

Frequency of Psychiatric Disorders in Adult Patients Hospitalized With Marital Problems

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Marriage is acknowledged as a demographic factor associated with both mental and physical health. It has been shown that married individuals have a longer life expectancy, lower death rates and self-reported morbidity, and better psychological well-being than those who are unmarried.¹ Although studies on marriage and mental health tend to focus on the average effect of marriage, the positive association may not hold across different contexts, particularly for marital problems. For instance, research has shown that low-quality, long-term marriages have significant negative effects on health.² However, to our knowledge, studies have not investigated the burden of psychiatric disorders and substance abuse in individuals hospitalized with marital problems. Our research evaluated trends in US hospitalizations with psychiatric disorders and substance abuse with marital problems from 2007 to 2014.

METHODS

Weighted discharges from the largest nationwide inpatient database, the National Inpatient Sample (NIS) (2007–2014), were queried addressing over 95% of the US

inpatient population. The NIS contains approximately 8 million annual discharges from over 1,050 hospitals, which represents a 20% stratified sample of all nonfederal acute care hospitals from 45 states, excluding long-term care and rehabilitation facilities.³ Adult patients with a history of marital problems were identified using ICD-9 CM codes V61.1x (counseling for marital and partner problems and spousal/partner abuse), V61.03 (family disruption due to divorce), and V61.04 (estrangement). From those without a history of marital problems, a 1:2 sample of controls was selected. Trends in psychiatric comorbidities were analyzed utilizing previously used codes.⁴ Categorical variables were compared using the χ^2 test in SPSS v24.0 (IBM, Armonk, New York). $P < .05$ was considered clinically significant.

RESULTS

Hospitalized adult patients who had marital problems ($n = 120,990$, 55.6% female) were more likely to be younger (18–44 years: 67% vs 29.8%, $P < .001$), male (44.4% vs 40.2%, $P < .001$), and White (79.8% vs 68.3%, $P < .001$); had private insurance coverage (44.6% vs 29.8%, $P < .001$) or self-pay/no-pay beneficiaries (21.40% vs 9.20%, $P < .001$); and belonged to the Midwest and Northeast regions compared to those without marital problems ($n = 241,924$). Figure 1 shows the prevalence of psychiatric disorders with marital problems compared to those without marital problems. The data showed that 97.6% of patients with marital problems had psychiatric disorders. Mood disorder was the most prevailing disorder (80.8%), followed by suicide/self-inflicted injury (34.2%), smoking (31.4%), and anxiety disorders (29.8%). From 2007 to 2014, the rate of screening and history of mental health and substance abuse in patients hospitalized with marital problems increased from 30.4% to 46.0%, whereas the anxiety rate increased from 22.8% to 40.5%, and suicide and the self-inflicted injury rate increased from 23.7% to 44.4% (Figure 2). Figure 3 shows the temporal trend of an increased burden of substance abuse (smoking: 26.5%–37.2%, drug abuse: 25.3%–29.8%, marijuana abuse: 11.1%–15.5%, and amphetamine abuse: 1.6%–4.0%) from 2007 to 2014 in patients hospitalized with a marital problem.

DISCUSSION

This study provides first-ever evidence of hospitalization rates for psychiatric disorders and substance abuse in

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Figure 1. Psychiatric Disorders With Versus Without Marital Problems

