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PSYCHIATRIC MORBIDITY AND PERSONALITY PROFILE IN DIVORCE SEEKING COUPLES

LALIT BATRA, SHIV GAUTAM

To what extent psychiatric morbidity and personality factors contribute to marital disharmony and decision to divorce is still an unanswered question in Indian setting. This study was undertaken with aims to find out (1) the prevalence of psychiatric morbidity in persons seeking divorce; (2) the prevalence of psychiatric morbidity in persons who had good marital adjustment; (3) the nature of psychiatric morbidity observed in these subjects, and (4) the personality profile of these subjects. Fifty randomly selected divorce seeking couples (n=100) from the matrimonial court of Jaipur City and thirty couples with good marital adjustment (n=60) selected from the community were studied. Probable psychiatric cases identified by administering GHQ (Hindi version) were diagnosed according to ICD-10 and personality profile of all cases was studied by using 16 PF. High psychiatric morbidity (50%) was found among divorce seeking couples in comparison to control group (13%). There was a high prevalence of neurotic disorders (22%) and mood disorders (16%) in experimental group. Schizophrenia and related disorders (10%) and substance abuse disorder (2%) were seen only in the experimental group. Specific personality factors related to divorce seeking individuals and persons with stable marriage have been identified. The implications of this study are highlighted.

Key words: psychiatric morbidity, personality, divorce.

INTRODUCTION

Marriage is a social institution through which a man and woman come closer to each other and start living together to fulfil certain social and personal responsibilities. Marriage is one of the most important events of life affecting social status as well as the psyche of an individual. It not only serves to satisfy the fundamental biological need of sexual gratification through a socially acceptable way but also helps the individual to achieve a higher level of personality maturation. In terms of protection hypothesis, marriage acts as a sort of insurance against psychological breakdown. Intact and harmonious marital relations are required not only for the psychic health of the individuals, but also for progeny and thus for society in a broader perspective (Sethi, 1982).

Conflict in marriage arises from many sources. At one end it is because of differences in information, belief, interests, desires, values and competition between partners; at the other end it is because of emotional or mental problems in one or both partners or with in-laws, sexual inadequacy, infidelity, economic problems, unwanted pregnancy or fear of pregnancy, loss of child etc.

Marital disharmony or breakdown has a number of damaging ramifications both for the adults concerned and children. It brings with it a higher risk of suicide, behavioral problems and deterioration in physical health. Mental disorders and marital problems are closely linked although there is controversy about their sequence (Briscoe & Smith, 1973; Brown & Harris, 1978). A number of studies (Pensor, 1944; Slater & Woodside, 1951; Kreitman, 1962 & 1968; Mayamma & Sathyavathi, 1988) have reported a relationship between marital problems and mental illness in couples. Other studies (Paykel et al, 1969; Brown & Harris, 1978; Agarwal, 1971) have reported psychiatric morbidity in cases of marital problems; however systematic epidemiological data are scarce in literature.

Kreitman (1962 & 1968) in a study of married couples admitted for mental illness found that the incidence of psychiatric morbidity is substantially commoner than would be expected by chance and also reported higher chances of developing neurotic symptoms in patient's spouse than same sex control subjects. Sathyavathi and Seth (1975) observed that neurotics as a group have a higher incidence of marital problems on several issues as compared to control group. In a study of patterns of marital disharmony presenting in a psychiatric clinic, Agarwal (1971) stated that difficulty in marriage usually arises due to multiplicity of factors. He reported a significantly higher number of emotional problems (55% of males and 72% of females) in couples with marital disharmony.

Personality plays an important role in a marital relationship. The need to be loved and to provide love, concern and care for another individual are the important aspects of personality that are essentially

required for success of marriage. Both the spouses act as a complementary need (Sethi, 1982). Studies of normal married couples are numerous but very few have studied personality of morbid couples.

