Marital Satisfaction Among Military and Civilian Family Practice Residents

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Physicians have a lower divorce rate than the general population, but evidence suggests there are many potential sources of stress in medical marriages, particularly during postgraduate training. This investigation was undertaken to survey the degree of marital satisfaction among third-year family practice residents, to compare the level of marital satisfaction of military with civilian residents, and to identify variables that correlate with resident marital satisfaction. Results indicate that most residents are happily married and that marital satisfaction is no different for residents training in military programs than it is for residents in civilian programs. Correlations between marital satisfaction and indexes of potential sources of marital stress show that factors enhancing medical marriages are similar to factors enhancing marriages among other professional groups and the general public.

Much has been written about the physical, psychological, and social demands of a medical career and how such demands affect marital satisfaction among physicians. Numerous reports suggest that a lack of time for recreation and family life, job pressures, poor communication with the spouse, the absence of psychosocial support structures, and other factors place great strain on medical marriages.[1-6] Nearly all of these reports, however, are anecdotal, meaning the conclusions they reach are based on opinion rather than on systematically collected data.

Empirical studies have shown that physicians have a lower divorce rate than other professional groups and the general population.[7,8] A relatively low divorce rate should not, however, receive outright acceptance as an index of marital satisfaction among physicians. Divorce is the end of a legal process that begins with dissatisfaction of varied intensity. Some couples have seemingly minor problems that end in divorce, while other couples endure long periods of disruption yet keep their marriages intact. It has been observed that many troubled medical marriages fall in the latter category. In such a case the partners may opt to maintain a poor marriage to preserve financial security or to be free of social stigma.[1]

The residency training period has been shown to be particularly stressful for residents, especially for residents with family responsibilities.[5] Research has also shown that residency programs vary widely in the types of psychosocial support they make available to residents. In addition, the data indicate that support addressed to residents' family needs is the type least likely to be available.[9]

Residency education in military settings would appear to add even more stress to residents' marriages than would be experienced by their civilian peers. Activities including participation in field exercises, physical training, combat training, and

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Table 1. Demographic and Background Data About the Study Sample (n = 169)

	Percent		Percent
Sex		Number of children	
Male	92	None	36
Female	8	One	27
Age (yr)		Two	30
26-30	73	Three	6
31-35	25	Four	2
36-41	2	Consulted counselor for marital problems	
Religion		Yes	15
Protestant	50	No	85
Catholic	21	Incurred financial debt from medical education	
Jewish	2	Yes	56
None	18	No	44
Other	9	Amount of debt	
Marital status		None	44
Married	95	$1,000-$10,000	30
Divorced	2	$11,000-$20,000	18
Separated	1	$21,000-$56,000	8
Cohabitating	2	Number of hours per week moonlighting	
When divorce occurred		None	63
Before residency (1)	.006	1-15	30
During residency (2)	.01	16-25	5
When current marriage began		26-50	2
Before medical school	39	Number of hours per week in residency activities	
During medical school	36	<70	45
Between medical school and residency	9	70-80	27
During residency	14	81-90	12
Number of years married		91-100	8
0-5	55	>100	7
5-10	39		
11-15	6		

other events are added to the resident's medical duties. These activities may add as many as 8 to 10 hours per week to the resident's already taxed time schedule. Not only do many residents question the relevance of such training, they also resent the added time away from home the activities demand. Consequently, it is possible that the general regimentation of military life, atypical demands of military medicine, and reduced time for family life place added strain on the marriages of military residents.

This article presents the results of a survey designed to answer three questions about marital satisfaction among third-year family practice residents: First, to what degree do the residents express satisfaction with their marriages? Second, is there a difference in the marital satisfaction of residents training in military programs vs residents training in civilian programs? Third, to what degree does marital satisfaction correlate with other personal, professional, familial, and social factors in the residents' lives?

Methods

A three-part questionnaire containing 43 items was prepared for the purpose of data collection. The first 13 items called for demographic data and background data about a resident's marital situation, financial indebtedness, time spent in residency activities (education and patient care), and time spent moonlighting (Table 1). The next 22 items were drawn from published reports about potential sources of marital adjustment problems among physicians.[2-6,10] These items probed such subjects as the use of free time with family members, reactions of the resident's spouse to some conditions of a medical marriage, and other marital issues (Table 2). Responses to the 22 items were given on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The Marital Assessment Questionnaire (MAQ), developed and described elsewhere by Hendrick,[11] accounted for the final set of eight items. Hendrick's research has shown the MAQ yields highly reliable data that provide a "brief but adequate picture of marital satisfaction." The MAQ represents the principal dependent variable in this study.

Two hundred thirty-eight third-year residents in 33 military and civilian family practice residency programs across the United States were asked to provide survey data. Sixteen military family practice residencies were contained in the sample, including seven US Army, five US Air Force, and four US Navy programs. Seventeen civilian residency programs were matched with the military residencies in size of parent hospital, number of family practice residents, location in the United States, and frequency of resident nights on call. The matching information was obtained from the *1981 Directory of Family Practice Residency Programs*.[12]

One person in each residency program was contacted by telephone and asked to accept responsibility for explaining the research to the residents, distributing the questionnaires, collecting the completed forms so that resident anonymity was protected, and returning the data to the researcher. These individuals were department chiefs, residency directors, staff physicians, chief residents, or departmental secretaries. All agreed to participate as a result of the telephone conversation, so that each program had a research coordinator for the purpose of this study. Questionnaires, a cover letter of explanation to the coordinator, letters of explanation for the residents, and a self-addressed, stamped return envelope were then sent to these individuals. The data collection phase of the study was accomplished during a seven-week period in January and February 1982.

