The Role of the Family Physician in the Crisis of Impending Divorce

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The divorce rate in the United States is approaching 30 to 40 percent. Because the family physician cares for the entire family, he often finds himself in the midst of the turmoil created by the crisis of impending divorce. Using a case presentation, we have offered some specific suggestions to help the family physician manage this common problem.

Few traditional training programs have adequately prepared the primary physician to be effective in marriage counseling. The integration of the behavioral sciences with the medical sciences should be a major goal of the developing discipline of family medicine. If training programs in family medicine successfully develop curricula that teach the skills required to support a troubled marriage, the family physician of the future may make a more significant contribution towards the preservation of the nuclear family.

If one considers divorce the death of the family, our national mortality rate is staggering. The fact that the nuclear family is in difficulty is clear from the soaring divorce rate in the United States. Furthermore, many marriages that do not end in divorce continue in misery. It may not be desirable to save all marriages, but every couple certainly deserves at least one concerted attempt with professional help to reconcile the differences.

Should it become obvious that there is no hope for a reconciliation, all parties involved will probably experience less pain during and after the divorce if they receive some help. Who will provide this professional guidance? The family physician is in a unique position to assume this responsibility.

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Illustrative Case Presentation

Karen and Dick first came to their family physician for premarital examinations in 1970. At that time, Dick was 20 and Karen was 18 years of age. Two weeks following the wedding, Karen developed a cystitis and was treated with appropriate antibiotics. Karen has been seen on several occasions by her family physician for acne. Dick has been treated for mild viral gastroenteritis. Their first child was born in 1973.

In 1974 Karen came to her family physician complaining of epigastric pain. A duodenal ulcer was discovered, and while probing for a possible emotional problem which might be aggravating her peptic-acid disease, the physician learned that Karen and Dick had recently separated and were filing for divorce. The family physician treated Karen's ulcer and tried to give her emotional support during this period of stress. A month later, however, she was admitted to the hospital making suicide threats and in a state of acute anxiety. At this point an effort was made to piece together a more detailed picture of the couple's emotional life.

Karen is the second of four children. Although her mother and father are living together, she remembers many difficult periods in their marriage, including a temporary separation when Karen was in grammar school. When Karen was 14 years old, her father, while intoxicated, tried to molest her. Although Karen excuses this assault because of her father's alcohol-

ism, she never felt really comfortable with him nor fully trusted him again.

Karen did not enjoy high school but she graduated with average grades. She met Dick when she was 15 years old and went steady with him until they were married after her graduation. They had no premarital sexual relations.

Dick comes from a broken home; his father deserted the family when Dick was an infant. Dick reportedly received little love from his mother who also had a drinking problem.

Karen and Dick's marriage was a stormy one from the beginning. Neither partner could really understand why they were having so much difficulty. A simple decision, such as whether to go bowling or to a movie, led to a major disagreement. Neither would yield to the wishes of the other. Sex was a problem from the very beginning. Karen did not enjoy sexual relations and never experienced orgasm. Dick tried to please his wife sexually and felt rejected when she apparently submitted only out of duty. They were unable to talk to one another. Karen found Dick "moody" and Dick described his wife as "bitchy." He says she never gave him a moment of peace and quiet. Dick asked her to work part time in order to help establish some financial security, but Karen did not enjoy working and always found reasons to quit. Dick enjoyed playing softball or basketball with his old friends from high school while his wife, left at home, felt lonely and deserted. Dick eventually became involved with another woman, which further convinced Karen that no man could be trusted. A mutual friend even propositioned Karen while she was separated from Dick.

When Karen became pregnant with their first child, there was a temporary calm. Dick was pleased at the prospect of becoming a father and was thoughtful of his pregnant wife. There was considerable hope that the child would help repair the marriage relationship. However, shortly after the birth of the baby, Dick left again. A legal separation was obtained, and suits for divorce were filed. Karen began to worry about how she was going to manage alone with the infant girl, and she found herself obliged to enroll in the state welfare program. Just prior to Karen's visit to the doctor for abdominal pain, Dick expressed an interest in returning home once again. Karen refused to have him back unless he agreed to seek some professional help. Dick refused to talk to a marriage counselor, psychologist or psychiatrist, but Karen succeeded in convincing him to agree to discuss their problems with their family physician. Both appeared to have a sincere interest in making the marriage succeed. Dick particularly wanted his daughter to have both a mother and father and he claimed still to be fond of his wife. Dick was aware of the traumatic experience Karen had had with her father and was trying to understand her sexual difficulties.

