

**Psycho-Social Determinants of Depression among  
Spouse-Caregivers of Male Patients:  
A Comparative  
Study of Single and Poly-Substance Use Disorders**

A Dissertation Submitted

To

**Sikkim University**



In Partial Fulfilment of the Requirement for the

**Degree of Master of Philosophy**

By

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**December 2019**

## **CERTIFICATE**

This is to certify that the dissertation entitled “**Psycho-social Determinants of Depression among Spouse-Caregivers of Male Patients: A Comparative Study of Single and Poly-Substance Use Disorder**” submitted by **Ms. Kuwari Barua** (Roll No. 18MPPS01 and Reg. No. 18/M.Phil/PSY/01) in partial fulfilment of the requirement for the award of M.Phil. Degree in Psychology of Sikkim University has not been previously submitted for the award of any degree/diploma of this or any other University and it is her original work. She has been working under my supervision.

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## **DECLARATION**

The work embodied in the dissertation entitled “**Psycho-social Determinants of Depression among Spouse-Caregivers of Male Patients: A Comparative Study of Single and Poly-Substance Use Disorder**” was conducted at the Department of Psychology under School of Human Sciences, Sikkim University, in partial fulfilment of the required for the award of M.Phil degree of Sikkim University. The work has not been submitted in part or full to this or any other university or institution, for any degree or diploma.

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**“PSYCHO-SOCIAL DETERMINANTS OF DEPRESSION AMONG SPOUSE-CAREGIVERS OF MALE PATIENTS: A COMPARATIVE STUDY OF SINGLE AND POLY-SUBSTANCE USE DISORDER”**

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## **ACKNOWLEDGEMENTS**

First and foremost, I am very much thankful and grateful to the Almighty for his mercies and blessings he showed to me till now. I would like to thank my family for being encouraging and supportive in my studies.

And then I would like to express my gratitude to my supervisor, Dr. Satyananda Panda, Associate Professor & Head, who gave me the wonderful opportunity to work under his supervision. He helped me in deciding this topic which had not been studied before. So, I am really blessed for I got such a nice opportunity to do a small study in this topic. This work would not have been possible without his guidance and support. I am really grateful to him for his continuous support and valuable time which he spent on my work to help me. He continuously inspired me to work hard with dedication for my dissertation. So, it has huge scope for its research and application. His encouragement and faith on my abilities have motivated me to complete this dissertation.

I would like to thank Guwahati Medical College and Hospital, GNRC Hospital, Serenity Foundation, Medicity Hospital, Borthakur Clinic and Critical Care Hospital and Al Anol Family Group who gave me permission to collect data from their institutes for my dissertation and helped me in completing my dissertation.

Last but not the least, I would like to give my big thanks to all my friends who have helped me and contributed in completing my work and have been supportive towards my work. My thinking and experience have broadened and increased to a big extent after doing such a hard work and I am satisfied with my work.

**(Kuwari Barua)**

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## CHAPTER I

### INTRODUCTION

In India, families have been the centerpiece of caregiving for persons with mental illnesses, also in most of the nonwestern world, and to a lesser degree in other parts of the world. The family caregivers are involved in the day-to-day activities of the patients, starting from monitoring the mental state, identifying the early signs of illness, relapse and deterioration, and helping the patient in accessing services. The family caregiver also supervises treatment, and provides emotional support to the patient. Families are significantly affected by the responsibility of their caregiving function (Chadda, 2014).

Substance abuse is the harmful use of psychoactive substances that affects a person's brain and behavior, including alcohol and illicit drugs and leads to an inability to control the use of a legal or illegal drug or medication. The psychoactive substances can cause dependence syndrome. It is a group of cognitive, physiological and behavioral phenomena that develop after repeated substance use and usually includes difficulties in controlling its use, a strong desire to take the drug continuing its use despite harmful consequences. A higher priority is given to drug use than to other activities and obligations and increased tolerance, and sometimes a physical withdrawal state is observed (Raphael, Raveendran & Vijayan, 2017).

Symptoms of drug addiction or behaviors include:

- Feeling of having to use the drug regularly - daily or even several times a day
- Blocking out of thoughts due to having intense urges for the drug

- In need of more drug to get over the same effect over
- Increasing the amounts of the drug over a longer period of time than you intended
- Maintaining a regular supply of the drug
- Even if one can't afford it, spending a large amount of money.
- Cutting back on social or recreational activities because of drug use or not meeting obligations and work responsibilities.
- Even though one knows, still continuing to use the drug, even it's causing problems in your life or causing you physical or psychological harm
- Doing things which otherwise one would not do, such as stealing
- Driving or doing other risky activities under the influence of the drug
- Using the drug or spending a good deal of time getting the drug, failing in your attempts to stop using the drug
- When an attempt to stop taking the drug, experiencing withdrawal symptoms.