Hagnell and Kreitman (1974) found that concordance on personality is more for healthy pairs than those in which either or both partner are ill. By using the Sjobring system (Sjobring, 1973) which included four aspects of personality namely, Capacity (which is equivalent to intelligence), Validity (corresponds to confidence, self reliance), Solidity (long range organization) and Stability (emotional attachment), Kreitman found in one hundred and fifty six of these couples, where both partners were healthy, significant correlation on personality measures were obtained for capacity ($p<.001$) and solidity ($p<0.01$). In eighty pairs where the husband was healthy and the wife was sick, only one significant correlation emerged, namely on capacity ($p<0.001$). In forty two pairs where the husband was sick but the wife was healthy or where both couples were ill (fifty couples) none of the variables yielded significant concordance. Agarwal (1971) has reported seven patterns of marital interactions, e.g. culturally approved role playing (37.5%), wife domineering husband passive (25%), husband emotionally indifferent (10%), both competing for dominance (10%), husband domineering wife passive (5%), both dependent (5%), and both avoiding (2.5%).

So far the literature reveals that research carried out in relation to marriage and mental illness consists of studies of spouses of the mentally ill presenting in psychiatric clinics or out patient departments. The population presenting with marital disharmony and subsequent decision to divorce has not been looked at. What actually leads to this vital decision of breaking the marriage - is it mental illness, individual personality pattern or other factors like social, financial or inability to deal with stress? These questions still remain unanswered in Indian setting. Therefore the interest of authors arose and the present study was undertaken to see to what extent psychiatric morbidity and personality factors contribute to marital disharmony and decision to divorce.

AIMS

1. To find out the prevalence of psychiatric morbidity in persons seeking divorce.

2. To find out the prevalence of psychiatric morbidity in persons who had good marital adjustment.

3. To determine the nature of psychiatric morbidity observed in these subjects.

4. To study the personality profile of the subjects.

MATERIAL AND METHODS

This study was conducted at the Matrimonial Court, Jaipur city, where the married couples were seeking divorce as a solution to their unresolved marital problems. It was decided to study two groups of individuals. In first group we studied fifty couples seeking divorce. The first two cases on the list of Matrimonial Court on every Monday from February to July 1992 were selected for the study. In these cases where subjects were not cooperative despite joint efforts of court and investigators or where literacy status of subjects was too low to understand the instruments of study, subsequent cases on the list of court were included in study.

For the control group, it was decided to study those couples who had a fairly well adjusted married life. For this purpose one sector of a colony called Jawahar Nagar was selected. Investigators went from house to house on holidays. After initial introduction, information was gathered whether the members of family had any knowledge about family courts and it was indirectly ascertained that no case was going on in the matrimonial court. Marital adjustment questionnaire (MAQ) (Kumar & Rohatgi, 1976) was given to both the spouses in one to one setting by investigators. For this purpose the help of a female doctor was sought, who could establish rapport with the lady of house. These couples who scored more than twenty of MAQ were requested to participate in the research.

The aims of the study were explained to the subjects and assurance was given regarding confidentiality. They were administered a socio-demographic data sheet, Hindi versions of Goldberg's GHQ (Gautam et al, 1987) and 16 Personality Factor questionnaire. Both partners were included in the study and interviewed separately. Each interview lasted for 90-120 minutes. Those who scored more than 12 on GHQ were subjected to detailed psychiatric evaluation by using Indian Psychiatric Interview Schedule (Kapur et al, 1974) for ascertaining presence of psychiatric symptoms. Diagnosis was made according to ICD-10, which was confirmed separately by both investigators. Inter-investigator agreement was more than 95%. Scores of 16 PF were analyzed and information thus obtained was subjected to statistical analysis.

Table 1
Comparison of GHQ scoring in two groups

S.No.	GHQ score	Experimental Group (A)Male (n=50)	(B)Female (n=50)	Total (n=100)	Control Group (C)Male (n=30)	(D)Female (n=30)	Total (n=60)
1.	Below 12	28 (56%)	22 (44%)	50	27 (90%)	25 (83.33%)	52
2.	B/W 12-17	4 (8%)	8 (16%)	12	1 (3.33%)	2 (6.66%)	3
3.	More than 17	18 (36%)	20 (40%)	38	2 (6.66%)	3 (10.00%)	5

X (B/W A & C) = 10.258 df = 2, p = <0.01 S
X (B/W B & D) = 12.104 df = 2, p = <0.005 HS
X (B/W EX. & CON) =17.58 df = 2, p = <0.001 HS