These problems were first discussed with the family physician by Karen. There followed a private interview with Dick. At a subsequent joint conference much time was spent discussing the sexual incompatibility. The family physician reassured the young couple that it is not uncommon for sexual trauma during adolescence to interfere with adult sexual functioning. Furthermore, if a girl at this stage of development is unable to form a meaningful relationship with her father, she may as an adult have difficulty trusting other men. The couple was able to relate this theory to Karen's experience with her father and her subsequent difficulty trusting men. The usual female sexual response, including the physiology of orgasm, was also discussed. Shortly after this, they once again slept with one another and Karen experienced orgasm for the first time. Their relationship began to improve steadily. Further discussions with the family physician centered around the need for talking openly with one another concerning their feelings. By discussing their differences with the family physician they were able to focus on areas of conflict and once the problems had been clearly defined each made an effort to change his behavior. Dick gave up some of his evenings playing baseball or basketball or else brought Karen along with him. Karen obtained a part-time job in the evenings and Dick enjoyed caring for the baby. They are now living together and have withdrawn their divorce suits. The couple report that they are talking with one another and that their relationship appears much improved.

The total expenditure of time in counseling on this case was six 40-minute sessions. Toward the end of this period, a teaching conference with a psychiatric consultant was arranged to discuss this couple's progress and their future management.

In general, once the family physician has obtained the knowledge and skills needed to be effective in this counseling effort, he should not hesitate to charge a fee commensurate with his customary hourly rate of compensation.

Discussion

The family physician is in a unique position to help a family during the crisis of impending divorce. Since, as in the case described here, he may have performed the premarital examinations, cared for both the man and woman during episodes of illness, and been entrusted with the health supervision of the valued child, the couple already have confidence in him and may turn to him for help during a difficult period. The troubled couple may seek out the family physician early if he has demonstrated, perhaps at the time of the premarital examinations, a willingness to help with problems.

Often, as in this case, one partner (usually the man, less frequently the woman) is reluctant to seek help from a psychiatrist or marriage counselor. The psychiatrist is someone outside the ordinary experience of most people and is consulted only for exceptional problems. For most people he is as remote as the radiologist or pathologist. In contrast, almost everyone has turned to a general medical doctor for help at one time or another. On rare occasions, the close relationship with the family doctor may make it difficult for a patient to discuss painful subjects, such as infidelity. In such instances, the physician should recognize the necessity of finding another source of help.

Few traditional training programs have adequately prepared the primary physician to be effective in marriage counseling. The general practitioner of yesterday, because of his sincere concern for the family's health and welfare, did support troubled couples, but he frequently failed to perceive the emotional conflicts of a disturbed marriage as a specific problem for his therapeutic intervention.

When a practicing family physician

is confronted with a marital crisis he has three choices. He may ignore the plea for help, he may refer the couple to another source for marriage counseling, or he may deal with the problem himself. If he chooses immediate referral, he risks engendering a feeling of rejection in the couple who had finally developed enough courage to confide in him. In addition, it is well known that a large percentage of these patients will not accept the referral. Family medicine training programs must help develop the skills and insights needed for future family physicians to help troubled couples.

The case described here required six 40-minute sessions, with the man and wife alone and then together, in order to obtain the data needed to understand the nature of their incompatibility. In order to be effective in obtaining potentially painful information, the physician must take a neutral stance. He must clearly demonstrate that his major role is to help the couple understand why they are having problems and aid them in finding possible solutions. This is accomplished by rational discussion facilitated by the physician referee. Only after the individuals are able to talk openly with one another about their feelings can any progress be expected. The physician must be comfortable with discussing the couple's sexual relationship, and, equally important, must have a thorough knowledge of human sexuality. The physician must have sufficient psychiatric background to enable him to recognize major neurotic problems or personality disorders when they exist, and, as with all fields of medicine, must recognize his limitations and seek psychiatric consultation when appropriate.

In this case history, a hysterical personality problem was recognized and openly discussed, and the sexual component of the marriage improved without extensive psychotherapy. The woman's problem with trust, particularly of men, was recognized as an area requiring continuing therapeutic efforts.

A psychiatric consultation was held after several counseling sessions with the family physician. This consultation was recorded on video tape and included a joint interview in which the husband and wife, a medical student, the family physician, and a psychiatrist participated.

The interview produced evidence to support the effectiveness of the previous counseling sessions. The husband and wife both placed great value on their newly acquired ability to talk meaningfully with each other. They indicated that their confidence in the family physician, whose detachment was tempered by empathy, enabled them to follow his advice and learn to understand rather than to condemn.

The family physician can make a significant contribution to the quality of family life, particularly when the husband and the wife are basically healthy and free of major psychiatric illness. In this situation there are two basic principles which have direct therapeutic implications for the management of marital problems.