The drug abuse or drug addiction results in drug dependence and a sort of urge or craving for more and more drugs are created. The number of drug addicts throughout the world is high and has thereby posed a great threat to humanity. The drug dependence has numerous consequences which can hardly be measured by a naked eye and its far-reaching significant effect is in almost every sphere of the addict's life (Adinoff, 2004). People may sometimes use only a particular type of drug or sometimes more than one drug. Poly-substance abuse or multiple substance abuse is the abuse or use of more than one drug like alcohol, cocaine, marijuana/hashish, other opioids, tranquilizers, methamphetamine/amphetamine, etc. (Degenhardt, Stockings, Strang, Marsden & Hall, 2016).

Research has consistently underlined the importance of caregivers in psychiatric disorders. With the emergence of de-institutionalization and the practice of community psychiatry, families are often integral parts of the treatment team (Dagaonkar et al., 2013). Srinivasan and Thara (2001) observed that in India, the majority of the patients live with their families. The assessment of burden has thus become particularly relevant and research shows that key family caregivers in India have a significant burden, are distressed and receive little social support.

Almost all aspects of family life are affected by a substance-dependent person. Within the family, in the role of a wife who is most affected by the individual's substance use, and a significant part of the family burden has to be experienced by the wife. In a developing country like India, such an impact becomes even more obvious, where women are already disadvantaged. It was concluded that the greatest burden was economically followed by stigmatization, emotional and relationship difficulties, and neglect of children. Domestic violence, crime, increased trafficking, and risk of HIV was recognized as possible outcomes of individual drug use. One of the major burdens the wives faced was the burden of blame – blame for the drug use in the family member, blame for hiding the issue from others and blame for not getting timely treatment. Thus, the wife often became the victim of not just the drug abuser but also the society. Drug abuse magnifies violence within marital relationships. Most women suffer abuse silently, responding with humiliation, frustration, helplessness, and suicidal thoughts. Shame and embarrassment caused many women to build “a wall of silence” around her, thus increasing isolation and helplessness in the situation (Sharma, Sharma, Gupta & Thapar, 2019).

Spouses of patients with substance-related disorders, a key member of such a dysfunctional family system, are most vulnerable to have significant psychiatric disorders such as adjustment disorders, mood disorders, anxiety disorders, and psychosocial problems. The spouse-caregiver often suffers from severe mental and emotional drain, feels utterly defeated, and has feelings of anxiety, resentment, and anger, with stress being cumulative over time. A study of unresolved grief in families of persons with severe mental illness found that levels of grief increased over time (Iseselo, Kajula & Yahya-Malima, 2016).

### **1.1 Burden in Caregivers**

Over the past few decades, families of persons with severe and persistent mental illness have increasingly assumed caregiving responsibilities for their adult family members. The family caregiving burden of persons with severe mental illness includes financial responsibilities, missed work, disturbance of domestic routines, constraints on social and leisure activities, and reduced attention to other family members. The financial strain due to medical costs and the patient's economic dependency are considerable. Often family members forego work outside the home to provide care for the person with mental illness.

The caregiver burden may be outlined because the strain or load is borne by an individual who cares for an unwell, disabled, or elderly family member (Stucki & Mulvey, 2000). It is a four-dimensional response to physical, psychological, emotional, social, and financial stressors associated with the caregiving experience.

The caregiver burden has been described as both observable and subjective. The objective burden is associated degree discernible, concrete, and tangible cost to the caregiver for taking care of the recipient. Subjective burden refers to the perceived costs, such as the extent to which the caregiver is bothered by performing these tasks and the positive or negative feelings experienced while giving care (Jones, 1996). The caregiver's perception of the burden, instead of the perception of different relations or attention suppliers, determines the impact on his or her life. The level of perceived burden has been correlated with higher risks of depression and lower quality of life for caregivers (Aronson, 1997).

The gradual process of losing a relative to a terminal illness is well recognized as a stressful and difficult period for families. When a family member is also providing daily care for the terminally ill relative, the process can be additionally taxing—with potential adverse emotional and physical health effects on caregivers. Caregivers face particular strains, both in managing high levels of care and facing the loss of a relative (Miyasaki, 2013).

Wives, husbands, daughters, and sons approach the exercise of caregiving in various ways (Given, Given & Sherwood, 2012). Spousal caregivers of older cancer patients have been shown to be at high risk for caregiver burden because they live with the patient, provide the most extensive and comprehensive care, maintain their role longer, often assume other household tasks, and tolerate greater levels of patient disability (Bevans & Sternberg, 2012). Perceived family conflict, withdrawal, changes in family dynamics, and loss of intimate exchange with the cancer patient may be associated with a range of negative psychosocial patient outcomes, as well as with caregiver burden. Relationships

that are less mutually satisfying among caregivers, caregivers' usual activities may be restricted by patient needs, which in turn may increase caregiver burden and resentment (Schulz & Eden, 2016). In recent years, the misuse, abuse, and dependence of prescription drugs has become a growing public health concern.