Table 2
Comparison of psychiatric morbidity in two groups

S.No.	Psychiatric Morbidity	Experimental Group (A)Male (n=50)	(B)Female (n=50)	Total (n=100)	Control Group (C)Male (n=30)	(D)Female (n=30)	Total (n=60)
1.	Present	22 (44%)	28 (56%)	50	3 (10%)	5 (16.66%)	8
2.	Absent	28 (56%)	22 (44%)	50	27 (90%)	25 (83.33%)	52

X (B/W A & C) = 10.05 df = 1 p = >0.005 S
X (B/W B & D) = 11.968 df = 1 p = <0.001 HS
X (B/W EX. & CON) 21.31 df = 1 p = <0.001 HS

Table 3
ICD-10 Diagnostic break up of psychiatric morbidity in two groups

Psychiatric Morbidity	Experimental Group (A)Male (n=50)	(B)Female (n=50)	Total (n=100)	Control Group (C)Male (n=30)	(D)Female (n=30)	Total (n=60)
F10. Substance abuse	2 (4%)	-	2	-	-	-
(a)Alcohol abuse	1	-	1	-	-	-
(b)Opiates abuse	1	-	1	-	-	-
F20. Schizophrenia	1 (2%)	3 (6%)	4	-	-	-
(a) Paranoid type	1	1	2	-	-	-
(b) Undifferentiated	-	2	2	-	-	-
F21.Schizotypal disorder	-	3 (6%)	3	-	-	-
F22. Persistent delusional disorder	3 (6%)-	-	3	-	-	-
F30. Mood disorder	7 (14%)	9 (18%)	16	1 (3.33%)	1 (3.33%)	-
(a) F32 Depressive ep.	7	9	16	1	1	2
F40. Neurotic disorder	9 (18%)	13 (26%)	22	2 (6.66)	4 (13.33%)	6
(a) F41.0 Panic dis.	1	-	1	-	-	-
(b) F41.1 Gen.anxiety	5 -	3	8	-	2	2
(c)F41.2 Mix.anx & dep	2 3	5 2	1	3		
(d) Hypochondriasis	1 3	4 -	1	1		
(e)Dissociative disorder	-	4	4	-	-	-

Table 4
Reported past history of psychiatric morbidity of two groups

Psychiatric Morbidity	Experimental Group (A)Male (n=50)	(B)Female (n=50)	Total (n=100)	Control Gro (C)Male (n=30)	(D)Female (n=30)	Total (n=60)
Absent	46 (92%)	39 (78%)	85	29	28 (93.33%)	57
Present	4 (8%)	11 (22%)	15	1 (3.33%)	2 (6.66%)	3

Table 5
History of psychiatric consultation in two groups

Consultation History	Experimental Group (A)Male (n=50)	(B)Female (n=50)	Total (n=100)	Control Group (C)Male (n=30)	(D)Female (n=30)	Total (n=60)
As indoor patient	-	2 (4%)	2	-	-	-
As outdoorpatient	4 (8%)	8 (16%)	12	1 (3.33%)	2 (6.66%)	3

Table 6
Significant difference in 16 PF of spouses of two groups

Factor	Male Mean	Male S.D.	Female Mean	Female S.D.	*t test*	*p value*	
Experimental group							
1. C	5.5	1.961	3.86	1.958	3.469	<0.001	HS
2. O	6.08	2.538	6.98	1.900	2.01	<0.01	S
3. Q2	6.38	1.748	5.50	1.854	2.44	<0.01	S
Control group							
1. I	6.2	1.584	4.86	2.080	2.80	<0.01	S
2. Q3	7.26	1.201	5.83	0.912	9.23	<0.001	HS

Experimental group df = 98; control group df = 58; HS = highly significant; S = significant.

