Troubled Marriages and Divorce: A Prospective Suburban Study

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A longitudinal survey of adjustment to divorce in Cleveland, Ohio, suburbs was conducted with a matched sample of married persons in order to identify some of the common complaints, feelings, concerns, and health hazards among separated and divorced persons. The study findings show that substantial numbers of divorced and married people turn to their physicians for help with personal problems, suggesting that physicians need to be prepared to help them appropriately. Based upon these findings, opportunities are described that are open to the family physician for detecting distress in the troubled marriage and in divorce, as well as for therapeutic intervention. Types of interventions include anticipatory guidance, counseling, and referral for more intensive therapy.

In the troubled marriage there is often an extended period of unhappiness and indecision. A physician alerted to the frequency with which such marital distress is exhibited in physical or psychological symptoms may be able to provide assistance in sorting out priorities and options. Following a crisis model of adjustment, the heightened physical and psychological distress experienced during the early stages of the divorce process decreases with time. Many divorced parents are not aware of the impact of marital turmoil and divorce on their children. The family physician plays an important part in helping parents recognize their continuing role in the lives of their children even if the marital relationship ends.

The effects of the significant increase in the rate of divorce on family well-being present a major challenge to family medicine. During 1982 there were 1,180,000 divorces in the United States.[1] Although down 3 percent from the number of divorces granted in 1981, the 1982 rate of 5.1 divorces per 1,000 population is more than double the 1960 rate of 2.2 per 1,000 population. These figures mean that during their lifetimes, depending on the age of the marital partners, anywhere from one third to two fifths of all marriages in the United States will end in divorce.[2] Divorce has become such a common life experience that health practitioners need to be well informed about its

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psychosocial and health-related effects. Although the explanations for the phenomenon vary, a variety of studies report that separated and divorced persons have higher rates of physical and psychological health disturbance than those who are married, and often have higher rates than those who are widowed.[3-7]

There has been not only an increase in the divorce rate but also a shift in its pattern. While divorce was previously more common among lower- and working-class families, the increase in the last decade has been especially great in families in the middle and upper-middle classes, so that there are now fewer differences by class in the frequency of divorce.[8]

In order to examine the increase in divorce among black and white families in the working to upper-middle classes, a prospective study of adjustment to divorce in selected Cleveland, Ohio, suburbs, using a control group of married persons, was begun in 1974.[9-11]

Methods

To avoid seasonal biases in filing rates, all divorce cases for the suburbs selected were drawn from the county divorce records for four months: June 1975, a high-filing month; December 1974, a low-filing month; and March 1975 and September 1974, two intermediate-level months. Because the Ohio divorce law changed on September 23, 1974 (a Monday) to include a no-fault provision, the first month sampled to include all fault-based divorce actions was actually from August 26 to September 20, 1974. Alternately the man or woman in each couple was selected for study, with no substitutions made for refusals. Interviewers were matched to respondents by race, sex, and, where possible, by age.

Of those respondents with whom contact was made (n = 322), 209 (64 percent) were interviewed. This response rate is comparable to that of other recent court-record-based surveys of divorced persons.[11] More important, tests for difference of means and chi-square analysis indicate that those interviewed do not differ significantly by sex, race, age, and median income of census tract of residence from those in the total sample population or in the sample of those located who obtained divorces. Subjects who refused do, however, differ significantly by race ($P < .01$), with more blacks than whites refusing to participate. To put these response rates in context, national surveys on less sensitive topics are now reporting response rates in the 60 to 70 percent range.[12]

Of the 209 subjects interviewed, 48.8 percent were men, 51.2 percent were women, 25.8 percent were black, 73.2 percent were white, and 1.0 percent were Oriental. As measured by the Hollingshead Index of Social Position,[13] 8.9 percent of the sample was in Class I, 23.1 percent in Class II, 31.0 percent in Class III, 31.0 percent in Class IV, and 5.9 percent in Class V. Eighty percent of the divorced respondents were initially interviewed within six months of filing, and 96 percent were interviewed within 10 months. At the first interview about three quarters of the respondents had been separated from their spouses for less than a year.

