

MEDICAL PRACTICE

Introduction to Marital Pathology

Health and marital breakdown

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At first thought, marriage may seem unconnected to the practice of medicine. But marital breakdown, which is increasingly common, is the source of an enormous amount of unhappiness and illness. Marital problems present in diverse ways to almost all doctors. In this series the causes, the effects, and the management of marital breakdown will all be considered.

Problems before marriage

Premarital problems are only a tiny proportion of all the problems related to marriage. Genetic advice may be sought before marriage. Venereal disease and sexual difficulties encountered in courtship may present to the doctor; contraceptive advice may also be wanted.

One distinct condition that the doctor may meet is engagement neurosis, or *engysis*, which is characterised by anxiety, depression, and appreciable hesitation about the pending marriage. One study showed that after five years half of these patients were married, but that a quarter of the original group, whether married or not, continued to have fluctuating ill health.¹

Dissolution of affective bond

Bowlby has shown how we form our first affectionate bonds with our parents, and that the consequences of the bond breaking are anxiety, anger, and depression.^{2,3} This capacity to form strong bonds with others continues in adult life. In courtship a person selects one particular partner and forms an affective bond. The bond continues and intensifies with marriage itself, which in our society is conventionally an exclusive and permanent relationship. When this bond is threatened and seems likely to break then, just as in infancy, a sequence of searching, protest, despair, and detachment—all accompanied by anxiety, anger, and depression—may be expected.

Most couples can cope with an expected separation. When the departure is unexpected, it usually leads to searching accompanied by anxiety and anger. Frantic telephoning and inquiring continue until the partner is found. Then follows strong protest, which may consist of shouting, crying, or screaming. Every practitioner has seen agitated, weeping patients who are occasionally drunk and sometimes have swallowed a handful of tablets and who are unhappily seeking help to bring back the departed partner. This is the adult imitation of the distressed young child who has temporarily lost its mother. If the mother does not return the child goes beyond the phase of search, protest, and despair to that of detachment. Similarly, after the searching, anxiety, anger, and depression, the deserted partner will progress slowly to detachment. Gradually, over months or years, the attachment ceases to exist. It is then—and then only—that the emotional link between the couple ceases. Anxious and hurtful exchanges give way to cool, indifferent, and even friendly remarks. This prolonged stress may be experienced privately or medical help may be sought. Marital pathology has become a common problem presenting to the doctor.

A study of psychiatric illness in several urban practices showed that marital problems were the factor most commonly associated with psychiatric illness. Women were more often affected than men.⁴ The authors ask why marital difficulties should be so predominantly a female problem. "Though such difficulties must concern both marital partners, husbands consult less frequently on this score." The reasons for this are multiple. Women are sensitive to marital problems that their husbands do not recognise. The difficulty often has to become pronounced before the husband becomes aware of the problem. Even then husbands believe that marital difficulties are a private problem that is rarely serious enough to bother the doctor. Often the husband refuses to act, and blames his wife, who in seeking help becomes the scapegoat. Wives may seek help to reassure themselves that they are not going "mad," as is often suggested by husbands who refuse to face the marital difficulty.

Psychosomatic and psychological symptoms

Patients may either ask for help directly for a marital problem, or indirectly by offering physical or psychological symptoms. Some patients find it easier to present a physical symptom, which may disguise the real problem. Patients, of course, are not frauds: they are genuinely seeking help and the doctor must lead them from the

symptoms to the marital problems. Psychosomatic symptoms are often pre-eminent: attacks of breathlessness, difficulty in breathing, pain in the chest, or aggravation of asthma; pain over the heart or palpitations; abdominal pains, feelings of nausea, and changes in bowel rhythm, usually diarrhoea; headaches, fainting attacks, paraesthesia, hot and cold feelings, or frequency, dysuria, backache, and sexual problems; or loss of hair and pruritus. Nasopharyngeal complaints are also commonly mentioned.

The patient presenting with psychological symptoms will usually be suffering from anxiety, a depressive illness, or a mixture of the two. The full anxiety attack will show physical manifestations of palpitations, breathlessness, flushing, sweating, insomnia, fatigue, and more psychological manifestations—of apprehension, fear, irritability, agitation, restlessness, and inability to concentrate—with or without specific phobic, obsessional, or hysterical symptoms. When depressed, the patient's mood may be anxious, but often tends towards misery with overt weeping and, if the depression deepens, indifference to life, people, and things. They may feel suicidal. The depression may be accompanied by severe insomnia, diurnal variation of mood, loss of energy, appetite, sexual desire, and weight, and an inability to remember, concentrate, or even work.