Table 7
Significant difference in 16 PF among two groups

S.No.	Factor	Experimental Group Mean	Experimental Group S.D.	Control group Mean	Control group S.D.	t test	p value
Husbands of two groups							
1.	B	4.92	1.998	6.26	1.928	3.824	<0.001HS
2.	E	6.86	1.829	5.13	1.502	4.580	<0.001HS
3.	L	6.48	2.314	5.03	1.564	3.240	<0.01S
4.	M	6.06	1.910	5.10	1.124	2.840	<0.01S
5.	O	6.08	2.538	4.36	1.751	3.570	<0.001HS
6.	Q1	6.50	1.897	4.90	1.295	4.510	<0.001HS
7.	Q2	6.38	1.748	5.26	2.049	2.490	<0.01S
8.	Q3	5.46	1.643	7.26	1.201	5.690	<0.001HS
9.	Q4	5.64	2.464	3.86	2.315	3.290	<0.001HS
Wives of two groups							
1.	A	4.94	1.315	4.03	1.272	3.005	<0.01S
2.	B	4.32	2.151	5.09	2.186	3.153	<0.01S
3.	C	3.86	1.958	5.46	1.569	4.035	<0.001HS
4.	E	6.35	1.791	4.70	1.493	4.470	<0.001HS
5.	F	4.78	1.982	3.90	1.446	2.290	<0.01S
6.	L	6.86	1.538	5.26	1.799	4.060	<0.001HS
7.	M	6.38	1.759	5.16	1.510	3.280	< 0.001HS
8.	N	5.72	1.565	6.86	1.655	3.080	<0.01S
9.	O	6.98	1.900	4.33	1.397	7.160	<0.001HS
10.	Q1	6.40	1.989	5.40	2.061	2.130	<0.01S
11.	Q4	5.80	2.138	3.83	1.723	4.530	<0.001HS

df = 78; HS = highly significant; S = significant.

RESULTS

General characteristic of sample: Fifty divorce seeking couples (n=100) and thirty well adjusted couples (n=60) did not differ on general parameters like age range (18-60 years), literacy status (all literate), duration of marriage (2-30 years) and religion (all Hindus).

DISCUSSION

From the GHQ scores (Table 1), it is clear that a significantly high number of males and females of the experimental group (50%) had a high GHQ score in comparison to the control group (13%). Forty four percent of male respondents of the experimental group (Table 3) suffered from psychiatric morbidity whereas fifty six percent of female respondents were psychiatrically ill. On comparison with the control group, both in cases of male and female, the difference was found to be statistically significant. On comparing both groups simultaneously, the difference was found to be highly significant (p .001). According to Briscoe and Smith (1973) and Brown and Harris (1978), psychiatric morbidity and marital problems are closely linked. A high percentage of psychiatric morbidity was reported in case of marital disharmony by a number of researchers including Kreitman (1970 & 1974), Overstone (1973), Sathyavathi & Seth (1975) and Agarwal (1971). Our findings support the above studies (Table 2).

The diagnostic break-up of psychiatric morbidity among divorce seeking couples shows that 18% of males and 26% of females of the experimental group suffered from neurotic disorders in comparison to males (6.66%) and females (13.33%) of the control group. The second common diagnosis was mood disorders (depressive episode and recurrent depressive episode); 14% of males and 18% of females of the experimental group showed features of depression (Table 3) in comparison to 3.33% each of males and females in the control group. Substance abuse disorder (4%) and persistent delusional disorder (6%) were only present among males of experimental group, whereas schizotypal disorder (6%) and schizophrenia (6%) were prominently present in females of experimental group. Such disorders were not observed in control group. Our findings are supported by the findings of a number of previous studies which indicate a higher percentage of psychiatric morbidity among the couples with marital disharmony or separation. Agarwal (1971) found emotional problems in 55% of husbands and 72% of wives in his sample. These findings also support the previous findings in which a higher percentage of females were found with neurotic disorder.

On looking at the past history, it was found that 8% of males and 22% of females had a history of psychiatric morbidity before the present crisis started (Table 4). Regarding history of psychiatric consultations, 2% of females had given a history of admission in hospital as inpatient, whereas no male had been admitted in hospital in the past (Table 5). In addition to that, 16% of females and 8% of males had sought outdoor treatment at psychiatric hospitals/clinics. This is in comparison to 3% and 6% of males and females of control group who had utilized such services. History of psychiatric consultation in the experimental group (14%) is higher than control group (5%).

Previous research in India is scanty on this subject. Most studies are of couples with psychiatric problems (Mahendru, 1975; Sathyavathi & Seth, 1975) which indicate that neurotics and their spouses perceive their marriage as disharmonious in comparison with normal couples who reported good marital adjustment.

