomatic group fell among the symptom group members and were all still within the normal range. Although it continues to be suggested that collateral MMPI data on the wives of sexually dysfunctional men would be useful (Robiner, 1982), to date, Green's work appears to be the only one that reports such data for comparative

purposes. Maddock (1980) included the wives and obtained MMPI's as part of a pre- and post-surgery psychological and behavioral evaluation. There has, however, currently been no results reported from this work. The present study is the first that presents data on the wives of men who are seeking penile prosthesis.

Previous research with the MMPI has produced somewhat discrepant findings as to the degree, if any, of psychopathology of these sexually dysfunctional men. Beutler, Karacan, Anch, Salis, Scott, and Williams (1975) found the mean MMPI profiles for those men diagnosed as having a psychogenically and biogenically based impotence to be quite similar and well within the normal limits. The psychogenic group did tend to have slightly higher elevations on the clinical scales, but in general there were no specific psychopathological indicators. Marshall, Surrige, and Delva (1980), in an attempt to cross validate Beutler's two point decision rule, found the mean profile for the psychogenic group to be within the normal range, while those diagnosed as organically impotent had higher elevations on scales 1, 2, and 3. They interpret this as the organic patients displaying a greater degree of psychological disturbance. Several other studies by Munjack and associates (1978 and 1981) also interpret MMPI findings of their sexually dysfunctional patients as reflecting more psychopathology than sexually normal males. Munjack's research seemed to find a greater range of scales elevated than research already discussed. Indeed, in the 1981 study, seven of the ten clinical scales were found to be higher than the normals (scales 1, 2, 3, 4, 6, 7, and 8). Given the relative elevations of scores in

Marshall's and Munjack's works, the issue of whether or not these scores constitute psychopathology is still open to question. Certainly, in the present study, it seems that rather than reflecting any psychopathology, the mean profile for the men in particular may reflect a certain degree of psychological discomfort, of despondency and anxiety, perhaps precipitated by their concern over their sexual problem and their need to seek potential radical surgical intervention for it.

#### SUMMARY

This chapter presented the analysis of the data and a discussion of the results. The means and standard deviations for both husbands and wives were presented for the MCI and MSQ. It was found that the present means on the MCI were lower than those reported as being average for the test. The means obtained for the husbands and wives on the MSQ, however, indicate a relatively high level of satisfaction with the marriage. Correlational data was obtained on both the MCI and MSQ for husbands, wives and all individuals regardless of sex. All three correlations were found to be statistically significant.

Mean, median and standard deviation scores were presented on the MMPI for both husbands and wives. Statistical significance was found between husbands' and wives' on scales 2 (Depression) and 5 (Masculinity-Femininity), while scales 1 (Hypochondriasis) and 7 (Psychoasthenia) evidenced a trend toward significance.

Finally, the MMPI data for the husbands was used to examine the

validity of Beutler's two point Decision Rule in differentiating organic from psychogenic impotence. The results did not confirm the findings by Beutler and associates.

Chapter Five, the final chapter of this study, presents a summary of the study along with its implications and recommendations for future research.



## CHAPTER V

### SUMMARY AND CONCLUSIONS

This study examined the characteristics of couples in whom the male partner was experiencing erectile difficulties and seeking treatment by surgical intervention with the penile prosthesis. A review of the literature reveals that there has been a general lack of baseline information on the men who seek out this more radical surgical treatment for sexual dysfunction. There has been even less focus on their wives or on any systematic attempt to assess the couple and their relationship. It was, therefore, the purpose of this study to (1) develop an overall psychological and relationship assessment program that can be utilized on an ongoing basis at WSVH Hospital for screening and counseling couples in which the male is a potential candidate for penile prosthetic surgery; (2) to examine and describe the psychological characteristics of the individual spouses as well as the nature of their relationship; (3) to establish normative baseline data for the Marital Communication Inventory and Marital Satisfaction Questionnaire on the WSVH Family Program population who has sought out prosthetic surgery; (4) to utilize the data from the study to generate and formulate hypotheses for further research in this area.

Twelve couples in whom the men were considered potential candidates for the penile prosthesis by their physicians were referred to the Family Mental Health Program for further assessment of their

suitability for surgery. Within the first three visits the Minnesota Multiphasic Personality Inventory, Marital Communication Inventory and the Marital Satisfaction Questionnaire were administered by the couples' counselor.

The results indicate that the couples have communication scores which are lower than expected from established norms. The scores on the marital satisfaction test, however, indicate relatively high levels of satisfaction with the marriage overall. A high positive correlation was found between the measures of communication and marital satisfaction.

