

Psychological Distress and Marital Adjustment in Spouses of Hepatitis C Patients

Mashal Qazi	Clinical Psychologist, Aaghaz Psychological Services, Abbottabad Email: mishalqazii@gmail.com
Muqaddas Sana	BS Student, Department of Psychology, Abdul Wali Khan University Mardan Email: muqaddus345@gmail.com
Samavia Abdullah	Implementation Support Unit, Directorate of Elementary and Secondary Education KP, Hazara University Mansehra Email: sam.abdullah93@gmail.com
Fareeha Bahadar	BS Student, Department of Psychology, Abdul Wali Khan University Mardan Email: khanfareeha656@yahoo.com

ISSN: 3006-6549 (ISSN-L)

ISSN: 3006-6557 (Online)

ISSN: 3006-6549 (Print)

Vol. 2, No. 2 (2024)

Pages: 28 – 34

Key Words

Psychological Distress, Marital Adjustment, Hepatitis C

Corresponding Author:

Mashal Qazi

Email: mishalqazii@gmail.com

Abstract: *This study examines the spouses of patients diagnosed with Hepatitis C as it pertains to the level of psychological distress and marital adjustment and effect of illness stage, gender and socioeconomic status. Caregivers who have to cope with chronic illness in their family are prone to psychological distress, i.e. anxiety, depression and lapses of thought. Fears associated with Hepatitis C add to this caregiving burden for spouses of Hepatitis C patients. This research explores the associations of the Kessler Psychological Distress Scale (K10) and Dyadic Adjustment Scale (DAS) scores between the two spouses. Results show a strong negative relationship between marital satisfaction, consensus, and cohesion and psychological distress. Results show that female spouses and those from lower socioeconomic background exhibit higher distress levels, leading to greater distress on marital adjustment. Furthermore, spouses of patients with advanced stage disease of Hepatitis C present with even worse difficulty in maintaining marital cohesiveness and satisfaction. These results emphasize the importance of targeted psychological and social support interventions for caregivers of patients with chronic illness to strengthen both the personal well-being and marital resilience of caregivers.*

Introduction

Patients with chronic illness don't only affect patients, they deeply impact their families, first and foremost their spouses who are often the primary caregivers. If the responsibility of caregiving leads to elevated levels of psychological distress which includes a spectrum of negative emotional responses such as anxiety, depression and irritability (Kanner, Coyne, Schafer, & Lazarus, 1981). These stressors are often compounded on spouses of Hepatitis C (HCV) patients because of the stigma that the disease brings and because of the significant health deterioration accompanying its progression. Typical cases of hepatitis C are infections by HCV virus which often become chronic liver disease, cirrhosis or liver failure and this consequently place emotional and relational strain on spouses (Franciscus, 2016).

Prolonged caregiving of chronic illness is well recognized as a cause of psychological distress, and cases of Hepatitis C, in particular, with an uncertain disease trajectory and often deteriorative,

can be devastating. Caregiver may show anxiety and depression, physical symptoms (such as fatigue and insomnia) and cognitive disruptions (Lazarus & Folkman, 1984). Psychological distress already provides discouraging evidence of compromised normal functioning, with caregivers having less capacity to handle day to day duties and connection with their social environment (Ridner, 2004). Erim et al. (2010) noted that, the biological course of the disease and the consequent psychological burden the disease subjects the patients and their families to upsurge the risk for depression and anxiety. This emotional toll may also negatively impact caregivers' total mental health as well as their capability of creating positive matrimony dynamics.

Couples who live with chronic illness in the family are dependent on marital adjustment (harmony and satisfaction in the marriage), which is essential in their daily lives. These facets of this adjustment are consensus, affectional expression, satisfaction and cohesion all of which are tested under strain of long-term caregiving (Sinha & Mukerjee, 1990). We have used the Dyadic Adjustment Scale (DAS), which has been used in studies in which elevated caregiver distress has shown negative correlation with marital satisfaction, cohesion, and dyadic consensus (Spanier, 1976). As chronic illness contexts typically involve spousal distress, Fang, Manne, and Pape (2001) indicate that it is spousal distress that is often exacerbated by the patient's impairment level and negatively impacts marital satisfaction and adjustment in ill couples. As noted by Pereira, Dattilio, Canavarro, & Narciso (2011), assessing HCV spousal caregivers shows that they are distressed not only in response to the physical demands of the caregiving, but also to emotional strains such as fear of infection, social isolation and stigmatization and that this results in increased discord within the marital relationship.