The divorced respondents were reinterviewed after obtaining their decrees (1975 to 1977) and two to three years later in 1978 to 1979. The interviews, which were a combination of fixed-choice and open-ended questions, took from 1 hour to 1.5 hours to complete, for a total of approximately 3 to 4.5 hours of interviews per divorced respondent.

After the initial interview, respondents were reinterviewed wherever they moved, including western Canada and the western United States. By the last interview, 19.6 percent of the respondents were lost either because they had moved and left no forwarding address or because they could not be recontacted. Of those contacted only 8 percent refused. The final sample comprises 68 percent of those initially interviewed. There are no statistically significant differences in loss by sex or race comparing the initial and final replies.

The control group sample of married persons was randomly selected from the same city blocks as the divorced to produce a sample matched for background characteristics. To match for three variables (sex, race, and marital status) was time consuming and expensive. It took 484 tries to obtain 178 controls. As a result, only 85 percent of the divorced respondents have a married match. Out of 278 married persons actually contacted, 100 (36 percent) refused, and 178 (64 percent) agreed to participate in the study.

Comparisons of the divorced and the intact family samples on background characteristics indicate there are no statistically significant differ-

ences in sex, race, income, or social class. The samples do differ on family life cycle stage, with the divorced more likely to have no children or young children and the intact family sample more likely to have at least one child over the age of 18 years or all children over 18 years. The study groups also vary on length of marriage and age, with more of the divorced respondents having been married a shorter period of time and being younger.

Table 1. Frequency Distribution of When the Marriage Started to Go Bad (n=205)

	Percent
Less than a year ago	14.6
One, but less than three, years ago	28.8
Three, but less than five, years ago	19.5
Five, but less than ten, years ago	19.0
Ten or more years ago	9.3
Event related or before marriage	8.8
Total	100.0

Results

The Decision to Divorce

If the increase in the divorce rate is matched by more rapid disintegration of marriages, there is likely to be little the physician can do to help couples weigh the pros and cons of their situation. For the most part, however, marriages do not disintegrate rapidly. A family physician alerted to some indicators of marital distress generally does have the time to provide couples with support and assistance during the predivorce period. The divorced respondents were asked, "When did your marriage start to go bad?" Only about two in five report that their marriages started to go bad within the past three years, that is, 14 percent in the past year and 28 percent from 1 year up to, but not including, 3 years ago (Table 1). For the remainder the difficulties were of longer duration, even from before the marriage. Another indication that the decision to divorce is often not made rapidly or easily is illustrated by reports from over one half of the respondents that they or their spouses first suggested divorce as a solution to their marital problems over a year ago. In addition, 44 percent of the divorced reported separating from their spouses at least once prior to the separation related to this filing. Ten percent of the intact families also reported previous separations. Among the intact families, 24 percent had also at some point in their marriage suggested divorce.

Thus, as these data suggest, a family physician sensitive to the length of time and indecision a couple involved goes through in considering a divorce often has time to offer intervention. Because of the relationship with and special knowledge of the patient's family, the family physician is often able to place a presenting problem in perspective, leading to earlier diagnosis and intervention.[14] Helping a couple to deal with marital conflict before it evolves into years of war prevents battle scars on all the family members. Children are particularly vulnerable and may be significantly affected emotionally by the conflict preceding the separation.[15]

Help With Personal Problems

While some may feel that nothing can be done to help a deteriorating situation, substantial numbers of the divorced respondents compared with the married respondents have sought professional help. All the respondents were asked whether at any time in their marriages they had sought help for personal problems. The divorced respondents were significantly more likely than the married to have ever sought help from any professional, including clergymen, physicians, psychologists or psychiatrists, marriage counselors, or social workers (Table 2). They are also more likely to report seeking help from a mental health worker (psychologist or psychiatrist, marriage counselor, or social worker) and more likely to have suggested going for help, even if the couple decided not to do so. However, in terms of specific health sources, they are less likely than intact family members to turn to their physician for help with personal problems. Physicians were used less as a help source for personal problems not only for earlier years of the marriage but also for the last year of the marriage. Based in part on the kinds of