The caregiver burden is defined as persistent hardship, stress, or negative experiences resulting from the provision of care by the caregiver. The caregiver burden is strongly related to sleep disturbances and depressive symptoms. It was reported that caregiver burden is negatively related to health-related quality of life, particularly mental health (Ejem, Bauldry, Bakitas & Drentea, 2018).

The caregiver burden increases with patients becoming increasingly dependent and requiring full-time care (Fox et al., 2016). According to Coelho and his colleagues (2015), the mean time spent per week providing informal caregiving is 5 days (24 h/day). This large amount of time spent caring has a strong impact on the life and healthcare of caregivers, themselves often elderly or ill, and often causes of diminished socialization and increased isolation, not only from friends but also from their children and extended family who are often unaware of the gradual increase in caregiving responsibilities. Some caregivers express guilt for feeling overloaded (Coelho et al., 2015).

## **1.2 Social Support in Caregivers**

Persons with severe mental illness require help and support to an increasing extent from a family member who takes on the caregiving role. If the patient lives with the family, the support the caregiver receives may be affected (Reinhard, Given, Petlick, & Bemis, 2008).

Social support is one area of study that is important in all situations of caregiving which may enhance understanding of caregiving. It plays a significant role in the caregivers' effective management of the burden and any related stress the caregivers may feel (Fink, 1995). It has been a focus of extensive research across a range of areas. Social supports have been defined as a multidimensional construct consisting of the supply of informational, emotional, and tangible aid (Norbeck, Lindsay, & Carrieri, 1981). Research has revealed that support builds a difference in how people deal with stressful circumstances, even if those support merely offer assistance for their own coping efforts (Thoits, 1986).

However, because of the stigma attached to psychiatric illnesses and the general lack of understanding of the cause, treatment, and prognosis caregivers may have difficulty obtaining support, Social support may play a more predominant role when individuals are exposed to particularly stressful circumstances or numbers of stressful events. This stress by support interaction would result in a stronger association between support and distress for individuals experiencing higher levels of stress ( Iseselo, Kajula, & Yahya-Malima, 2016).

Families are an important source of social support to persons with co-occurring substance abuse and mental disorder (Biegel, Ishler, Katz & Johnson, 2007). The effect on their families can be expected to be greater than that on families with a member with a single disorder due to the significantly worse pathology with which individuals with a co-occurring substance abuse disorder present and to the nature of these (Drake & Mueser, 1996).

Studies have shown that social support can alleviate caregiver stress and increase coping; though, social support may not always result in a positive result for the recipient. The availability of social support and network is important as it provides both instrumental and emotional support to caregivers. Caregivers with less social networks and low satisfaction with the support they received were reported to have a significantly higher burden than caregivers with stronger social ties. The extent of caregivers' available social support and network served as the most important stress mediator (Ang & Malhotra, 2018). According to Brodaty and Donkin (2009), the extent of burden reported by primary caregivers of persons with dementia was not related to the behaviour problems caused by the illness but was associated with the social support available, specifically the number of visitors to the household.

The concept of social support as a buffer against stress in crisis situations is not new. Positive social support has been demonstrated to enhance adaptation to illness, whereas negative social support may result in the exacerbation of patient or caregiver outcomes such as depression and psychosocial distress. Positive social support comprises either instrumental or emotional or both. The relative importance of one type of support over the other may vary over the course of illness (Choo, Low, Karina & Poi, 2003). For example, instrumental support may be particularly helpful during the acute phases of some chronic illnesses, when symptoms may limit individuals' abilities to perform daily tasks on their own while for some other people, ongoing disability may require ongoing compensatory assistance. There may be times, however, when emotional support may be equally important, or more important, than instrumental help (Allen, Goldscheider & Ciambrone, 1999). In some situations, particularly when illness and disability isolate the



individual from the mainstream, the need for emotional support may be constant.

Caregivers who have greater emotional and social support usually report low levels of depression and high levels of life satisfaction. In addition, caregivers who are actively engaged in social and recreational activities, such as church attendance or visiting with family members and friends, also adapt to care-giving with less depression than those who are more socially isolated (Goodhead & McDonald, 2007).

Knowing that others are available when needed to help manage stressors or difficulties may sustain or bolster an individual's sense of control over particular stressful or difficult situations that occur (Thoits, 1995). Subsequently, a sense of control concerning one's ability to handle particular situations may protect or promote psychological or emotional well-being. Believing that support will be available when needed (for example, perceived social support) can act as a buffer of the negative effects of stress on psychological well-being (Ozbay et al., 2007).