The MMPI data indicate that there is no one profile configuration that is characteristic of either the husbands or the wives. As a group, neither the husbands nor the wives evidence any signs of psychopathology. Statistical significance was found between the husbands' and the wives' scores on scales 2 and 5, while scales 1 and 7 evidenced a trend toward significance.

A composite description of the couples under investigation presents them as in their early to mid-fifties, without a high school degree, working in a blue collar job. They are predominantly Black and Protestant. Married for an average of 19.8 years with adult children, it is likely that the husband has been married before. The husbands' erectile dysfunction is likely to be of a primary organic basis and to have persisted for approximately two to four years. The wife is without primary sexual symptomatology. Although intercourse is generally unsuccessful, the couple continue to attempt sexual activity and have not abandoned that aspect of their lives. As a

couple, they appear to be generally satisfied with the overall state of their marriage, but are experiencing some problem in communicating effectively with each other.

Both husband and wife are essentially without any significant psychopathology. The husband can be characterized as having somewhat more than the usual concerns with his body, to be experiencing some subjective discomfort expressed in terms of some degree of depressive affect, anxiety and moodiness. He is somewhat passive and tends to feel rather uncomfortable and estranged in his dealings with others, although people continue to remain important to him.

The wife is lacking in any significant anxiety, depression, concern over her body or femininity. She does seem to evidence somewhat more than the usual degree of feelings of personal sensitivity, guardedness and tension.

As a result of the small sample used in this study, the results should be tempered with caution. Nonetheless, the findings have important implications for treatment and point to the direction for additional research needed in this area.

#### IMPLICATIONS

The results of this study have implications primarily in the area of clinical practice and treatment. The study provides the clinician with important information about the nature of the relationship of the couple seeking treatment for sexual dysfunction. It also provides some insight into the individual characteristics and concerns of both

husbands and wives on entering treatment. Although the course of treatment may differ for each couple, the present study provides the clinician with certain entry level concerns and issues that the couple may be experiencing. The results suggest that initially treatment be directed toward reducing stress, anxiety, tension and enhancing the self image of the males. Since the wife does not appear to be experiencing the same degree of anxiety and concern as the husband, it might be important initially to help her gain a greater empathy and understanding of him and the effect the impotence may be having on his functioning and sense of self. As treatment progresses, a strong focus should be placed on developing more effective communication skills for the couple.

#### RECOMMENDATIONS FOR FURTHER RESEARCH

The results reported in this study suggest the following recommendations:

1. A follow up study utilizing these 12 couples one year after treatment is currently being planned. In addition to readministering the current tests, an expanded, open-ended interview questionnaire will be given to assess both partners' reaction to treatment with special emphasis placed on those who received the penile prosthesis. Their reactions to the prosthesis and its effect on their relationship will be assessed as well as any other pre- and post-treatment changes.
2. Increasing the size of the sample through continuing the study at

WSVA would add to the reliability of the study.

3. Replicating the current study utilizing a different population would help to generalize the results across various racial and socioeconomic populations.
4. Including a control group would provide a basis for comparison for the individual psychological characteristics of the husbands and wives as well as for the dynamics within the relationship. Of particular interest might be the inclusion of couples in whom the husband has an organically based impotence such as from hypertension or diabetes, but chooses not to seek treatment for his dysfunction.
5. While the MMPI can provide the clinician with considerable information about intrapsychic and interpersonal functioning, its usefulness as a diagnostic tool to answer questions about the etiology of erectile dysfunction appears to be quite limited. A recent unpublished dissertation by Camic (1983) suggests that the Millon Behavioral Health Inventory (MBHI) is able to differentiate among organics, psychogenics and controls, classifying 81.25% of the subjects correctly. It is also effective in assessing prosthesis patients prior to surgery. Indeed, his findings suggest that the MBHI was more sensitive in determining which patients would develop emotional difficulties or psychosomatic symptoms than the MMPI. Therefore, the inclusion of the MBHI as part of the present screening battery would provide a wider spectrum of clinical information and assistance in the treatment of these individuals.

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APPENDIX A

FORM M  
A MARITAL COMMUNICATION INVENTORY

DEVELOPED BY  
MILLARD J. BIENVENU, SR.

1979 REVISION

This inventory offers you an opportunity to make an objective study of the degree and patterns of communication in your marital relationship. It will enable you and your wife to better understand each other. We believe you will find it both interesting and helpful to make this study.