Table 2. Professional Help for Personal Problems

	Divorced First Interview (n = 207) (%)	Married (n = 178) (%)	Chi-square 1 *df*
Help Ever Sought*			
Any professional help	61.5	50.0	5.0**
Mental health help	45.9	12.4	50.6†
Help suggested but not sought	40.1	12.9	32.2†
Physician help	26.2	43.8	13.1†
Help in the Past Year			
Psychologist or psychiatrist	24.7	6.7	22.6†
Physician	23.7	41.0	13.3†
Clergyman	21.3	8.4	12.0†
Marriage counselor	13.5	1.7	19.0†
Social worker	9.2	4.5	3.2

*Combines help sought in earlier years and in the last year of marriage
**$P < .05$
†$P < .001$

data to be presented, this lack of help-seeking behavior appears to be due to the type of symptoms being experienced and patients' perceptions of where to turn for help. As has previously been reported,[16-18] the family physician may not be perceived as a source of help unless family problems manifest themselves through physical symptoms. It should also be noted that in 1974, when the study began, of the approximately 3,000 physicians in the Cleveland area, fewer than two dozen were board-certified family physicians.

Many family physicians are concerned about the impact of family issues on health status and report spending about 20 percent of their time counseling patients.[19] The data presented here indicate that in a community-based suburban sample, substantial numbers of married persons (41 percent) and about 25 percent of divorced persons in the last year of marriage do turn to their physicians for help with personal problems. Since both the patient and the physician identify the physician as being a resource for personal problems, physicians need to have the skills to aid their patients appropriately.

Prevalence and Timing of Common Symptoms

The next question to explore is whether the signs and symptoms of distress indicating marital turmoil were frequent enough for a physician alert to their possibility to pick them up. The answer is a strong yes. At the second interview the divorced respondents were asked whether they experienced different kinds of changes during any stage of their divorce. Virtually all, 93.8 percent (n = 161), mentioned at least one of eight changes, with respondents on the average mentioning 4.8 areas of their lives being adversely affected at some point during the divorce process. They were most likely to feel low or depressed (85.4 percent); this was followed by loneliness (84.9 percent), trouble working efficiently (81.0 percent), drinking more (76.5 percent), smoking more (76.1 percent), feeling their health had suffered (75.5 percent), having trouble sleeping (69.0 percent), and losing or gaining weight (41.6 percent). Although at least two in seven respondents retrospectively reported one or the other of the periods to be the most distressing,

the period during which the greatest number reported disturbance was before the decision to divorce—the period of indecision and ambivalence about what course of action to take. At this time 51.6 percent reported difficulties in adjustment.

When the divorced respondents reported three or more divorce-related changes, such as feeling low, having trouble working or sleeping, and so forth, during the pre-decree period (that is, the period of decision through filing for the divorce) they were significantly more likely to report having gone to the physician during the past year ($\chi^2 = 4.3$, 1 *df*, $P < .05$). Only 12.0 percent of those with zero to two changes (n = 49) reported a physician visit. Although those with higher levels of distress were more likely to turn to a physician for professional help, it was still the minority of those with difficulties. Of those who reported three or more difficulties (n = 111), 27.0 percent reported having sought help from a physician. Although the differences are not statistically significant, a similar pattern occurred for visits to mental health workers; only 37.8 percent of those with three or more difficulties reported having sought help vs 26.5 percent of those reporting zero to two difficulties. While some patients realized their marriages were troubled and that they needed help, others may have exhibited their distress through physical symptoms and may not have been able to make the connection between their symptoms and family problems. Patients often look for an answer to their distress in the physical realm. When patients report these physical symptoms, it is important for the physician to enter into the differential diagnosis the possibility of a marital problem or difficulties in other important relationships.

