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The Golombok–Rust Inventory of Sexual Satisfaction (GRISS)

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The Golombok–Rust Inventory of Sexual Satisfaction (GRISS) is a short 28-item questionnaire for assessing the existence and severity of sexual problems. The design, construction and item analysis of the GRISS are described. It is shown to have high reliability and good validity for both the overall scales and the subscales.

The Golombok–Rust Inventory of Sexual Satisfaction (GRISS) (Rust & Golombok, 1983) is a short measure of sexual dysfunction which may be administered to heterosexual couples or individuals who have a current heterosexual relationship. It provides overall scores, for men and women separately, of the quality of sexual functioning within a relationship. In addition, subscale scores of impotence, premature ejaculation, anorgasmia, vaginismus, infrequency, non-communication, male dissatisfaction, female dissatisfaction, male non-sensuality, female non-sensuality, male avoidance and female avoidance can be obtained.

The test specification was drawn up by a 'think tank' of sex therapists at the Maudsley Hospital Sexual Dysfunction Clinic. It specified seven major areas of interest: frequency, satisfaction, interest, dysfunctions, anxiety, communication and touching.

The pilot version contained 96 items—48 for the man and 48 for the woman. Piloting was carried out on 51 client couples at the Maudsley Sexual Dysfunction Clinic and 36 non-clinical couples from the Institute of Education, University of London, where one of the partners was taking a part-time course as a mature student.

The first stage of item analysis aimed to eliminate items with extreme scores or with frequent response refusal. The second stage involved the identification of stable subscale scores. Promax oblique factor analysis was used to identify subscales in the first instance. The subscale items indicated were then factor analysed separately for each subscale using orthogonal rotations. The original subscale length varied between five and nine items. The final subscales have four items each which were selected according to the following criteria: (*a*) stability of the factor structure, with a common factor accounting for more than 50 per cent of the variance, (*b*) an equal number of items (two each) with positive and negative loadings, (*c*) content continuity along the full length of the indicated dimension, (*d*) factorial consistency between the clinical and student samples, and (*e*) face validity. Four of the subscales thus generated were about the specific problems of anorgasmia, vaginismus, impotence and premature ejaculation. Six subscales gave separate male and female scores for avoidance, dissatisfaction and non-sensuality. The remaining two subscales measured infrequency and non-communication about sex within the couple.

In the third stage, overall scales were sought to describe the state of the couples' sexual relationship. These were derived from an orthogonal factor analysis of the scored subscales, together with items which had not entered into the subscale construction or which correlated with two or more of the subscales. This factor analysis yielded an orthogonal two-factor solution representing a male and a female factor. On the basis of this, separate male and female main scales were constructed, representing the additive effects of the four-item subscales from men and women respectively. Four items, two for men and two for women, dealing with interest in sex generally, are retained in the questionnaire and contribute towards the two main scales but are not included in the subscales. Interest in sex did not form a stable subscale but did have high loadings on the main scale factors. Following item analysis the GRISS has 56 items – 28 for men and 28 for women.

The GRISS was standardized on a sample of 88 sex therapy clients from clinics throughout the UK. A combination of norm referencing and criterion referencing yielded transformed scales which give a good indication of the existence and severity of any problems. Transformations are to a pseudo-stannine scale (from 1 to 9) with a score of 5 or above indicating a problem. Distributions of these transformed scales are approximately normal for the clinical sample, but skewed towards the lower end of the scale to facilitate measurement in non-clinical populations. As the pilot study involved more than one level of item selection, the structure of the main scales and the subscales was replicated for the selected items. The characteristics of the factor analysis were stable across both the pilot and the standardization samples.

For the main scales the split-half reliabilities were found to be extremely high: 0·94 and 0·87 for the female and the male scales, respectively. The reliabilities of the subscales are given a minimum value by the internal consistencies, which were obtained from the factor analysis of the items in the standardization sample. The values obtained are high for scales with this number of items, averaging 0·74, and ranging between 0·61 for non-communication and 0·83 for anorgasmia.

For 68 men and 63 women (of whom 62 were couples) from sexual dysfunction clinics, therapists completed validation questionnaires in which they were asked to define the severity and nature of any sexual problems for men and women separately. Those subjects ($n = 42$ for women, $n = 57$ for men) in the clinical group who had been diagnosed as having a problem were compared with a control group of 59 subjects (29 men and 30 women) taken from a random sample of GP attenders (Golombok *et al.*, 1985). Both the overall female scale (point biserial $r = 0{\cdot}63$, $P < 0{\cdot}001$) and the overall male scale (point biserial $r = 0{\cdot}37$, $P < 0{\cdot}005$) were found to discriminate well between the clinical and non-clinical groups.

The specific dysfunctional groups as diagnosed by the therapists were also compared with the GP control group. All clinical groups differed from the control group on their target subscale: impotence ($t = 7{\cdot}55$, $P < 0{\cdot}001$), premature ejaculation ($t = 5{\cdot}37$, $P < 0{\cdot}001$) and anorgasmia ($t = 3{\cdot}46$, $P < 0{\cdot}005$). For vaginismus there was no overlap whatsoever between the two groups.

Additional t test comparisons were carried out between the two groups for the eight subscales which did not measure specific dysfunction. Infrequency, male and female dissatisfaction and female avoidance were all significant at the 0·001 level, while female non-sensuality was significant at the 0·005 level.

A further measure of validity was obtained by correlating the therapists' ratings of severity of problems (0 = no problem, 1 = slight problem, 2 = moderate problem and 3 = severe problem) with the overall male and female scales. These were $r = 0{\cdot}56$ ($n = 63$, $P < 0{\cdot}001$) for women and $r = 0{\cdot}53$ ($n = 68$, $P < 0{\cdot}001$) for the men, which were good for an instrument of this type.

Follow-up validation of the main scales against therapists' estimates of improvement during therapy was carried out on 30 clinical couples after their fifth sex therapy session. The therapists, who were blind to the GRISS results, rated both the man and the woman separately on a five-point scale ranging from 0 = 'improved a great deal' to 4 = 'got worse'. For the men, the correlation between the therapists' ratings of improvement and the change in the main male score was 0·54 ($P < 0{\cdot}005$). For the women the equivalent correlation was 0·43 ($P < 0{\cdot}01$).

The GRISS is a highly reliable measure of sexual dysfunction. It discriminates well between those with and without sexual problems and is a good outcome measure of change during therapy. It relates closely to therapists' ratings of diagnosis and severity of sexual problems and its subscales are highly successful at identifying impotence, premature ejaculation, anorgasmia and vaginismus, as well as infrequency, male and female dissatisfaction, female avoidance and female non-sensuality. The major application of the GRISS will be to assess improvement as a result of sexual or marital therapy and for comparing the efficacy of different treatment methods. It can also be used to investigate the relationship between sexual dysfunction and extraneous variables. The subscales are also helpful in diagnosis.

References

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