Caring research on caregiver distress has emphasized that socioeconomic status and gender are important correlates of psychological distress and marital satisfaction. They also found that caregivers coming from low income households are often more distressed because these caregivers lack resource and speed networks. Misra et al. (2000) also mentioned that in low income settings, women, often times, take the role of the primary caregiver, which results in the finding that there are more reports from women than men of distress. In fact, female caregivers have much heightened concerns about the health and future of their family, and may strain marital relationships even more (Cleary & Mechanic, 1983), which would tend to lead to them being able to fall asleep. In line with the findings of Alavian et al. (2006) who showed that HCV patients' caregivers who were females were more dissatisfied in marriages and had higher levels of distress as result of the combined burden of caregiving and family responsibilities.

The progression of the HCV from acute to chronic stages and associated stages affect the caregiver mental health as advanced stages will cause higher psychological burden and causes an impact on marital adjustment. Since HCV is chronic, liver inflammation continues and with potential failure, requires increased caregiver involvement and adaptations over time (Ogilvie, 2015). Spouses experience increasing levels of distress as HCV advances, and this presents a negative impact upon their marital relationship (Machado et al., 2014, studies). For instance, Mueller (1994) points out stressed caring can be experienced by caregivers to patients with HCV, which demands relational support to the alleviate affects.

Caregivers identified mitigating factors against psychological distress in caregivers include effective spousal support. Previous studies have indicated it is dyadic cohesion and consensus in relationships that facilitate caregiver coping better, which in turn provides better psychological outcomes (Hashmi et al. 2007). Supportive communication and emotional bonding between marriage partners of HCV patients play an important role as an effective coping mechanism for stress created by caregiving (Sison, 1976). Marital support in buffering roles is critical especially in chronic illness situations where marital satisfaction is a predictor of individual and relational well-being.

Methodology

The first aims to investigate the relationship between psychological distress in spouses of Hepatitis C patients and marital adjustment using cross sectional quantitative research design. Among the population of interest are male and female spouses of patients diagnosed with Hepatitis C, particularly those from the Ayub Medical Complex and Combined Military Hospital in Abbottabad,

Pakistan. The goal of the study is to see if gender, socioeconomic status, and disease stage influence levels of psychological distress and marital adjustment, and these are measured on well-established psychometric scales.

The sample is 100 males (n = 50) and 100 females (n = 50) of Hepatitis C patients' spouses. Participants were recruited from two major hospitals: Abbottabad. The hospital was located in Combined Military Hospital and Ayub Medical Complex. A purposive sampling method was employed in sampling to be certain that each person sampled was a primary caregiver for a person diagnosed with Hepatitis C who would therefore experience the psychological and marital consequences of caregiving. The inclusion criteria required participants to be in a legal marriage to the patient, residing full time with them, and actively engaged in his or her caregiving. We recorded demographic variables (such as gender and socioeconomic status) and patient's disease stage (acute/chronic) to find out how they affect the levels of psychological distress and marital adjustment.

This study used the Kessler Psychological Distress Scale (K10) and Dyadic Adjustment Scale (DAS) to assess psychological distress and marital adjustment. The K10, a 10-item scale, measures general psychological distress with a 5-point Likert scale (1–5). Higher scores indicate greater distress, with Cronbach's alpha ranging from 0.42 to 0.74, depending on the population. The DAS, a 32-item scale, measures marital adjustment across four subscales: Consensus, Satisfaction, Cohesion, and Affectional Expression, with a Cronbach's alpha of 0.878. SPSS was used for data analysis, calculating means, standard deviations, and Pearson correlations. Cronbach's alpha for both scales indicated strong reliability (0.876 for K10, 0.878 for DAS). T-tests were used to explore differences in distress and adjustment by gender, socioeconomic status, and disease stage (acute vs. chronic).

This study was done with the permission of the Ethics Boards of Ayub Medical Complex and Combined Military Hospital, Abbottabad. Participants were told about what the study entailed (for example, its purpose and voluntary participation and right to withdraw at any time), and that they had this right. All data were kept completely protected by ensuring anonymity and confidentiality, secured from when collected to when analyzed; the research team was the only party allowed to gain access to the data. The results are anonymously reported in order to protect participant privacy.