Instead of merely treating the symptoms, the informed physician can help refocus the patient's thinking to the underlying turmoil. A few questions about the patient's marital relationship can be revealing and can help redirect the patient's understanding of the presenting physical problems.

The Natural History for Divorce Distress

To examine health status differences prospectively, only those divorced and married cases for which data are available initially (n = 178) and only those divorced cases for which data are available across all three time periods (n = 133) will be used. While this reduces the number of cases, it is the most stringent, appropriate test for differences. Comparisons of the health status scores for the matched sample of divorced and married respondents at the initial interviews show that the divorced respondents had scores significantly higher than those of the married respondents on subjective distress, a measure derived from the Psychiatric Status Schedule[20] assessing anxiety, depression, suicidal thoughts and gestures, and leisure time impairment (Figure 1). They also had significantly higher scores on the number of times sick enough to be in bed and number of physician visits during the past year. There is, however, no significant difference between the divorced and married respondents on the number of psychophysiological conditions (asthma, headaches, nervous stomach, etc).

Coupled with data from the married respondents showing heightened distress for those who had ever separated from their spouses or who had ever suggested divorce (Table 3), these data illustrate that marital turmoil and divorce are associated with health disturbance. The physician alert to the association of health disturbance and marital turmoil may be able to help patients explore their feelings and options and alleviate or handle their distress in other ways.

Figure 2 illustrates what happened to the health of the divorced respondents examined prospectively. The divorced respondents initially had higher mean scores, indicating heightened physical and psychological distress. Their scores go down significantly across time. The major improvement in health status for the divorced group occurred between the first and second interviews. The mean time difference between these two interviews was a year. At this point the couples had been separated for about 18 months on the average. Comparisons of the first and second interview means displayed in Figure 2 indicate that at the second interview the number of physician visits was significantly lower ($t = 5.2$, $P < .001$) as were the number of psychophysiological complaints ($t = 2.9$, $P < .01$), the number of times the respondent was sick enough to be in bed ($t = 3.3$, $P < .001$), and subjective distress ($t = 2.6$, $P < .01$). For all the indicators there was no further group decrease in distress levels at the third interview; in fact, distress levels went up slightly but insignifi-