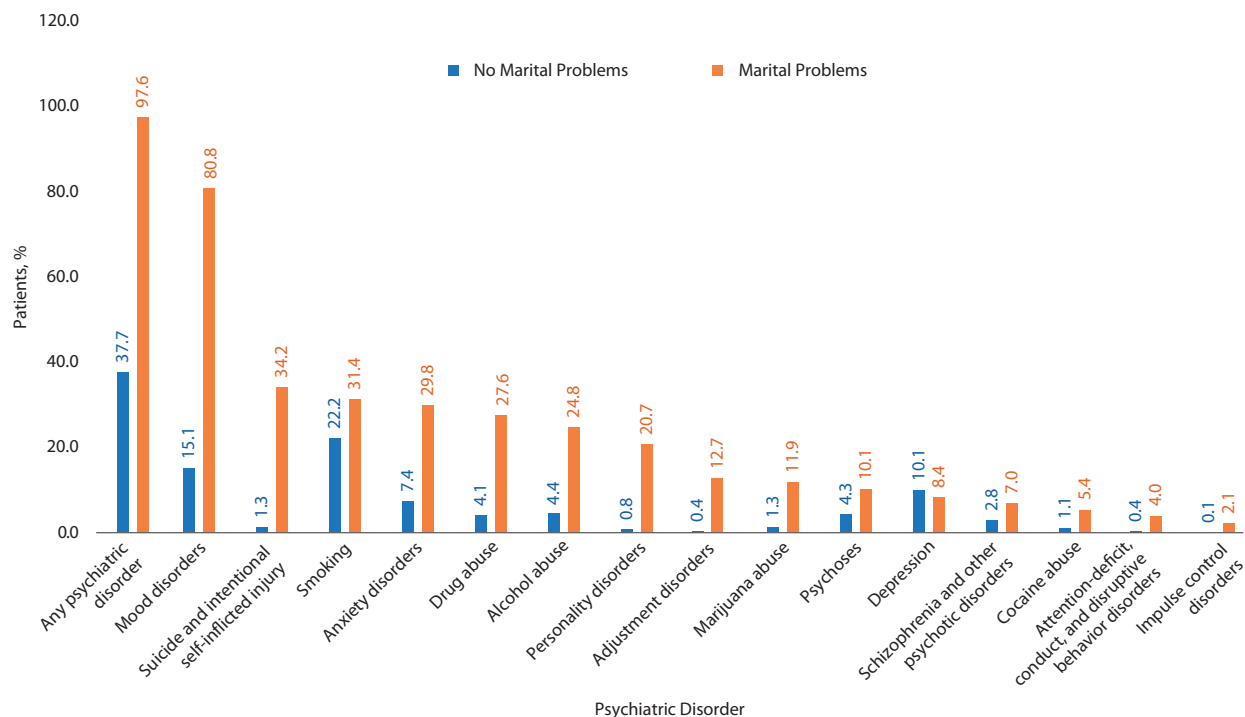
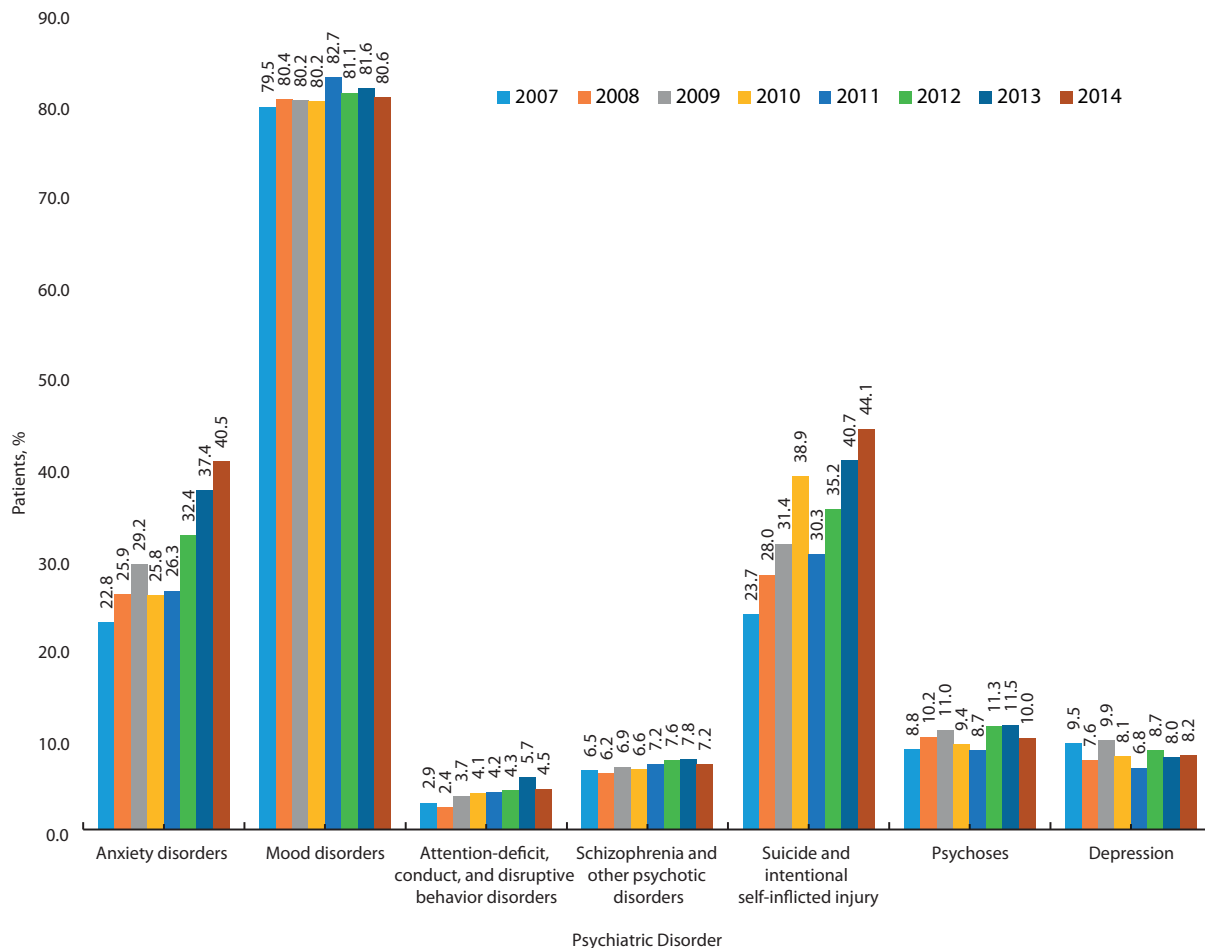
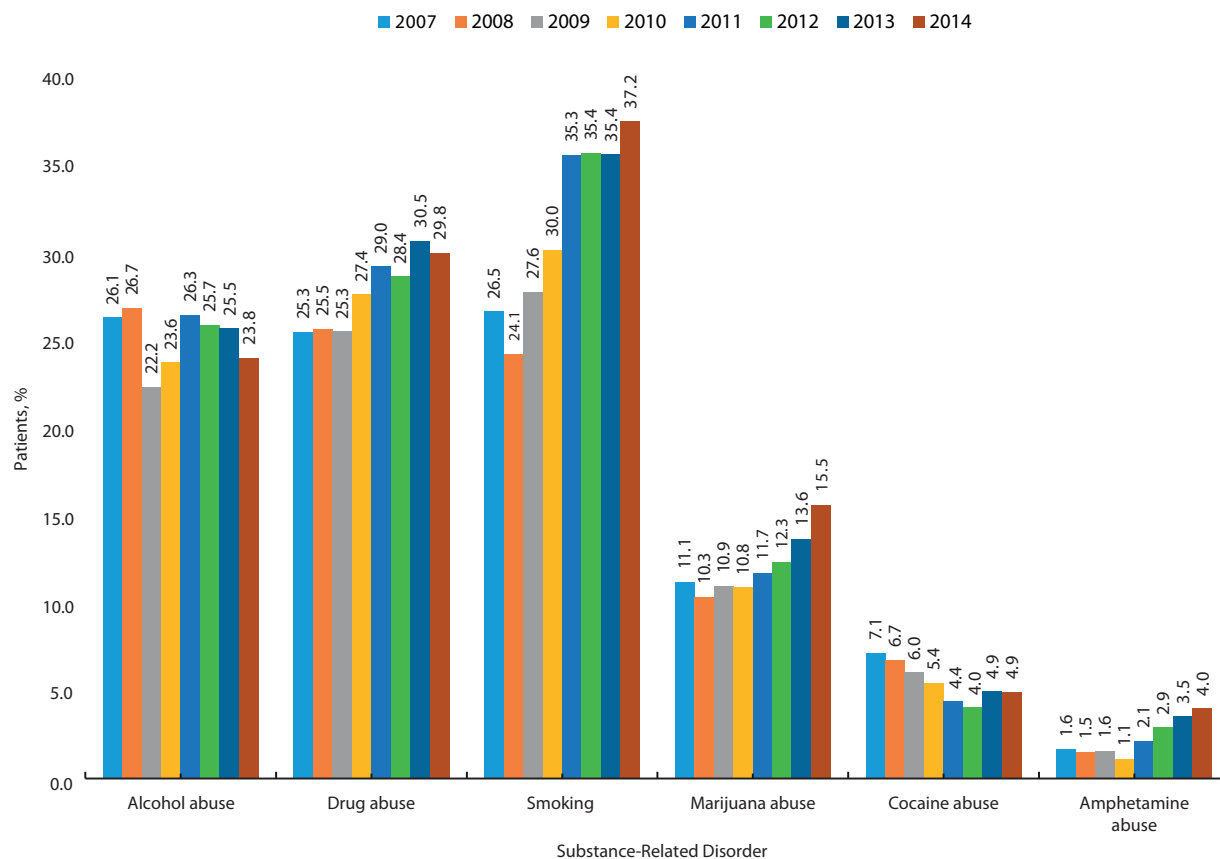


Figure 2. Temporal Trends in Psychiatric Disorders Among Patients Hospitalized With Marital Problems



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Figure 3. Temporal Trends in Substance Abuse–Related Hospitalizations Among Patients With Marital Problems



individuals with marital problems. Historical data also indicate the rising need for health care in the context of the relationship between marriage and health.⁵ Individuals who reported having marital problems exhibited an overall significant burden of psychiatric disorders. One possible explanation could be that mental health issues and subsequent hospitalizations result in strain on marital life. Another explanation is that individuals experiencing marital problems can have subsequent worsening of mental health issues due to added stress. Furthermore, the alarming rise in suicide and self-inflicted injury along with marijuana and amphetamine abuse requires special attention and highlights the need to improve marital well-being.

The study's focus on primary diagnoses minimized misclassification. However, we may have missed cases of hospitalizations due to secondary diagnoses. Furthermore, it is unclear how marital problems lead to hospitalization. Nevertheless, future research is warranted for marital health checkup by investigating the association between various

marital characteristics and other potential risk factors for psychiatric conditions leading to hospitalizations.

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