Introduction to Marital Pathology

Definition and extent of marital pathology

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British Medical Journal, 1979, 2, 478-479

Any definition of marital pathology must consider both the stability and the quality of a marriage. Appreciable conflict or alienated indifference produce marital pathology, as do repeated departures and a final separation. But marriages where a couple never stop arguing, or where affection, companionship, and sex have ceased may be stable; the marriage bond survives and has a meaning for the couple.¹ Thus marital pathology exists when the minimum needs of one or both partners are not met. Then separation and divorce are contemplated, and eventually realised, unless change occurs.

International character of divorce

Marital problems occur in every Western society. A study of marital problems in Finland, Sweden, Norway, England and Wales, the Netherlands, Belgium, France, the Federal Republic of Germany, Switzerland, Austria, and Italy showed that divorce was increasingly common in every country, and suggested that the causes were similar everywhere.² Most of the countries showed a rise in incidence after the second world war, a decline in the '50s, and then a constant upward trend after 1960. This is inexplicable in purely national terms, and must have to do with changes in the nature of marriage and the family in Europe.² Similar trends are seen in the United States.³ Is this phenomenon, however, extending beyond countries with Western cultures? Divorce is increasing among the elite in Lagos, the capital of Nigeria.⁴ The special circumstances in Lagos include the Nigerian civil war (1967-70) but other factors appear to be similar to those in Western societies.

Marital breakdown in England and Wales

The statistics of marital breakdown are expressed in several ways in England and Wales. The first is through decrees made absolute. Divorce has been increasing ever since it became available in 1857. Before the second world war, however, divorce decrees granted annually never exceeded 10 000. Then the divorce rate peaked after the war because of the vulnerability of war marriages. The rate subsided by 1960, since when it has increased again, and surged in 1971, when the Divorce Law Reform Act came into operation (table).⁵

A second statistical expression of marital breakdown is the number of petitions filed annually for divorce. Some are withdrawn or postponed, and rarely they are not granted. Petitions show, as expected, the same rise as actual divorces. Given that divorce rates for 1971-3 continue indefinitely—which is the case so far—and that marriage continues at the current rate (there has, in fact, been a slight fall), then 22% of all women would divorce at least once by age 45. Thus roughly one in four marriages is heading for dissolution.⁵ The total number of people divorced is a third expression of the problem. From

TABLE I—Divorce decrees made absolute in England and Wales from 1940-77

Year	Number of decrees made absolute (in thousands)
1940	7.6
1950	30.3
1960	23.4
1970	58.2
1971	74.4
1972	119.0
1973	106.0
1974	113.5
1975	120.5
1976	126.7
1977	128.0

when divorce was introduced in 1857 it was almost a century before the first million people were divorced. The second million was reached in only a further 15 years by 1967, and the third million in only six years. At current rates, some six million people will divorce during the remaining years of this century.⁶

Divorce and children

Divorcing couples who were childless fell from 33% of the total in 1960 to 25% in 1973. In 1960 divorcing couples, excluding the childless, had an average of 2.0 children but by 1973 this had risen to 2.3. At one time childlessness was thought to be related to marital breakdown.⁷⁻⁸ This view was severely criticised⁹ and present evidence does not favour it.¹⁰ But evidence exists that large families produce stress. Rates of physical and mental ill health increase with family size, and a critical point is reached with four children.¹¹ The mothers of families in Aberdeen with four or more children come twice as often from large families, often marry in their teens after knowing their husband for less than a year, often have a premarital conception, and, not surprisingly, often experience marital discord.¹² Large families, however, are not common, and their contribution to marital breakdown is small. More importantly, marrying and conceiving early are associated with divorce.

The Finer report estimated that in April 1971 620 000 one-parent families with one million children existed. Of these families, 100 000 were motherless and the other 520 000 fatherless. Of the fatherless families, 190 000 were separated, 120 000 were divorced, and 90 000 single. One-parent families formed about one-tenth of all families with children.¹³ Current estimates suggest that 750 000 families with one and a quarter million children have only one parent.¹⁴ The social and psychological privation of one-parent families is considerable. In the United States, of the 10 million children living in one-parent homes, more than one-third lived with a divorced parent, about twice the number living in a home broken by death.¹⁵

Timing of marital breakdown

Table II shows that nearly half of all divorces occur in the first nine years of marriage.¹⁶ This vulnerability of the early years of marriage is supported by other evidence. One study in the United States showed that the third year of marriage produced more divorces than any other.¹⁷ Another study found that most separations occur during the

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TABLE II—Percentage of divorces occurring after different durations of marriage

Duration of marriage (years)	%, of all divorces			
	1951	1961	1971	1974
<4	10.3	11.3	13.4	16.5
5-9	31.5	30.6	30.5	29.8
10-14	24.4	22.9	19.4	18.6
15-19	14.1	13.9	12.6	13.0
>20	19.7	21.2	24.2	22.1

first year of marriage, and most divorces within three years.¹⁸ A more extensive study in Sweden, that calculated the annual risk of divorce up to 40 years after marriage, showed that divorce increased from the time of marriage to a maximum after four years.¹⁹