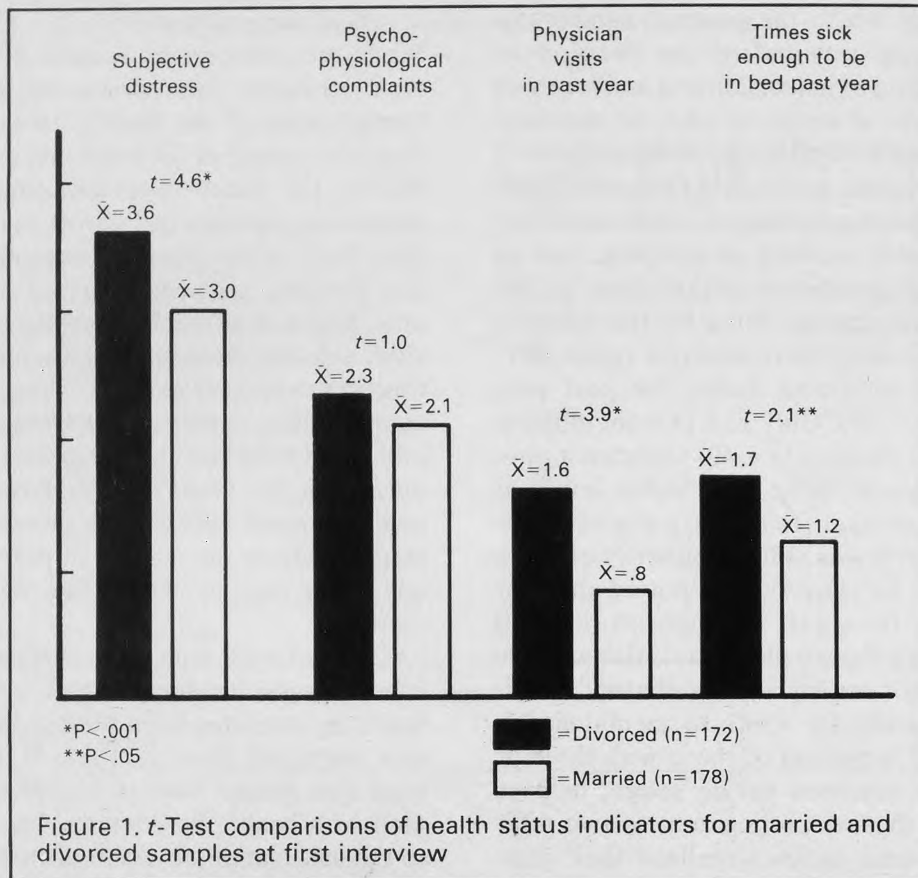

Figure 1. *t*-Test comparisons of health status indicators for married and divorced samples at first interview

Table 3. One-Way Analysis of Variance for Health Status Indicators and Indicators of Marital Distress for the Married

	Health Indicators			
	Subjective Distress		Psycho-physiological Conditions	
Indicators of Marital Distress	Mean	No.	Mean	No.
Ever Separated From Spouse				
No	1.91	160	2.06	160
Yes	3.23	17	2.76	17
(df) *F*	(1,175)	5.127*	(1,175) 2.7	
Divorce Ever Suggested				
No	1.70	135	1.97	135
Yes	3.05	43	2.63	43
(df) *F*	(1,176)	11.63**	(1,176) 5.02*	

*P < .05
**P < .001

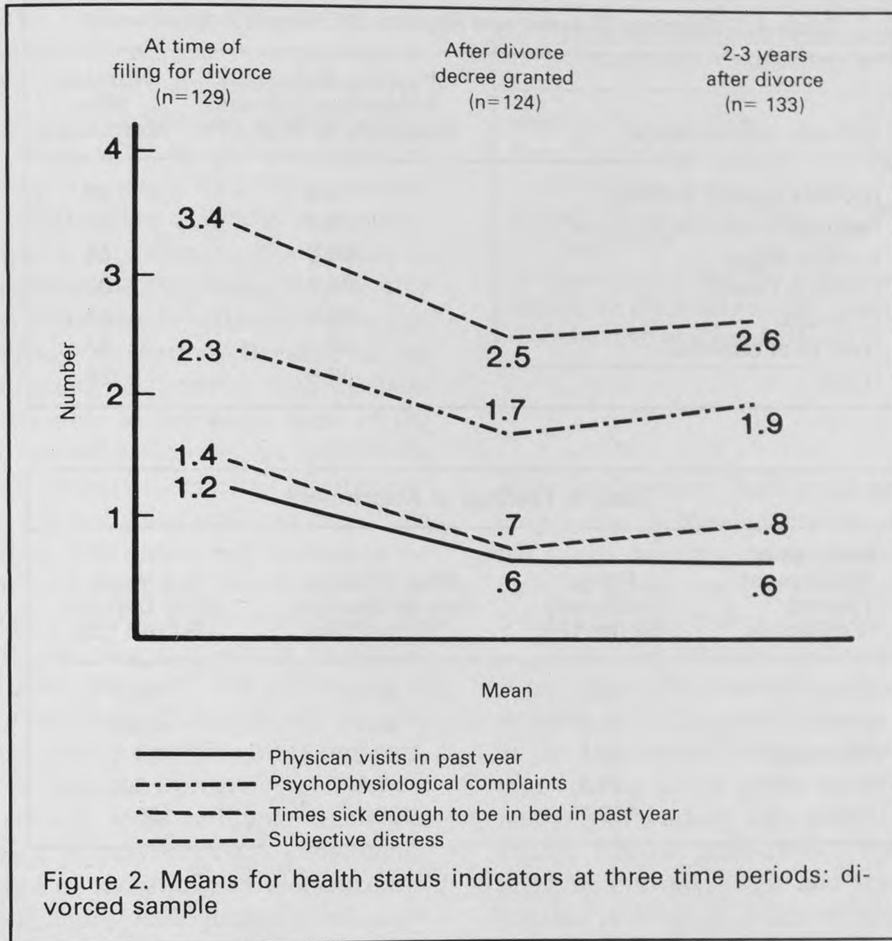

Figure 2. Means for health status indicators at three time periods: divorced sample