Results

In the current research data of 200 spouses of diagnosed hepatitis c patients were analyzed. Three statistical methods (alpha coefficient, correlation and t-tests) are applied. The results of this analysis are given below:

Table 1

Frequency and percentages across demographics variables (N=200)

Variable	Males (n=92)	Females (n=108)
Economic Status		
Lower	59 (64.1%)	68 (62.9%)
Higher	33 (35.8%)	40 (37.0%)
Illness Stages		
Acute	35 (38%)	47 (43.5%)
Chronic	57 (61.95%)	61 (56.4%)

Table 1 shows distribution of sample on the basis of gender, economical status and illness stages. As shown in table percentage of lower and higher economical status (males; 64.1% and 35.8%) respectively and (females; 62.5% and 17.5%) respectively . similarly, percentage according to illness stages that is acute and chronic is (males; 88% and 68.9%) and (females; 43.5% and 63.4%) respectively.

Table 2

Reliability and Descriptive Statistics of Scales

Scale Name	No. of Items	Alpha Coefficient	Mean	Standard Deviation
KPDS	10	.876	3.231	.131
DAS	32	.878	3.298	1.496

The result in Table 2 clearly reveals that Kessler psychological distress scale (KPDS) and Dyadic adjustment scale (DAS) have excellent reliability values, which are 0.876 and 0.878 respectively.

Table 3

Correlation Coefficients and Gender Differences in Dyadic Consensus and Psychological Distress (N=200)

Variable	Males (n=92)	Females (n=108)	t(198)	p	95% CI	Correlation Coefficient
KPDS & DAS						-.539 p < .01
KPDS & Dyadic Consensus						-.282 p < .01
Dyadic Consensus (DC)	50.62 (6.814)	52.55 (6.252)	2.08	.03	LL = 3.75, UL = -0.103	

Note. KPDS = Kessler Psychological Distress Scale, DAS = Dyadic Adjustment Scale, DC = Dyadic Consensus. **p < .01**

Table 1 also reveals inverse relationships between ratio of the study subjects’ KPDS scores and DAS (-.539, p < .01) and Patient’s Dyadic Consensus (-.282, p < .01) implying that the higher the psychological distress the lower the degree of marital adjustment and poor agreement of spouses of the Hepatitis C patients. Also noted was gender – Dyadic Consensus corroborated earlier findings of female participants having higher consensus scores than their male counterparts (t(198) = 2.08, p = .03). That means female spouses enjoy a better relational compatibility than male spouses.

Mean, Standard Deviation, t-values, and Correlations by Economic Status, Illness Stage, and Psychological Distress (N=200)

Variable	Low Status (n=127)	High Status (n=73)	Acute (n=82)	Chronic (n=118)	t(198)	p	95% CI	Correlation Coefficient
Dyadic Consensus (DC)	49.83 (6.26)	54.85 (5.87)	53.56 (6.47)	50.34 (6.33)	5.58	0.00	LL = -6.79, UL = -3.24	
KPDS & DAS								-.539 p < .01
KPDS & Dyadic Consensus								-.282 p < .01

Note. KPDS = Kessler Psychological Distress Scale, DAS = Dyadic Adjustment Scale, DC = Dyadic Consensus. **p < .01**

The results painted in table 4 indicate that hypothesis 3 – dyadic consensus would have significant negative effect on psychological distress once the controls are exercised, was supported, partly. Dyadic consensus was significantly higher among relatives of patient with higher economic status (t(198) = 5.58, p < .01) and those with acute illness (t(198) = 3.50, p = .001) so it can assumed that better agreement of the spouses is related to both higher economic status and acute stage of illness. Also, low positive correlations were obtained between KPDS and DAS (-.539, p < .01) and low positive correlation was done between KPDS and Dyadic Consensus (-.282; p < .01) showing that high level of psychological distress is associated with poor marital adjustment and low consensus.

Discussion

The purpose of this study was to investigate relationships between psychological distress and marital adjustment among spouses of Hepatitis C patients, and to examine the impact of gender, socioeconomic status and stage of disease. The results show important correlations between these factors and underscore the complexity of caregiving roles in chronic illness contexts. For each outcome, the result is discussed in light of the hypotheses of the study and comparisons are made to extant literature, and with regard to its implications for caregiving support. One major objective was

to investigate the relationship of psychological distress among spouses of Hepatitis C patients to marital adjustment. The first hypothesis stated that a negative relationship exists between marital adjustment (DAS) and psychological distress ($P = K10$). And as shown in Table 3, there was a significant negative correlation between psychological distress and marital adjustment. Consistent with previous research that greater psychological distress in caregivers is frequently related to lower levels of marital satisfaction, cohesion and consensus (Spanier, 1976; Fang, Manne and Pape, 2001), this finding reflects that a greater percentage of children with ASD caregivers is associated with lower marital satisfaction, as well as lower levels of marital cohesion and found consensus. The data is consistent with the notion that caregiving for chronic illness, especially Hepatitis C, drains the emotional bank account of care, impacting both marital quality and satisfaction.