DIRECTIONS

1. Please answer each question as quickly as you can according to the way you feel at the moment (not the way you usually feel or felt last week).
2. Do not consult your wife while completing the inventory. You may discuss it with her after both of you have completed it. Remember that the counseling value of this form will be lost if you change any answer during or after this discussion.
3. Honest answers are very necessary if this form is to be of value. Please be as frank as possible. Your answers are confidential. Your name is not required.
4. Use the following examples for practice. (Put a check ( ) in one of the four blanks on the right to show how the question applies to your marriage.

USUALLY    SOMETIMES    SELDOM    NEVER

Does your wife talk about  
her real feelings?

\_\_\_\_\_

Does she let you know when  
her feelings are hurt?

\_\_\_\_\_

5. Read each question carefully. If you cannot give the exact answer to a question, answer the best you can but be sure to answer each one. There are no right or wrong answers. Answer according to the way you feel at the present time.

	USUALLY	SOMETIMES	SELDOM	NEVER
1. Do you and your wife discuss the manner in which the family money should be spent?	_____	_____	_____	_____
2. Does she discuss her work and interests with you?	_____	_____	_____	_____
3. Do you have a habit of keeping your feelings to yourself?	_____	_____	_____	_____
4. Is your wife's tone of voice irritating?	_____	_____	_____	_____
5. Does she have a habit of saying things which would be better left unsaid?	_____	_____	_____	_____
6. Are your mealtime conversations easy and pleasant?	_____	_____	_____	_____
7. Do you find yourself keeping after her about her faults?	_____	_____	_____	_____
8. Does she seem to understand your feelings?	_____	_____	_____	_____
9. Does your wife nag you?	_____	_____	_____	_____
10. Does she listen to what you have to say?	_____	_____	_____	_____
11. Does it upset you to a great extent when your wife is angry with you?	_____	_____	_____	_____
12. Does she pay you compliments and say nice things to you?	_____	_____	_____	_____
13. Is it hard to understand your wife's feelings and attitudes?	_____	_____	_____	_____
14. Is she affectionate toward you?	_____	_____	_____	_____
15. Does she let you finish talking before she answers?	_____	_____	_____	_____

	USUALLY	SOMETIMES	SELDOM	NEVER
16. Do you and your wife remain silent for long periods when you are angry with one another?	_____	_____	_____	_____
17. Does she allow you to pursue your own interests and activities even if they are different from hers?	_____	_____	_____	_____
18. Does she try to lift your spirits when you are depressed or discouraged?	_____	_____	_____	_____
19. Do you avoid disagreeing with her because you are afraid she will get angry?	_____	_____	_____	_____
20. Does your wife complain that you don't understand her?	_____	_____	_____	_____
21. Do you let your wife know when you are displeased with her?	_____	_____	_____	_____
22. Do you feel she says one thing but really means another?	_____	_____	_____	_____
23. Do you help her understand you by saying how you think, feel, and believe?	_____	_____	_____	_____
24. Are you and your wife able to disagree with one another without losing your tempers?	_____	_____	_____	_____
25. Do the two of you argue a lot over money?	_____	_____	_____	_____
26. When a problem arises between you and your wife are you able to discuss it without losing control of your emotions?	_____	_____	_____	_____

	USUALLY	SOMETIMES	SELDOM	NEVER
27. Do you find it difficult to express your true feelings to her?	_____	_____	_____	_____
28. Does she offer you cooperation, encouragement and emotional support in your role (duties) as husband?	_____	_____	_____	_____
29. Does your wife insult you when angry with you?	_____	_____	_____	_____
30. Do you and your wife engage in outside interests and activities together?	_____	_____	_____	_____
31. Does your wife accuse you of not listening to what she says?	_____	_____	_____	_____
32. Does she let you know that you are important to her?	_____	_____	_____	_____
33. Is it easier to confide in a friend rather than your wife?	_____	_____	_____	_____
34. Does she confide in others rather than in you?	_____	_____	_____	_____
35. Do you feel that in most matters your wife knows what you are trying to say?	_____	_____	_____	_____
36. Does she monopolize the conversation very much?	_____	_____	_____	_____
37. Do you and your wife talk about things which are of interest to both of you?	_____	_____	_____	_____
38. Does your wife sulk or pout very much?	_____	_____	_____	_____
39. Do you discuss sexual matters with her?	_____	_____	_____	_____