The first is the fact that *problems which arise early in the marriage are frequently related to unfulfilled expectations.* Most people enter this contract hoping that the marriage will develop in a certain fashion and they expect something wonderful to happen. Often these expectations are a romanticized view of what life together will be like. They may dream about all the good things, and forget about the fact that the trash has to be taken out, the dishes have to be washed, and the bills have to be paid. Very often unrealistic expectations will be met by reality shortly after the honeymoon. This will be experienced as disappointment or deprivation. The husband or wife or both may feel cheated, as if the other person had lied, and there is a continuing spiral of recriminations, resentment, and bitterness which commonly leads toward divorce.

The second general type of problem is a *differential rate of maturation.* This usually appears after the couple has been married for a few years. People usually get married at a time when they suit each other's emotional needs and their personalities complement one another. After marriage one or the other may move ahead in terms of maturity. For example, the husband, who is usually the breadwinner, enters the business world, meets people and takes on responsibility. He has to develop poise to conduct his sales meeting or to interact with his associates. The demands of his work stimulate him and guide him to a more rapid maturation in contrast with his wife who might be sitting at home or staying with her mother and remaining in a kind of adolescent or even childish stage. It also sometimes happens the other way around. The husband may be working at a job but still continuing his own adolescent activities. He may spend considerable time with the boys, playing ball or bowling, while the wife takes over the major responsibilities of the family such as paying the bills, balancing the checkbook, taking care of the babies, and solving family problems. She may be the one stimulated to mature more rapidly. After a while this maturational difference may develop into an incompatibility which was not present at the time of marriage.

In this case study it is possible to find elements of both major areas of incompatibility. Both Karen and Dick abstained from having sexual relations before marriage and each had developed detailed fantasies of the pleasures they would eventually enjoy. They spoke freely of these expectations during their courtship. Karen had an additional dream. She envisioned their spending the evenings in a humble but quaint apartment basking in the contentment that comes from enjoying one another's company. The sexual expectations were unfulfilled from the very beginning. Karen's dreams of their evenings together were shattered by Dick's leaving to play ball with the boys. In addition, before the marriage Karen had no idea that her husband would someday ask her to work outside the home and contribute to their earnings.

The problem of differential rates of maturation was also operating to some degree. Dick continued his adolescent activity of playing sports with his former high school friends. He was unwilling to curtail this activity to meet his wife's wish that they spend more time together. It was Karen who assumed almost total responsibility for the care of the child. She managed the household budget and was forced to do more and more of the odd jobs within the apartment. She began to resent having to assume the major adult responsibilities while her husband continued to have fun.

The fantasies and expectations which are attached to marriage are usually not mentioned spontaneously. They must be inquired about gently, with an awareness that they tend to be

deeply personal and are often associated with painful disappointment. As in most psychotherapeutic efforts, it is useful to obtain detailed descriptions of the expectations. This enables the patient to communicate his own unique qualities and interests and gives the interviewer a clearer image with which to work.

Where applicable, the family physician tries to demonstrate how various aspects of the marital problem are results of unfulfilled expectations. Next, he and the couple try to discover why they have been unfulfilled. Was the patient unaware of the fantasy or its implications? Did he fail to communicate his wishes to his spouse clearly or meaningfully? Were some of the wishes unrealistic?

The basic strategy is to determine what was desired, what is missing and why it is missing. As the reasons for lack of fulfillment are discovered, remedies can sometimes be found. When each member of the couple understands his own and his partner's inner wishes, he is often willing to give something desirable if the other is willing to reciprocate. In some instances, the physician helps a person recognize that he has been expecting more than the spouse could humanly provide.

The problem of differential rates of maturation is more complex, but the basic approach can be similar. In addition to a detailed exploration of marital expectations, it is usually necessary to obtain information about occupational ambitions, personal goals, newly developed interests, and attitudes toward children. It is necessary to ascertain how the couple was similar at the time of marriage and how they have become different. Then it is important to find out how this has happened and what interests the couple continues to share. Ways must be sought to prevent the differences from undermining shared interests. In fact, it is often possible to find means to help a couple enhance their mutual satisfaction by using to advantage some differences between them.

It is natural for a couple to turn to a trusted family physician during the crisis of impending divorce. In the past, the physician's role in managing this threat to family life has been ill-defined. The family physician, the one who first finds himself in the midst of the turmoil of impending divorce, and the psychiatrist, who possesses special knowledge of human behavior and psychoanalytic theory, could collaborate to refine and evaluate the effectiveness of the family physician's role during this crisis. We have described one model of such collaboration and have offered some specific suggestions for the management of this all too common family problem.