This result calls for directed efforts to aid caregivers' mental health. The use of marital counselling, stress management and psychological support services may help to help caregivers keep a good mental state which in turn will improve marital relationships.

Hypothesis 2 was that there was a negative correlation between psychological distress and dyadic consensus. The moderate negative correlation that the variables show in Table 4 indicates that as one variable increases, the other decreases. As distress increases in the marriage, the ability to come to mutual agreement and maintain harmony on marital matters decreases. Consistent with research stressing the potential that psychological stress can injure marital dynamics by heightening the possibility of disagreements and lack of communication (Hashmi, Khurshid, & Hassan, 2007), this result is obtained.

This finding is of high importance because it shows that, indeed, emotional burden of caregivers does have a negative impact on personal health, but also expands such effect to the marital bond by worsening cooperation and congruence in decision making. Communication focused support to caregiver couples may enhance dyadic consensus and help attenuate some of the effects previously mentioned.

Hypotheses 3 and 4 predicted that female caregivers report higher psychological distress and lower dyadic consensus than male caregivers. Table 5 agrees with the former findings that female spouses scored significantly lower on dyadic consensus and reported more distress. Such is consistent with previous literature that indicates women, in the traditional roles of primary caregiver, often endure greater psychological burden from their traditional caregiver roles and socio-cultural expectations for caregivers (Cleary & Mechanic, 1983, Misra et al., 2000). These emotional and physical demands upon female caregivers are related to diminish marital quality in the form of more difficulty achieving marital consensus and satisfaction among female caregivers.

This finding has implications for the need of gender sensitive support systems, especially in contexts where caregiving roles disproportionately may fall on women. This relative abstract could be reduced by providing additional psychological resources for female caregivers and the spread of caregiving responsibilities between families.

Hypotheses 5 and 6 hypothesized that the caregivers from lower level of socioeconomic backgrounds would have higher psychological distress and lower marital adjustment than caregivers from higher level of socioeconomic backgrounds. This is strongly supported by their results in table 6, which indicate spouses in lower income groups to have significantly higher distress and lower marital adjustment than the other groups. The results reported here are consistent with studies showing that constrained economic resources exacerbate caregiver stress by diminishing healthcare, mental health and support network access (Caron & Liu, 2011). Financial strain can further upset relationships, and along with this can contribute to marital discord and marital dissatisfaction (Alavian et al., 2006).

Practice and policy implications address the unique needs of economically disadvantaged caregivers. The accessible and affordable services of psychological services, financial counselling and marital support programs may reduce the cumulative stress among low income caregivers who will in turn improve both the caregivers and marital relationships.

Hypothesis 7 and 8 proposed that caregivers of patients in the chronic stage of Hepatitis C (Hep C) would demonstrate greater psychological distress and less positive marital adjustment than

caregivers of patients in the acute stage of Hepatitis C (Hep C). Table 7 provides support for these hypotheses and shows that caregivers of patients in the chronic phase report significantly greater distress and lower marital adjustment. As with research which indicates, the longer and more severe the caregiving role, the more likely the emotional toll onto the caregiver (Ogilvie, 2015). Emotionally and physically, chronic illness is often 'rampant', presenting on-going care demands and escalating emotional and physical demands that subsequently take their toll on both the personal well-being and the quality of marriage (Machado et al., 2014).

This result emphasizes the need for on-going support for caregivers as the disease progresses. Consequently, psycho social interventions, caregiver training, and regular respite care could form part of healthcare service utilization to facilitate caregivers move to stage changes in chronic illness, thereby sustaining marriage, and basis of caregiver mental and general health.

Conclusion and Implications

Study findings provide a nuanced view of the psychological and relational challenges spouses of somebody with Hepatitis C face. The finding of a negative correlation between psychological distress and marital adjustment reinforces the hypothesis that improving caregiver well-being will ultimately help to create healthier marital dynamics. Caregiver experience is strongly influenced by gender, socioeconomic status, and disease stage, and they need to be addressed in any intervention. Healthcare providers can take an active part by providing mental health services, economic support and marital counselling so as to lighten caregiver stress and support marital harmony.

Taken together these findings contribute to our knowledge of caring for chronic illness more generally, with policy and clinical practice implications. Additional research may be driven by longitudinal designs to answer questions regarding how marital adjustment and psychological distress change and adapt over the time course of caregiving, suggesting a more dynamic and adaptive support framework for the caregiver within similar chronic illness contexts.