### **1.3 Depression in Caregivers**

One of the most important potential adverse consequences for caregivers is depression because it is a risk factor for adverse outcomes including functional decline and mortality and is common, associated with poor quality of life. Previous work suggests depression in caregivers results from a complex interplay of factors that includes characteristics of the patient and caregiver, as well as cultural factors (Covinsky et al., 2003). Evidence from previous work suggests that caregiver depression is influenced by difficult patient behaviors such as anger and aggressiveness (Lavretsky, 2005). Several studies suggest that caregivers with poorer health, or fewer financial resources, are at higher risk for

depression. Some evidence also suggests that women and spousal caregivers are at higher risk for depression. Caregivers themselves report facing more stress, psychological problems, physical health problems, social isolation, and family conflicts than do persons who are not caregivers. Caregivers who are highly stressed are more likely to cause depression, abuse or neglect, and institutionalization of care recipients. This may be a direct consequence of caregivers' anger, inability to cope, care recipient's behavioral disturbance, lack of emotional support and social isolation (Penning & Wu, 2016).

While caregivers as a group show negative effects of caregiving stress, there are also important individual differences in caregiver reactions. Severe depression and low morale are experienced by some caregivers, while in spite of facing severe stress; others manage to stay away from these problems. Additional demographic, health and social factors have been explored as risk factors for caregiving depression (Glajchen, 2012). Prior researchers have identified some of the potential risk factors such as female gender, caregivers in poor health, and family conflict. Subjective appraisal, or how caregivers subjectively perceive their caregiving duties, has also been identified as important in research on cancer and dementia caregiving (Lavretsky, 2005).

In the presence of dependence, the whole family structure can be shaken, however, the family members suffer varying degrees of closeness and distancing, faced with the negative impacts of this behavior (Macron, Rubira, Espinosa, & Barbosa, 2012).

Commonly in the family, a member assumes the role of caregiver, being the person most directly linked to the care and/or emotionally to person dependent on the drug, a condition that not only directly affects their quality of life, but also predisposes them to the emergence of depressive symptoms (Robinson, Rodgers, & Butterworth, 2008).

The extent of depression related to caregiving is believed to be quite significant across a wide range of populations and environments. Although there has been an extensive amount of research studies of caregivers of persons with Alzheimer's disease indicating significant levels of depression among these caregivers (Neundorfer et al., 2001), there has been less research examining caregiver depression in the mental health and substance abuse fields. Studies of caregivers of persons with dementia have reported greater proportions of depressed caregivers than would be expected in the general population. These caregivers are at high risk for developing depression and depression-related problems associated with their caregiving role (Alfakhri et al., 2018).

Overall, research has shown that caregivers are more likely to be depressed if they appraised caregiving tasks as stressful, felt less self-efficacy, felt less satisfaction from their role as caregiver, or they found little meaning in their role as caregiver. Less distress is also typically found in caregivers with larger social networks, higher perceived satisfaction with support, and increased participation in social activities (Noonan & Sharon, 1997). Despite the growing body of literature suggesting that caregivers are at heightened risk of adverse mental and physical health effects, limited theoretical research has focused on family caregivers providing such care to relatives who are terminally ill. It is imperative to identify predictors of caregiver well-being within hospice settings and to develop theoretical models of the caregiver stress process that can guide conceptually and empirically based psychosocial intervention.

In summary, research in mental illness and dual disorders provides evidence that family members' stressors can negatively affect family members' well-being. However, little attention has been given to the effect of women's co-occurring mental disorders and

women's personal social networks on family caregiver depressive symptomatology. Family caregivers who are stressed by the caregiving experience and who subsequently develop physical and/or mental health problems of their own may not be able to provide adequate support and assistance to their ill family members. Unmet family caregiver needs can therefore negatively affect the caregiver and the care recipient (Chang et al., 2016).

The family is the primary source of attachment, socialization and nurturing for humans in our current society. Therefore, the impact of substance use disorders (SUDs) on the family and individual family members' needs attention. Each family and each family member are uniquely affected by the individual using substances including but not limited to having unmet developmental needs, impaired attachment, economic hardship, legal problems, emotional distress, and sometimes violence being performed against him or her (Lander, Howsare, & Byrne, 2013). For children, there is also an increased risk of developing a SUD themselves (Zimic & Jakic, 2012). Thus, treating only the individual with the active disease of addiction is limited in terms of effectiveness. The social work profession more than any other health care professional has historically recognized the importance of assessing the individual in the context of his or her family environment. Social work education and training emphasize the significant impact the environment has on the individual and vice versa.

#### **1.4 Operational Definition**

**Burden-** Burden is described as a problem or a responsibility as a burden, meaning that it causes someone a lot of difficulties, worry or hard.

**Substance abuse** - Substance Abuse is characterized by repeated use of a substance or substances in situations where use leads to markedly negative outcomes.

**Single substance use**- Single substance use is the consumption of only a single substance.

**Poly-substance abuse**- Poly-substance use or abuse is the consumption of more than one substance over a period of at least 12 months.

**Perceived social support**-Perceived social support is the impression that one is cared for, has support available from other people.

**Depression**- Depression is a mood disorder characterized by persistently low mood and a sense of disappointment and loss of interest. 350 million people are affected by depression, globally.