	USUALLY	SOMETIMES	SELDOM	NEVER
40. Do you and your wife discuss your personal problems with each other?	_____	_____	_____	_____
41. Can your wife tell what kind of day you had without asking?	_____	_____	_____	_____
42. Do you admit that you are wrong when you know that you are wrong about something?	_____	_____	_____	_____
43. Do you and your wife talk over pleasant things that happen during the day?	_____	_____	_____	_____
44. Do you hesitate to discuss certain things with your wife because you are afraid she might hurt your feelings?	_____	_____	_____	_____
45. Do you pretend you are listening to her when actually you are not really listening?	_____	_____	_____	_____
46. Do the two of you ever sit down just to talk things over?	_____	_____	_____	_____

ABOUT YOU

Read the following sentences and complete them with the first thing that comes to your mind. It is important for you and your spouse to agree that you will not hold anything against each other for expressing your views. Your goal is to better understand each other, so please be frank in order to benefit as much as you can from this activity.

1. LATELY, OUR RELATIONSHIP \_\_\_\_\_

---

2. THE MAIN PROBLEM I SEE FACING US AT THIS TIME IS \_\_\_\_\_

---

3. ABOUT MY SPOUSE, I APPRECIATE: \_\_\_\_\_

a. \_\_\_\_\_

b. \_\_\_\_\_

4. TWO THINGS I WANT FROM MY SPOUSE THAT I'M NOT GETTING

a. \_\_\_\_\_

b. \_\_\_\_\_

5. IT WOULD HELP OUR RELATIONSHIP IF I \_\_\_\_\_

\_\_\_\_\_

6. I'M WILLING TO \_\_\_\_\_

\_\_\_\_\_

General Information:

Your Age \_\_\_\_\_ Wife's Age \_\_\_\_\_ Length of Present Marriage \_\_\_\_\_

Your religious preference \_\_\_\_\_

Your wife's preference \_\_\_\_\_

Have you ever been married, divorced, or widowed before: YES NO

If YES, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your Education \_\_\_\_\_ Occupation \_\_\_\_\_

Wife's Education \_\_\_\_\_ Her Occupation \_\_\_\_\_

Your Children's Ages:

Ages of Boys \_\_\_\_\_ Ages of Girls \_\_\_\_\_

APPENDIX B

## MARITAL SATISFACTION QUESTIONNAIRE

10      9      8      7      6      5      4      3      2      1      0

---

Pleased

Half yes  
Half no

Not Pleased

After each question, write down the number that most clearly approximates your present feelings about your marriage or your spouse.

I AM

- (1) Pleased with the amount we talk to each other.
- (2) Happy with the friends we share in common.
- (3) Satisfied with our sex life.
- (4) In agreement with the way we are spending money.
- (5) In agreement with the amount of time you or we spend at work and at home.
- (6) Pleased with the kind of parent you are. (If you have no children, are you pleased with your mutual plans for having, or not having, children?)
- (7) Of the opinion that you are "on my team."
- (8) Pleased with our leisure time together (e.g., sports, vacations, outings, etc.).
- (9) Basically in agreement with your outlook on life (e.g., values, attitudes, religious beliefs, politics, etc.).
- (10) Generally pleased with the way you relate to members of your family (parents, siblings, etc.).
- (11) Satisfied with the way you relate to members of my family (e.g., my parents, siblings, etc.).
- (12) Pleased with your general habits, mannerisms, and overall appearance.

APPENDIX C

PRINCIPAL INVESTIGATOR: \_\_\_\_\_

PROPOSAL TITLE: \_\_\_\_\_  
\_\_\_\_\_

1. I understand that the purpose of this research study is to \_\_\_\_\_  
\_\_\_\_\_

2. Dr. \_\_\_\_\_ has explained in detail the tests to be  
done on me. I understand that the tests to be done are \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. I understand that the known risks, discomforts, and side effects that  
can be expected are \_\_\_\_\_  
\_\_\_\_\_

4. I understand for any injuries sustained as a result of participation in a  
research protocol eligible veterans are entitled to medical care and treat-  
ment: In some circumstances, compensation may also be payable under 38USC351,  
or under the Federal Tort Claims Act. Non-eligible veterans and non-veterans  
are entitled to medical care and treatment on a humanitarian emergency basis.  
However, any compensation would be limited to situations where negligence  
occurred and would be controlled by the provisions of the Federal Tort Claims  
Act.

5. I understand that the benefits I may receive as a result of my taking  
part in this study are \_\_\_\_\_  
\_\_\_\_\_

6. I understand that if I do not take part in this study, this will not in  
any way stop me from receiving other currently available accepted medical  
care or testing for this condition.