cantly. These data, then, support a crisis model of adjustment to divorce, that is, physical and psychological distress is heightened initially and decreases with time.

These data suggest that along with exploring the medical cause of a patient's complaint, the physician may be able to assist those going through divorce to understand that the symptoms they are experiencing are often a common, uncomfortable part of the process of coping with divorce and will generally abate with time. By the same token, symptoms that are particularly severe or have not significantly improved within approximately a year after divorce are a strong indication for referral for more intensive assistance.

Those persons having the most difficulty in adjusting to the divorce are most likely to report moderate to high symptoms of subjective distress. The divorced respondents were asked an open-ended question about what were the most difficult adjustments to make to the divorce. Distress was highest when people mentioned divorce-related concerns such as accepting the rejection by the spouse, handling the stigma associated with divorce, and adjusting to the reality of the end of the marriage (Table 4). Heightened distress was also associated with feelings about the children, with role changes such as household chores and changes in living arrangements and employment, and with living on one's own with its feelings of loneliness, being independent, and being a single parent. As other studies have shown,[21,22] parents are often not aware of their children's distress or concern. This is reflected by the small number in this study (less than 20 percent of those with children) who specifically mention the children; however, as is also shown by the responses, when parents are aware and concerned, their distress is high. As also indicated in Table 4, distress is less highly associated with finances, new relationships,

Table 4. Subjective Distress and Reports of Difficult Adjustments

Difficult Adjustments	Persons Reporting Subjective Distress Moderate to High (%)	Number Who Mentioned
Divorce-related feelings	74.4	39
Feelings about the children	70.4	27
Role changes	68.4	65
Living on own	64.7	102
Finances	54.8	42
New relationships	54.1	37
None	26.9	26

Table 5. Feelings of Attachment

Feelings of Attachment Toward (Ex)Spouse	Filing for Divorce (%) (n=129)	After Divorce Decree Granted (%) (n=124)	2-3 Years After Divorce (%) (n=133)
None	13.2	32.3	38.3
Low	41.9	40.3	43.6
Moderate	20.2	20.2	14.3
High	24.8	7.3	3.8
Total	100.1	100.1	100.0

or the number of difficult adjustments that had to be made.

Finally, to illustrate some of the long-term adjustment difficulties associated with divorce, one of the more difficult and confusing aspects of divorce for the divorcing person and those working with him or her is that the individual may be simultaneously glad to be rid of and mourning the loss of the spouse. The feelings of comfort, security, and well-being experienced in relationships have been called attachment. Originally focused on children's affectional bonds,[23-25] this concept has been extended to adults as well.[26-30] In this study a measure to examine continuing attachment to the spouse in divorce was developed. Based on results of a factor analysis, four items cluster to produce an attachment dimension: spending a lot of time thinking about the spouse, a feeling of disbelief that the couple is getting a divorce, wondering what the spouse is doing, and feeling that one will never get over the divorce.[31] As indicated in Table 5, all but 13 percent of the respondents at the initial interview have some sense of attachment to their spouses. While these feelings fade with time, the majority remain somewhat attached to their ex-spouses at the third interview. This is on the average four years and two months after separating from the spouse. Feelings of attachment may also be reactivated for short periods of time when ex-spouses meet unexpectedly or must discuss issues concerning the children. The family physician can help the divorced parties or those experiencing marital turmoil to understand the longstanding nature of emotional ties and the normalcy of ambivalent feelings.