**Spouse-caregivers**- Family members (wife or husband) of the patient living with the patient for at least 12 months and primarily take active responsibility for meeting the patients' needs.

## CHAPTER II

### REVIEW OF RELATED LITERATURE

The term 'review' means to organize the knowledge of the specific areas of research in order to evolve an edifice of knowledge to show that the study should be an addition to existing. It is very essential for a researcher in any field of knowledge human knowledge to know complete and thorough information on the work done in her country and abroad in the specific area of her research. This acquaints her with up-to-date knowledge and techniques relevant to her work. It develops her insight into the problem and saves her from unnecessary trial and error. The review of literature serves a variety of purposes in research and assures familiarity with both, previous theory and research to the investigator. In short, we can say that the review of related literature serves a few major functions:

- i) It provides the conceptual framework of reference for contemplated research
- ii) It provides an understanding of the status of research in the problem area.
- iii) It offers an estimate of the likelihood of success of contemplated studies and the implication or worth of the findings and predictions of the choices made to go on with.

The literature refers to the knowledge of a particular area of investigation in any discipline which includes theoretical, practical and research studies. The investigators constantly go on adding to the vast stores of knowledge with the result that it makes possible the progress in all areas of human endeavor. The review of the literature reveals

what problems have already been investigated, what questions have been answered, what issues still remain to be subjected to research.

According to Tuckman (1978), the reference to the relevant literature helps the research in:

- a) Discovering important variables in the field of the study.
- b) Distinguishing what has been done from what needs to be done, and
- c) Formulating the hypothesis.

In fact, research begins with some original ideas and concepts that are interrelated through an anticipated relationship called the hypotheses. These expectations are tested by collecting the relevant data and the results based on these data are interpreted and extended by converting them into new concepts. The literature has widely discussed the collective and/or individual consequences of drug dependence on society, where collectively the family is the first to be affected in their functional and organizational dynamics. Thus, studies have provided information regarding the problems faced by the families of drug-dependent people, faced with situations generated by the use, causing disagreement and fragilization in interpersonal relationships.

## **2.1 Researches on Burden in Caregivers**

Figlie, Fontes, Mores and Paya (2004) in their study with family members of drug-dependent people showed an increase in the risk of the emergence of mental disorders in

58.0% of the spouses, and a greater frequency of physical assaults, deaths of family members and involvement with the police in those homes.

Perlick et al. (2008) conducted a study on 500 primary caregivers of patients with bipolar disorder to identify caregivers at risk for adverse health effects associated with caregiving, stress, coping, health and service use. It was found that burden was high in burdened caregivers and avoidance coping levels, and lower mastery and social support were present in burdened caregivers than effective and stigmatized caregivers.

Stigmatized caregivers reported the highest perceived stigma. Better health outcomes were seen in effective and stigmatized groups and less service use than the burdened group over time and poor self-care was observed in stigmatized than effective caregivers.

Macron et al. (2012) carried out a cross-sectional study of 109 caregivers. Of 109 caregivers, 55.9% were mothers, 23.8% had depressive symptoms. The more common factors found were emotional aspects, vitality, pain and mental health. A significant correlation in quality of life, depression, and stress of caregivers was seen. According to findings, stress is high in caregivers and that quality of life is compromised, highlighting the need for providing emotional support.

Mattoo et al. (2013) conducted a study with ICD-10 diagnosed substance dependence subjects and their families using family burden interview schedules on 120 men with alcohol and/or opioid dependence. It was found more often the alcohol dependence opioid and alcohol + opioid dependence group had a wife as a caregiver and were older, married, currently working, and having a higher income. The family burden was found to be moderate or severe in 95-100 percent of cases. The family burden was found to be



associated with low income and rural location. There was no relation with age, knowledge or length of the dependence of the patients, or with family size, kind of caregiver or caregiver's schooling and employment. Almost all caregivers reported a moderate or severe burden, which indicated the gravity of the situation.

Subodh et al. (2014) studied interpersonal violence (IPV) against wives by substance-dependent men. Of the 267 wives, the prevalence rates for IPV were: 55% for the whole sample, 63.19% for alcohol dependence and 42.33% for opioid dependence. IPV was found to be associated with a higher age of husband, lower education or unemployment of spouse, nuclear family structure and lower-income of family. The research suggests that compared to opioid dependence IPV against wives is highly prevalent among substance-dependent men with alcohol dependence.

Kronenberg et al. (2015) examined the possible differences in correlations between caregiver burden and expressed emotion (EE) across patient groups in informal caregivers for patients with SUD, SUD+ADHD or SUD+ASD. When caregivers for patients with SUD were compared to caregivers for patients with SUD+ADHD, no differences in caregiver burden or expressed emotion. A non-significant moderate difference was seen in caregivers of patients with SUD versus SUD+ASD. When the number of contact hours between patients and caregivers for the SUD only group was controlled for, it disappeared. Informal caregivers for patients with only SUD are evidence for high levels of burden and EE than informal caregivers for patients with SUD and a co-occurring ASD.