Literature concerning personality assessment of morbid couples is scarce in our country, particularly personality factors and marital disharmony has not been reported. Some authors have studied the role of disturbed communication as an important factor in marital disharmony (Friedman, 1972; Knox, 1971; Mayamma & Sathyavathi, 1985). Analysis of 16 PF scores (Table 6) of the experimental group showed that males score high on factors C and Q_2, which mean that males in the divorce seeking group were emotionally stable, mature, self-sufficient (factor C), resourceful, who prefer their own decision (factor Q2).

Females in the experimental group had significantly higher scores on factor O and low scores on factor C and factor Q_2 meaning that these females were more emotionally unstable, affected by feelings, easily upset, changeable (Factors C), apprehensive, self-reproaching, insecure and worrying a lot (factor O). Simultaneously, they were also more dependent (factor Q_2) in comparison to males. It was interesting to note that in both males and females of the experimental group, a high sten score on factor E was found, which means all of them were assertive, aggressive, competitive and stubborn (dominance). These scores were higher in comparison to normal population.

On statistical evaluation of control group a significant difference was found on Factor 1 and Q_3 (Table 6) which are indicative of overprotected, clinging, tender mindedness (premsia) and controlled, exacting will power, socially precise and compulsive traits of personality of males. An inclination towards high scores for factor C and N in both spouses of control group shows the number of traits of their personality like conscientious, persistent, moralistic, astute, polished, socially aware. On the other hand, low scores on factor Q_4 show the relaxed, tranquil, torpid, unfrustrated and composed nature of both males and females with good marital relations between them.

On comparison of personality traits between males of both groups (Table 7), a statistically significant difference was seen for the factors B, E, L, M, O, Q_1, Q_2, Q_3 and Q_4. Males of experimental group were found to be less intelligent, more aggressive, assertive, competitive and stubborn, suspicious, hard to fool, imaginative, Bohemian and absentminded. They were also found with more apprehensive, self reproaching, insecure, worrying troubles, experimenting, freethinking, self-sufficient, resourceful, preferring own decision, and tense and frustrated type of personality in comparison to control group, which is indicative that males with such personality patterns have a high risk of developing a marital crisis.

When we looked at the relationship of personality of females to marital crisis, statistical significance was seen in 11 factors when compared with females of the normal control group. It is quite clear (Table 7) that females in the experimental group were more emotionally unstable, affected by feelings, easily upset, changeable (Factor C), aggressive, assertive, competitive (Factor E), suspicious, hard to fool, imaginative, Bohemian, absent minded, as well as more apprehensive, self reproaching, insecure (Factor O), tense, frustrated, driven and over-wrought (Factor Q_4). Females of the experimental group were also more outgoing, warm hearted, easy-going (Factor A), dull (Factor B), experimenting, liberal with free thinking in comparison to normal control females. On the other hand, females of the control group were more intelligent (Factor B), more mature (Factor C), humble, mild and accommodating (Factor E), astute, polished, socially aware, (Factor N) and more relaxed, tranquil, torpid and unfrustrated (Factor Q_4) when compared with females of the experimental group.

These findings are statistically significant and show personality traits of divorce seeking females and females of normal couples. From these it is clearly evident that personality traits of females in stable marriages are contrastingly different from those in unstable marriages.

CONCLUSION

From the study it can concluded that divorce seeking couples have high a psychiatric morbidity in comparison to well adjusted couples. Personality factors of divorce seeking couples also differ from couples having stable marriages. In the majority of cases, the individuals concerned and the Honorable Court were not aware of this finding. Implication of the study are that Judicial Officers dealing with matrimonial cases should be well versed with psychiatric problems and personality aspects of their clients while dealing with them. With increasing cases of divorce in our country, this study makes a beginning for a case of concentrated efforts to develop marital therapy and its incorporation during the initiation of court proceedings of marital disharmony.

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Lalit Batra MD, Senior Resident, Institute of Human Behavior and Allied Sciences, (IHBAS), Shahdara, Delhi; Shiv Gautam MD, DPM, MNAMS, Professor, Department of Psychiatry, SMS Medical College, Jaipur.*

* Correspondence