Discussion

The data reported in this study support a crisis model of marital distress. In marital turmoil the threat of loss or the actual loss and the changes that may occur produce a period of disorganiza-

tion. Some of the implications of these data for family medicine are, first, that marital relationships generally do not disintegrate overnight. There is often an extended period of unhappiness and indecision about what to do. The physician who is alert to the frequency with which couples experience such difficulties and who is aware of the extent to which this distress is exhibited in physical or psychological symptoms may be able to provide some assistance in sorting out priorities and options during this period. Because of the physician's continuing relationship with the family, it may be possible to recognize some of the signs of discord and offer intervention early in the process. Second, couples themselves often recognize that things are not going well and may make efforts to seek help. Still others may be open to the suggestion from their physician that there is a link between physical or psychological symptoms and family problems, and they may accept an offer of assistance. In other instances the physician can make an offer of assistance that may only be acted upon later. Since family members often feel comfortable going to their physician for help, these data suggest that with some additional training in the area of marital and divorce counseling, family physicians should be more able to recognize distress and provide appropriate guidance and counseling.[32] If the family physician does not wish to do counseling, he or she should be aware of the great likelihood of distress in those experiencing marital problems or contemplating divorce and initiate an appropriate referral for supportive educational sessions, counseling, or more intensive therapy when necessary.

Table 6 illustrates those points at which the family physician might provide assistance or arrange for referrals along with some sources of information about how to proceed. Anticipatory guidance or short- or long-term counseling may be needed. Such efforts at assistance might include work with individuals, couples, the nuclear or extended family group, or the single parent and offspring. Educational-counseling support groups also provide assistance to those going through the divorce process.[27,41,42] The physician might consider developing such a group or refer patients to a church group or social service agency that has organized one. Since four out of five divorced people remarry,[2] the family physician should also be aware of the kinds of problems that can arise when this happens. Such problems may be particularly acute in blended families that include his, her, and, possibly, their children. Becoming a blended family may be one of the most difficult transitions for families to negotiate.[39]

Table 6. Situations Potentially Requiring Guidance, Counseling, or Referral
Marital difficulties[33,34]
Period of decision concerning separation or divorce: clarify issues and courses of action[35]
Impact of marital turmoil and divorce on children[15,21,22]
Divorce-related feelings and experiences[27,36]
Issues for the newly single (parent)[27,37]
Cohabitating and remarriage[38-40]

To increase awareness in residency training of issues relating to troubled marriages, divorce, and remarriage, a Couples Conference has been used at the University Hospitals Family Practice program during which residents and faculty discuss methods of working with patients who are experiencing marital difficulties. With assistance in mapping out next steps and sometimes by using another resident or a faculty member as cotherapist, the resident begins to gain more skill in techniques of short-term counseling with individuals and couples.

A third point illustrated by the results of this study is the relative lack of awareness or concern that many divorced parents have about the impact of marital turmoil and dissolution on their children. Children are often greatly affected by the divorce of their parents. A child's response varies according to family situation and age. Nevertheless, divorce can be a major cause of depression in children. An overwhelmed parent may perceive his or her child's quiet behavior as an indication of acceptance of the divorce and not recognize the child's depression. This may explain why research data do not reflect more awareness by parents of their children's reactions. Helping parents to recognize that their children are indeed affected by the divorce and have been affected by the marital turmoil is an appropriate role for the family physician. The work of Wallerstein and Kelly[21] suggests that with some minimal assistance many parents can become more attuned to helping their children

in adjusting to the divorce. The family physician should be able to provide this assistance or make appropriate referrals to parents by helping them recognize the continuing role each has to play as a parent even after the marriage is ended.

Family medicine as a discipline is concerned with prevention and continuity of care. Because of this focus, the family physician must increase his or her sensitivity to the distress of marital turmoil and divorce and become more proficient in assisting the couple, each individual partner, and any children in finding the kind of support and, possibly, counseling needed.

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