Sarkar, Patra, and Kattimani (2016) conducted a narrative analysis of the inter-relationship between substance use disorder and the family. The study suggests domestic violence and adverse familial circumstances, both often arise as a consequence of substance use. Even though the spouses of substance abusers reported better rates of grief and psychopathology, children of patients with substance user disorders display a higher degree of behavioral disturbances. Codependences often build up in the familial relationship, which is responsible for the substance use disorder. Substance use places pretty a burden on the family, both psychologically as well as in terms of resources. However, family members offer inspiration, emotional support, and practical assistance during the management of substance use disorders and hence need to be engaged in the therapeutic course. Finally, the changing family arrangement and family dynamics in India might control the burden in the future, on both the consequences of substance use disorder on the family and the familial resource accessible for treatment.

Vaishnavi et al. (2017) assessed the pattern of the burden on the caregivers of alcohol-dependent patients and the relationship between the severity of dependence and the burden on caregivers of 200 patients with alcohol dependence. The caregivers of alcohol-dependent patients reported a significant objective burden and subjective burden. In addition, the severity of alcohol dependence and the sphere of burdens such as financial burden, disturbance of family interaction, and commotion of family routine activities were positively linked with a high level of significance.

Shekhawat, Jain, and Solanki (2017) conducted a study to assess and compare the level of burden on wives of alcohol and heroin-dependent patients and also to determine the

correlation between sociodemographic factors and caregiver burden using burden assessment schedule. Wives of both alcohol and heroin-dependent patients were found to have the moderate-to-high burden of caregiving, those of heroin-dependent patients perceived more burden in the factors of impact on the marital relationship, appreciation of caregiving, impact on the relation with others, and overall burden as compared to wives of alcohol-dependent patients. Also, a significant negative correlation was found between the impact on the marital relationship, appreciation of caregiving, and impact on the relation with others and patients' education status as well as between appreciation of caregiving score and wives' age.

Kaur et al. (2018) conducted a cross-sectional study on 349 caregivers of substance abusers using pretested and semi-structured questionnaires. 44.69% of caregivers were wives and none were trained in caregiving professionally. 37.53% provided family care while emotional support to the patients was provided by only 10% women and 2% men, no gender-specific association with emotional support was found to be significant. 54.15% of caregivers developed stress while caregiving, 12.60% were found to face social and financial problems. Quality of life is found to be compromised and stress is found high among caregivers, stressing the need for establishing emotional support.

Swaroopachary et al. (2018) compared the amount of burden among caregivers with the severity of alcohol dependence in patients. Family Burden Interview Schedule was administered to assess the burden experienced by them. The severe burden was more seen in females, most were unemployed and domestic violence was present in families.

Therefore, it was concluded that more severe is the dependence, more is the amount of burden experienced by the caregivers.

Sharma et al. (2019) evaluated family burden perceived by primary caretakers of individuals with substance dependence. 150 individuals and primary caretakers attending psychiatry OPD and emergency were included in the study. The majority of caretakers experienced a moderate objective burden (65.3%) and severe subjective burden (74%). The objective burden was more in areas of financial burden and disruption of routine activities. A significant relationship was found between objective burden and monthly family income, monthly expenses on substance, number and type of substances, treatment history, sex and type of caretaker. The subjective burden was dependent on sex and type of caretaker and treatment history of the patient. It was concluded that substance dependence is associated with a substantial burden for family members, more for subjective and objective burden in families with low income and with patients who are dependent on more substances and had taken treatment in the past. A higher proportion of severe burden was reported by female caretakers.

## **2.2 Researches on Social Support among Caregivers**

Clark and Drake (1994) collected data from families of 169 people with co-occurring mental illness and substance abuse indicates that they give a substantial amount of time and money to their relatives with dual disorders. Families are in general a major starting place of support for people with psychological illness, but substance abuse leave an added burden on family members and could lessen the quantity of direct support they provide. More rigorous present substance abuse appears to reduce family expenditure but

not direct caregiving. Clients experiencing severe alcohol troubles were more expected to live with parents than with any other family members.

Bhowmick, Tripathi, Jhingan, and Pandey (2001) examined the relationship between social support, coping resources and codependence in the wives of 30 individuals with drugs and 30 individuals with alcohol dependence. Out of the sixty patients, 49 patients were found to be mutually dependent. The codependent group had more harm in the economic and the lawful area of the husbands while the nondependent group had more harm in the psychosomatic sphere. Mutually supporting wives had lesser coping assets and social support. Husbands' length of drug or alcohol misuse, overall coping abilities, and husbands' dependence severity were found to be important predictors of the growth of codependence in the spouses.