7. I understand that I may withdraw from this study at any time without its affecting the medical care which I am entitled to receive.

8. I have read this consent form or have had it read to me, and I understand its content. I have asked all questions that have occurred to me, and these questions have been answered in a manner which I understand. I understand the possible risks and possible benefits, and I agree to participate in the research study.

---

Patient's Signature

---

DATE

---

Principal Investigator's Signature

---

DATE

---

Signature of Witness

---

DATE

**PART I-AGREEMENT TO PARTICIPATE IN RESEARCH  
BY OR UNDER THE DIRECTION OF THE VETERANS ADMINISTRATION**

I, \_\_\_\_\_, voluntarily consent to participate as a subject  
*(Type or print subject's name)*  
in the investigation entitled \_\_\_\_\_  
*(Title of study)*

2. I have signed one or more information sheets with this title to show that I have read the description including the purpose and nature of the investigation, the procedures to be used, the risks, inconveniences, side effects and benefits to be expected, as well as other courses of action open to me and my right to withdraw from the investigation at any time. Each of these items has been explained to me by the investigator in the presence of a witness. The investigator has answered my questions concerning the investigation and I believe I understand what is intended.
3. I understand that no guarantee or assurance has been given me since the results and risks of an investigation are not always known beforehand. I have been told that this investigation has been carefully planned, that the plan has been reviewed by knowledgeable people, and that every reasonable precaution will be taken to protect my well-being.
4. In the event I sustain physical injury as a result of participation in this investigation, if I am eligible for medical care as a veteran, all necessary and appropriate care will be provided. If I am not eligible for medical care as a veteran, humanitarian emergency care will nevertheless be provided.
5. I realize I have not released this institution from liability for negligence. Compensation may or may not be payable, in the event of physical injury arising from such research, under applicable federal laws.
6. I understand that all information obtained about me during the course of this study will be made available only to doctors who are taking care of me and to qualified investigators and their assistants where their access to this information is appropriate and authorized. They will be bound by the same requirements to maintain my privacy and anonymity as apply to all medical personnel within the Veterans Administration.
7. I further understand that, where required by law, the appropriate federal officer or agency will have free access to information obtained in this study should it become necessary. Generally, I may expect the same respect for my privacy and anonymity from these agencies as is afforded by the Veterans Administration and its employees. The provisions of the Privacy Act apply to all agencies.
8. In the event that research in which I participate involves certain new drugs, information concerning my response to the drug(s) will be supplied to the sponsoring pharmaceutical houses(s) that made the drug(s) available. This information will be given to them in such a way that I cannot be identified.

I, \_\_\_\_\_  
**NAME OF VOLUNTEER**  
HAVE READ THIS CONSENT FORM, ALL MY QUESTIONS HAVE BEEN ANSWERED, AND I FREELY AND VOLUNTARILY CHOOSE TO PARTICIPATE. I UNDERSTAND THAT MY RIGHTS AND PRIVACY WILL BE MAINTAINED. I AGREE TO PARTICIPATE AS A VOLUNTEER IN THE PROGRAM.

9. Nevertheless, I wish to limit my participation in the investigation as follows:

VA FACILITY	SUBJECT'S SIGNATURE
WITNESS'S NAME AND ADDRESS (Print or type)	WITNESS'S SIGNATURE
INVESTIGATOR'S NAME (Print or type)	INVESTIGATOR'S SIGNATURE

Signed information sheets attached       Signed information sheets available at \_\_\_\_\_

SUBJECT'S IDENTIFICATION (If State or Government agency, State or City) \_\_\_\_\_ SUBJECT'S I.D. NO. \_\_\_\_\_ WARD \_\_\_\_\_

**AGREEMENT TO PARTICIPATE IN  
RESEARCH BY OR UNDER THE DIRECTION  
OF THE VETERANS ADMINISTRATION**

VA FORM 10-1086  
SEP 1979

SUPERSEDES VA FORM 10-1086  
JUN 1975, WHICH WILL NOT BE  
USED.