Divorce usually occurs, however, some time after the couple have stopped living together, and, as already described, the period between break-up and reconstruction of personal relationships is a crucial one for the individual.²⁰ One study found that in two-thirds of 805 divorces, a delay of at least two years occurred between separation and divorce; for a third it was greater than four years; and the median was 2.9 years.²¹ This same study also showed that in two-fifths of these divorces the marriage effectively ended in the first five years. Another study has shown that for divorces occurring in the first 20 years or more of marriage the start of major marital problems occurred for half of the couples in the first five years of marriage.²² Thus, although marital breakdown may occur at any time, the early years are crucial.

No research has been done on the impact of preventive and counselling work but the early years of marriage seem to be the important time. This is, however, a complex matter because these early years naturally include a good deal of adjustment to marriage and this adjustment may be confused with failure of the relationship. Research is needed to distinguish between these two groups; and, indeed, to find the most appropriate way of helping couples to adjust to marriage.

Marital breakdown continues throughout the whole span of

marriage, and a sizable proportion (22%), divorce after 20 years. Clearly, while the early years are crucial, different factors leading to dissolution operate at various stages of the marriage.

This is the second in a series of 11 papers and no reprints will be available from the author.

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For how long should beta-blockers be continued after a patient with angina has been stabilised and is free of symptoms?

If a patient with angina becomes completely asymptomatic on treatment with a beta-adrenergic blocking drug the following possibilities should be considered: (1) he is symptom free because of the beta-blocker, in which case he clearly needs to go on taking it; (2) he has restricted his activity so that aided by the beta-blocker he no longer gets angina. This is extremely common, and again clearly the patient should continue taking the drug; (3) he has obstructive coronary artery disease but has lost his angina and is no longer dependent on the beta-blocker for the relief of symptoms; or (4) the chest pain was not caused by cardiac ischaemia and the diagnosis of angina was incorrect. Beta blockers are extremely effective in preventing angina of effort by improving exercise tolerance, particularly when combined with nitrates. These drugs can and should be continued indefinitely, being interrupted only if surgery is required and is followed by cure of the symptom. Sometimes angina gets better spontaneously even though the underlying disease persists. This may be due to infarction of an ischaemic territory or for reasons that are not well understood. The place of beta-blockers in treating coronary heart disease in the absence of angina, particularly in patients who have had infarcts is still not clear. Their use may possibly reduce the incidence or the size of future infarction or reduce the chance of arrhythmic sudden death, but none of these have been shown in convincing controlled studies. Finally, if there is doubt about the diagnosis and particularly if the patient is young or engaged in an occupation that may put the lives of others at risk a diagnosis should be secured by full investigation before deciding whether to continue beta-blocking drugs.

I have recently confirmed both by slide test and Paul-Bunnell a diagnosis of glandular fever in a woman aged 59. How unusual is this diagnosis in this age group?

Glandular fever is unusual, but not unknown, at this age. The fact that both the slide test and the Paul-Bunnell test (which measure

different things) results are positive is very much in favour of the correct diagnosis. Confirmation could be obtained by measuring Epstein-Barr virus titres. As the reactions may just possibly be falsely positive due to an abnormal protein in a patient of this age it might be worth measuring the ESR and immunoglobulins.

What are the hazards to laboratory workers of regularly handling liquid mercury? Should regular estimations of urine mercury concentrations be performed and how often should they be carried out? What steps should be taken if a worker is found to have a concentration higher than the normal range?

Metallic mercury absorption in laboratory workers can produce the neurological, psychiatric, oral, and renal signs of chronic mercury intoxication.¹ These effects seem to be reversible if exposure ceases on detection of any symptoms or signs of intoxication. Absorption is mainly by inhalation, as mercury vaporises at room temperature, especially in warm places—for example, near a radiator—but some absorption may be by ingestion. Good housekeeping (including proper laboratory design, correct handling and dealing with spillages, and atmospheric level monitoring) is essential to prevent intoxication.² Estimations of both urine protein and mercury concentrations at regular intervals—for instance three-monthly—are the ideal, as either proteinuria or a raised urine mercury concentration may occur separately as an early sign of mercury intoxication. A raised urine mercury concentration—that is, 200 µg/l in a urine of SG 1016—should be confirmed by a repeat analysis on a fresh specimen and followed by (1) a thorough review of housekeeping procedures and (2) immediate medical examination and measurement of protein and mercury in the urine analysis on all exposed subjects. Decisions such as whether to remove a subject from the laboratory procedure, or to stop the procedure pending the results of all investigations, would depend on the severity of the clinical and urine protein abnormalities.

¹ Guidance Note MS12, *Mercury—Medical Surveillance*. London, HMSO, March 1978.

² Guidance Note EH17, *Mercury—Health and Safety Precautions*. London, HMSO, September 1977.