Chang, Brecht, and Carter (2001) identified the predictors of caregiver's burden, satisfaction, depression, and social support. Caregiver/care-recipient characteristics and social support were taken as the independent variable and caregiver burden, satisfaction, depression, anxiety, and hostility were taken as the dependent variables. The study was conducted on 81 women caregiver/care-recipient dyads. Difficulty arranging assistance from confidante or friends was related significantly and positively with caregiver burden and depression, and negatively with satisfaction.

Hogan, Linden, and Najarian (2002) using a computerized search strategy reviewed 100 studies that evaluated the efficacy of the presence of support to good long-term health outcomes. The current issues vary from cancer, isolation, weight loss, and substance abuse to need of parenting ability, surgical treatment, and delivery preparation. For the

use of analysis and assessment, the studies were subdivided into (1) group vs. individual interventions, (2) treatment offered by peer vs. professionally-led and (3) interventions where a boost of network size or perceived support was the chief aim against individuals where construction of social skills (to assist support establishment) was the center. On the whole, this review provided some support for the overall use of social support interventions. However, there is still not enough evidence to conclude which interventions work best for what problems.

Beigel, Ishler, Katz and Johnson (2008) examined the impact of having a female family member with substance use or co-occurring disorders on family caregivers and explored predictors of subjective burden (worry, stigma, and displeasure) and objective burden (family disruption) on caregivers and on types of burden. Behavioral issues of the receiver and requirement of social support for caregivers calculated higher degrees of family member trouble, with different kind of social support calculating different kind of burden. Having a dual disorder did not predict family member burden.

Orford, Copello, Velleman and Templeton (2010) used the stress-strain-coping-support (SSCS) model to study substance misuse and its effect on the family. SSCS model suggest that having a close relative with a substance abuse issues comprises a type of stressful life conditions, often venerable, which place affected family members at danger of experiencing damage in the shape of physical and/or mental ill-health. Social support and coping are the two added essential building blocks of the representation. Affected family members are seen as common people faced with the charge of coping with such stressful life situations. It is an assumption of the model that family members need not be powerless in maintaining their own health and helping their relatives when faced with

difficulty to cope with the situation. High-quality quality social support, in the shape of emotional support, good quality information, and material aid is important for affected family members, sustaining their coping efforts and contributing optimistically to their wellbeing. Therefore, it can be seen as a way of increasing the positive social support available from professional sources.

Steiner et al. (2010) used Lazarus and Folkman's (1984) model of stress and coping as a framework to examine marital satisfaction among husbands of patients with fibromyalgia syndrome. Husbands of patients with fibromyalgia syndrome (HFMS) reported low physical and psychological health than husbands of women with no illness, also, role strains for the reason that of their wives' circumstances. Amongst HFMS, a sexual and household role injures and social support was connected to marital contentment. Social support single-handedly mediated the connection between role strain and marital contentment, and no other variable moderated the association.

Dasgupta et al. (2013) conducted a study on 220 women reporting husband's partner violence or heavy alcohol use and were assessed on high social support in the community, and a number of depressing days in the past 30 days. 40% of women reported high local social support, and 33% reported not having local social support at all. Women showing high local social support were found to be considerably report a reduced amount of depression, still after suffering from husbands' spousal for husbands' recent spousal violent behavior and his dangerous alcohol use, together which were also significantly associated with depression. Local social support reduces the risk of depression among women in Mumbai contending with husbands' spousal violence and risky alcohol use. These results support the probable utility of community-based social

support structure to reduce the threat of depression amongst this vulnerable group of women.

Gupta, Mattoo, Basu, and Sarkar (2014) aimed to identify the psychiatric morbidity in wives of substance-dependent men and to assess social support and coping as its correlates. Two groups (50 each) of substance-dependent men (alcohol and opioid) and their wives were interviewed. In both groups, more than 70 percent of the spouses had scored more in psychiatric morbidity. The psychiatric diagnosis was present in 16 percent and 20 percent of the wives in alcohol and opioid dependence groups, respectively, depression and dysthymia being the commonly encountered diagnoses. Social support was comparable across both groups. The most common coping mechanisms utilized were those of denial and internalization. Psychological morbidity was found to be common in wives of patients with substance use disorders.

Mattoo et al. (2015) identified that perceived stigma towards substance use may determine family members' willingness to help in the treatment process of a substance user. This research intended to compare the perceived stigma in the direction of substance use among Indian substance users and their family caregivers. Fifty dyads of alcohol- and opioid-dependent men and their family members were interviewed. Perceived stigma of patients and the family members correlated with each other in both the alcohol- and opioid-dependent groups. Being currently employed predicted higher perceived stigma scores among patients while being unmarried predicted higher perceived stigma scores among family members.



Casado et al. (2018) included 56 studies a meta-analysis, which provided 46 independent comparisons for perceived support and 16 for received support. Most of these studies were cross-sectional. There was a moderate, negative association of perceived social support on the subjective burden and a very small, negative association of received support on the subjective burden.