PART II - AGREEMENT BY SUBJECT'S REPRESENTATIVE TO ALLOW SUBJECT TO PARTICIPATE IN RESEARCH BY OR UNDER THE DIRECTION OF VETERANS ADMINISTRATION		DATE
<p>1. I, _____, am authorized to give consent <i>(Type or print name of subject's representative)</i></p> <p>for _____ by virtue of _____ <i>(Type or print subject's name) (Relationship, legal appointment, etc.)</i></p> <p>I voluntarily consent for this person to participate as a subject in the investigation entitled _____ <i>(Title of study)</i></p>		
<p>2. I have signed one or more information sheets with this title to show that I have read the description including the purpose and nature of the investigation, the procedures to be used, the risks, inconveniences, side effects, and benefits to be expected, as well as other courses of action open to me and my right to withdraw the subject from the investigation at any time. Each of these items has been explained to me by the investigator in the presence of a witness. The investigator has answered my questions concerning the investigation and I believe that I understand what is intended.</p> <p>3. I understand that no guarantees or assurances have been given me since the results and risks of an investigation are not always known beforehand. I have been told this investigation has been carefully planned, that the plan has been reviewed by knowledgeable people, and that every reasonable precaution will be taken to protect the well-being of the subject.</p> <p>4. In the event the subject sustains physical injury as a result of participation in this investigation, if the subject is eligible for medical care as a veteran, all necessary and appropriate care will be provided. If the subject is not eligible for medical care as a veteran, humanitarian emergency care will nevertheless be provided.</p> <p>5. I realize I have not released this institution from liability for negligence. Compensation may or may not be payable, in the event of physical injury arising from such research, under applicable federal laws.</p> <p>6. I understand that all information obtained about the subject during the course of this study will be made available only to doctors who are taking care of the subject and to qualified investigators and their assistants where their access to this information is appropriate and authorized. They will be bound by the same requirements to maintain the subject's privacy and anonymity as apply to all medical personnel within the Veterans Administration.</p> <p>7. I further understand that, where required by law, the appropriate federal officer or agency will have free access to information obtained in this study should it become necessary. Generally, I may expect the same respect for the subject's privacy and anonymity from these agencies as is afforded by the Veterans Administration and its employees. The provisions of the Privacy Act apply to all agencies.</p> <p>8. In the event that research in which the subject participates involves certain new drugs, information concerning the subject's response to the drug(s) will be supplied to the sponsoring pharmaceutical house(s) that made the drug(s) available. This information will be given to them in such a way that the subject cannot be identified.</p> <p style="text-align: center;">I _____ NAME OF SUBJECT'S REPRESENTATIVE</p> <p style="text-align: center;"><b>HAVE READ THIS CONSENT FORM. ALL MY QUESTIONS HAVE BEEN ANSWERED, AND I FREELY AND VOLUNTARILY CHOOSE THAT THE SUBJECT PARTICIPATE. I UNDERSTAND THAT THE SUBJECT'S RIGHTS AND PRIVACY WILL BE MAINTAINED. I AGREE TO THE SUBJECT'S PARTICIPATION AS A VOLUNTEER IN THIS PROGRAM.</b></p> <p>9. Nevertheless, my consent for the subject's participation in the investigation is limited as follows:</p>		
ADDRESS OF SUBJECT'S REPRESENTATIVE (Print or type)	SIGNATURE OF SUBJECT'S REPRESENTATIVE	
WITNESS'S NAME AND ADDRESS (Print or type)	WITNESS'S SIGNATURE	
SUBJECT'S NAME (Print or type)	SUBJECT IS NOW A PATIENT AT (Name of VA Facility)	
INVESTIGATOR'S NAME (Print or type)	INVESTIGATOR'S SIGNATURE	
<input type="checkbox"/> Signed information sheets attached. <input type="checkbox"/> Signed information sheets available at:		
SUBJECT'S IDENTIFICATION (I.D. plate or print name - last, first, middle)	SUBJECT'S I.D. NO.	AGE
<b>AGREEMENT BY SUBJECT'S REPRESENTATIVE TO PARTICIPATE IN RESEARCH BY OR UNDER THE DIRECTION OF THE VETERANS ADMINISTRATION</b>		

APPROVAL SHEET

The dissertation submitted by Marilyn A. Mendoza has been read and approved by the following committee:

Dr. Manuel S. Silverman, Director  
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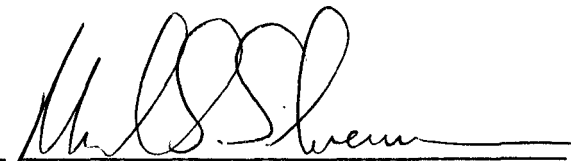
Dr. John Wellington  
Professor, Counseling Psychology and Higher Education,  
Loyola University

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

2-2-84

Date

  
Director's Signature