The survey data were analyzed in three steps. First, descriptive statistics were tabulated for the demographic data, and the reliability of the MAQ data was assessed using Cronbach's alpha coefficient. Second, the t test was used to compare the marital satisfaction (MAQ scores) of residents in military programs with residents in civilian programs. Third, correlation coefficients were calculated for the MAQ scores of the residents and their responses to the 22 items on potential sources of marital adjustment problems, time spent in residency activities, and time spent moonlighting.

Potential confounding variables that could not be accurately determined were degree of marital satisfaction before residency began, problem areas not associated with residency, and ego strengths and weaknesses of the marriage partners. Input from spouses was not included in this study. As with any survey research when participation is voluntary, a systematic bias may be introduced by those who are willing to participate. A greater percentage of military residents responded than did civilian residents.

Results

Of the 238 third-year family practice residents who were surveyed, 169 responded by supplying complete data (71 percent). The research sample includes 99 of 113 military residents (88 percent) and 70 of 125 civilian residents (56 percent) who were asked to participate in the study. Table 1 gives a summary of the demographic and background characteristics for the entire study sample. In particular, the table shows that only 3 of the 169 married residents had been divorced.

Since the MAQ is the dependent variable in this study, it is important to demonstrate that the eight-item questionnaire provides a reliable measure of marital satisfaction. Calculation of Cronbach's alpha coefficient for the MAQ data yielded a value

Table 2. Correlations of 22 Marital Adjustment Variables With MAQ Scores

Marital Adjustment Variables	Correlation
I have less and less in common with my spouse as the years pass	−.58*
My spouse is envious of my professional status	−.43*
My spouse resents the intimate, caring relationship I have with my patients	−.34*
When I have free time with my family, I tend to be tired and grouchy	−.34*
I have become "distant" because I deal with patient complaints all day	−.34*
Because of the medical profession, I feel (or would feel) pressure to maintain my marriage even if it is failing	−.32*
Even at home, I feel that my orders are to be followed	−.26*
Much of our time together is taken up by routine houshold chores	−.24*
The time requirements of this residency leave too little time to meet personal and family needs	−.22*
We live in an area of the country or part of a state I don't like just because the residency is there	−.17*
My spouse resents the loss of importance he/she had while supporting me through medical school	−.16*
My spouse has to put his/her career "on hold" until after the residency	−.16*
My salary puts financial burdens on my family	−.14
We have to make our plans weeks in advance, and even then we are subject to last-minute disappointments	−.10
My work schedule causes late or interrupted dinners	−.09
Conversation at parties and social events is usually limited to medical topics	−.09
I have enough "free time" to spend with my spouse	−.08
My spouse feels welcome at the hospital	−.08
I resent the time we spend with my in-laws	−.05
I would hesitate to seek marriage counseling from one of my colleagues	−.04
A telephone call can easily ruin our plans	−.04
I have enough time to spend with my children	−.01

*Statistically significant at the .05 level or less

of 0.90, which is highly acceptable. It is also noteworthy that although MAQ scores can range from 8 to 40, only 13 of the residents (7.7 percent) had MAQ scores lower than 24 (the scale midpoint).

Results from the test to determine whether the MAQ scores of residents in military settings (mean = 32.46, SD = 5.49) could be distinguished from MAQ scores of their civilian counterparts (mean = 32.41, SD = 5.55) indicate there is no significant difference between the two groups ($t\,[167] = -.29$, NS).

Correlation coefficients between MAQ scores and the 22 indexes of potential sources of marital adjustment problems are reported for the complete sample in Table 2 (n = 169). The correlations are shown according to decreasing strength of association. All are in the expected negative direction. This means that relatively high MAQ scores coincide with relatively low scores on the other measures. Twelve of the correlations are statistically significant at $P < .05$.

The number of hours per week spent in residency activities had no correlation with MAQ scores ($r = -.04$, $P = .63$). Hours spent moonlighting also was a nonsignificant variable ($r = -.07$, $P = .40$).

Discussion

These survey data clearly indicate that the third-year residents contained in the study sample are, with few exceptions, happy in their marriages. This finding is in agreement with past empirical research that shows most medical marriages remain intact and function well despite the inevitable pressures and demands physicians routinely encounter. Although it is important to remember that most of the residents in the sample were relatively young (less than 30 years old) and had been married for fewer than five years, the extent of their marital satisfaction (measured by the MAQ) is remarkably good compared with the public's general impressions of medical marriages.

The data do not support the argument that the experience of postgraduate medical education in military settings places greater stress on residents' marriages than does postgraduate education in civilian programs. Mean MAQ scores for military and civilian residents were almost identical. This suggests that the strength of a medical marriage is not measurably affected by the process of fulfilling a military commitment.

Correlates of marital satisfaction that are revealed in the survey data contain few real surprises. It stands to reason, for example, that residents who are satisfied with their marriages tend to disagree with such statements as "I have less and less in common with my spouse as the years pass," and "Even at home I feel that my orders are to be followed." Clearly, factors including a sense of togetherness and consideration for one's spouse and family enhance medical marriages in the same way that they contribute to marital satisfaction among other professional groups and the general public.

The results of this study should not be generalized to include the family physician's entire marriage. The relative youth and brief marital experience of most study group participants are a reminder that few of the residents have reached the age (35 to 45 years old) when divorce most commonly occurs. Each stage of a medical marriage has unique problems and sources of stress. Consequently, family medicine educators should be alert for early signs of marital problems among residents. Even though the survey data show the incidence of marital problems is low, counseling will always be needed for a small subset of residents.

Quite apart from the data and discussion, this investigation shows that cooperative, multisite studies in family medicine are as feasible as they are necessary. The study could not have been done without help from a research coordinator at each of the participating residency programs. That the assistance was easy to obtain and contributed to the rapid collection of reliable data suggests similar procedures can be used in other family medicine research projects.

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