Depression is one of the commonest responses to marital stress. It may occur in the acute phase of marital difficulties, during the period of separation or divorce, and sometimes continue after the divorce. In a retrospective study of 150 women, a proportion of a much larger sample who petitioned for divorce, no fewer than 130 complained of symptoms suggestive of depression, and the remaining 20 mentioned symptoms but did not consider them a disturbance of health.⁵ The 130 women who complained of symptoms mentioned, in order of frequency: crying, weight change, sleep disturbance, tiredness, lack of concentration, increased smoking, self-neglect, and drinking. The symptoms are most severe during the latter part of the marriage and during the early separation, when an attachment still exists but is under threat. The association of separation, divorce, and depressive illness has been confirmed in other studies.⁶ Recently other studies have paid attention to life events that may trigger depressive or schizophrenic disorders. Some have shown that marital disruption and divorce carry a high probability of starting a depressive illness.⁷

Suicidal attempts

Suicidal attempts are associated with marital pathology. A study of self-poisoning in 68 married men and 147 married women showed that marital disharmony was a major precipitating factor in 68% of the men and 60% of the women. Some 30% of the marriages of the men and 26% of the women had broken down, and in 17% the break-up had been within a month of the suicidal attempt.⁸ In a selection of 130 people, taken from a wider sample of 577 cases in Oxford, 83% of the married men and 68% of the women complained of marital problems.⁹ Three features stood out in this study. Firstly, during the previous twelve months, half of the married men and a tenth of the married women had had an extramarital affair. Secondly, the event most frequently related to the suicide attempt was a quarrel with a key person; this had occurred seven days before the attempt in 48% of cases and mostly in the two days before. Thirdly, separation from a key person was the most common precipitating event in those under 20. Those who repeat their suicide attempts are most likely to ultimately kill themselves. In a study of 204 patients with a history of repeated suicide attempts, separation or divorce, or both,¹⁰ was one of the features present—a finding confirmed in another study.¹¹

The exact incidence of suicide in society is unknown. It has nevertheless been estimated that throughout the world at least 1000 people commit suicide daily—half a million people dying each year is a reasonable estimate.¹² Figures computed first for West Sussex and Portsmouth for 1968 and also for England and Wales for 1970 give some remarkable results (B M Baraclough, personal communication). The suicide rate per 100 000 of the population over the age of 15 in West Sussex and Portsmouth is shown in the table. The highest rate

Effect of marital state on suicide rate in West Sussex and Portsmouth

Marital state	Suicide rate/ 100 000 population
Married	9.9
Single	16.3
Widowed	16.3
Divorced	47.9
Married but living apart	204.4

is in those who are married but living apart: those who have not resolved their affectional bond, are isolated, and have yet to reconstruct their life. This trend is also shown in the figures for England and Wales, where the suicide rates for the married are 7.8 per 100 000, rising to 11.1 for the single, 23.9 for the widowed, and 35.5 for the divorced. An important clinical finding is that the vulnerable state of being separated and divorced is aggravated by the existence of children.¹³

Health of children

Young children whose parents are experiencing severe marital distress may show the whole range of physical symptoms including disorders of sleep, feeding, and elimination; aggravation of any psychosomatic disorder such as asthma, abdominal pains, and headaches; and attention seeking, clinging, and crying.

Recent research has highlighted the presence of behavioural problems in children experiencing parental stress. This has been shown in preschool children who are the offspring of marriages characterised by frequent arguments, disagreements about the children, failure to make combined decisions, and low satisfaction on the mother's part with the help received from her husband.¹⁴ The same behavioural disorder is found, associated with marital discord, in older children.^{15 16} Another finding is that conduct disorder—consisting of lying, destructive acts, undue aggression, stealing, and truancy from school—is found predominantly in boys. Severe parental discord is so important that it is strongly associated with conduct disorders even when the home is unbroken.^{17 18}

This is the first in a series of eleven papers. No reprints will be available from the author.

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A severely subnormal epileptic man is addicted to collecting and eating cigarette-ends. He is a long-stay inpatient, and the only method we can think of for dealing with his problem would be a satiation technique—namely, to make a large collection of cigarette-ends and persuade him to chew the lot. Is this likely to be effective and are there any hazards?

The suggestion of using a satiation technique is not to be recommended. The National Poisons Information Service at Guy's Hospital point out that two cigarettes contain a lethal amount of nicotine. Therefore, to satiate a person with a large collection of cigarette-ends must be dangerous because of the risk of nicotine intoxication. Nausea, vomiting, tachycardia, and alimentary tract hurry may erroneously be taken as response to aversion treatment when in fact they are due to poisoning.