Limitations

Study findings provide a nuanced view of the psychological and relational challenges spouses of somebody with Hepatitis C face. The finding of a negative correlation between psychological distress and marital adjustment reinforces the hypothesis that improving caregiver well-being will ultimately help to create healthier marital dynamics. Caregiver experience is strongly influenced by gender, socioeconomic status, and disease stage, and they need to be addressed in any intervention. Healthcare providers can really influence the relieving of a caregiver stress by offering mental health services, economic support and marital counselling.

Taken together these findings contribute to our knowledge of caring for chronic illness more generally, with policy and clinical practice implications. Additional research may be driven by longitudinal designs to answer questions regarding how marital adjustment and psychological distress change and adapt over the time course of caregiving, suggesting a more dynamic and adaptive support framework for the caregiver within similar chronic illness contexts.

References

- Alavian, S. M., Kachuee, A., Lankarani, K. B., Assari, S., & Farmanara, A. (2006). Marital adjustment in Iranian patients with chronic hepatitis. *Middle East Journal of Digestive Diseases*, 18(4), 45-52.
- Caron, J., & Liu, A. (2011). A descriptive study of the quality of life of community-dwelling individuals with severe mental disorders. *Quality of Life Research*, 20(5), 823-832. <https://doi.org/10.1007/s11136-010-9820-6>
- Cleary, P. D., & Mechanic, D. (1983). Sex differences in psychological distress among married people. *Journal of Health and Social Behavior*, 24(2), 111-121. <https://doi.org/10.2307/2136633>
- Erim, Y., Tagay, S., Beckmann, M., Bein, S., Cicinnati, V. R., Beckebaum, S., & Senf, W. (2010). Depression and protective factors of mental health in people with hepatitis C: A cross-sectional study. *Journal of Psychosomatic Research*, 68(5), 487-490. <https://doi.org/10.1016/j.jpsychores.2009.10.011>

- Fang, C. Y., Manne, S. L., & Pape, S. J. (2001). Functional impairment, marital satisfaction, and psychological distress in spouses of older adults with cancer. *Health Psychology, 20*(6), 453-457. <https://doi.org/10.1037/0278-6133.20.6.453>
- Franciscus, A. (2016). *Hepatitis C support project: HCV basics*. Hepatitis C Support Project.
- Hashmi, H. A., Khurshid, M., & Hassan, I. (2007). Marital adjustment, stress, and depression among working and non-working married women. *Pakistan Journal of Psychology, 38*(2), 43-60.
- Kanner, A. D., Coyne, J. C., Schafer, C., & Lazarus, R. S. (1981). Comparison of two modes of stress measurement: Daily hassles and uplifts versus major life events. *Journal of Behavioral Medicine, 4*(1), 1-39. <https://doi.org/10.1007/BF00844845>
- Kessler, R. C., & Mroczek, D. (1994). Final versions of our non-specific psychological distress scale. *University of Michigan, Ann Arbor*.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer Publishing.
- Machado, A. A., Silva, A. L., Torres, L. D., & Cerqueira, M. L. (2014). Quality of life and psychological well-being of hepatitis C patients: A cross-sectional study. *Journal of Clinical Psychology in Medical Settings, 21*(1), 47-55. <https://doi.org/10.1007/s10880-013-9377-3>
- Misra, R., McKean, M., West, S., & Russo, T. (2000). Academic stress of college students: Comparison of student and faculty perceptions. *College Student Journal, 34*(2), 236-246.
- Mueller, P. S. (1994). End-stage liver disease and liver transplantation. *Liver Transplantation and Surgery, 1*(1), 19-27. <https://doi.org/10.1002/lt.500010105>
- Ogilvie, A. (2015). Chronic hepatitis C and health-related quality of life: Understanding the patient perspective. *Journal of Clinical Nursing, 24*(1-2), 87-98. <https://doi.org/10.1111/jocn.12623>
- Pereira, M. G., Dattilio, F. M., Canavarro, M. C., & Narciso, I. (2011). Psychological intervention with couples dealing with chronic illness: A case study. *Journal of Family Psychotherapy, 22*(4), 309-321. <https://doi.org/10.1080/08975353.2011.627066>
- Ridner, S. H. (2004). Psychological distress: Concept analysis. *Journal of Advanced Nursing, 45*(5), 536-545. <https://doi.org/10.1046/j.1365-2648.2003.02938.x>
- Sinha, S. P., & Mukerjee, N. (1990). Marital adjustment and subjective well-being in Indian educated housewives and working women. *Journal of Psychology, 124*(6), 701-708. <https://doi.org/10.1080/00223980.1990.10543261>
- Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and Family, 38*(1), 15-28. <https://doi.org/10.2307/350547>