### **2.3 Researches on Depression among Caregivers**

Gallagher et al. (1989) screened 158 family caregivers who sought help to increase their coping skills and 59 caregivers who volunteered for a longitudinal study of Alzheimer's disease. According to Research Diagnostic Criteria, among help-seekers 46% had depression and among non-help-seekers, only 18 % had depression. Men were found to be less depressed than women.

Aranda, Castaneda, Lee, and Sobel (2001) investigated stress, coping responses, and social support variables as predictors of psychological distress among 171 Mexican American men and women. The study tested gender differences in the rates of depressive symptoms as well as differences in factors associated with depressive symptoms. The result indicated that although men and women did not differ significantly in terms of the rate of depressive symptoms, they did differ in terms of the sources of stress and social support associated with depression.

Wijngaarden, Schene, and Koeter (2004) studied the caregiving consequences of 260 spouses and relatives of depressed patients. About 25–50% of caregivers were concerned about the patient's general wellbeing, management, security, and future. They had to insist the patient to take on activities or do any tasks. There was relative

nervous tension, and they felt loaded, particularly when the patient was in a severe phase. Caregivers frequently felt anxious and had to consult a (mental) health practitioner. Moreover, children were found to be affected; caregivers stated elevated levels of complex behavior, loss of enthusiasm, insomnia, less activities, and less awareness at school. Caregiving outcomes in depression arise often and cause misery in caregivers and patient's offspring. Attention should be directed towards supporting relatives and partner of depressed patients. Special attention should be paid to the patient's children.

Pirraglia et al. (2005) investigate the relationship between depression and caregiver burden among informal caregivers of HIV-infected individuals on 176 HIV patients and their informal caregiver. In the study, 47% of informal caregivers constitute the patient's partner, friends 18%, and 35% were family member. High caregiving burden was found in 27 % informal, and depression in 50%. Informal caregiver depression was found to be considerably greater with high caregiver burden. Depression was strongly linked with high caregiver burden between HIV-infected individuals' informal caregivers, whom themselves had complicated life conditions.

Takahashi, Tanaka, and Miyaoka (2005) studied 23 informal home based caregiver of demented patients, 24 professional caregivers employed in the dementia ward of a psychiatric hospital, and 31 controls using severity of dementia to observe the disparity in depressive state and related factors using Clinical Dementia Rating Scale, Mini-Mental State Examination, MMSE and levels of caregivers depression using Beck Depression Inventory; BDI, care burden using Zarit Caregiver Burden Interview, ZBI

and quality of life using World Health Organization–Quality of Life, WHOQOL. Informal caregivers were found to have the highest BDI score and ZBI and the lowest QOL among the three studied groups. Among informal caregivers, it was found to have a positive strong association between BDI and ZBI scores. The BDI and ZBI scores were significantly high when patients exhibited behavioral problems. The four WHOQOL categories (physical domain, psychological domain, social relationships, and environment) had a powerful negative association with BDI. It was established that the psychological domain points of WHOQOL, role strain dimension of ZBI and MMSE score were appreciably related with BDI. A strong negative correlation was found in professional caregivers' BDI score with the physical and mental domains and environment divisions of WHO-QOL, their BDI score was significantly related with the psychosomatic domain and surroundings.

Musil et al. (2008) used the resiliency model of family stress, adjustment, and adaptation as the framework to examine the main and moderating effects of social support and resourcefulness in the relationship between family life stresses and strain and depressive symptoms in grandmothers raising grandchildren, grandmothers in multigenerational homes, and non-caregivers to grandchildren. Grandmothers raising grandchildren reported more depressive symptoms. High amount of strain and low subjective support and resourcefulness were connected with high level of depressive symptoms for all grandmothers.

Douglas and Spellacy (2009) selected social support as the framework to investigate possible indicators of depression in 35 adults with severe traumatic brain injury and

their carers to study the extent of relationship between social support as well as the criterion variable of depression in the framework of demographic and disability-related variables that have been recognized as significant associate of depression. 57% of the individuals with TBI and 60% of their caregivers were divided as showing significant indication of depression. As theorized, social support add up significantly to the prediction of depression.

Robison et al. (2009) collected data from 4,041 informal caregivers to examine six health and psychosocial outcomes of caregiving, in the context of multiple characteristics of the caregiving situation. Caregivers rated their health better than non-caregivers and do not report more depressive symptoms or social isolation. Multiple negative outcomes were associated with living with the care receiver, insufficient earnings, and care receivers' unmet requirement for community-based long-term care services. Care receiver memory issues and caregiver/care receiver connection do not suggest health or psychosocial outcomes.

Biegel et al. (2010) studied 82 women receiving substance abuse treatment and the family member providing the most social support for each woman using a stress-process model to examine the impact on family caregivers' depressive symptomatology of having a female family member with substance use or co-occurring substance use and mental disorders. Caregiver depressive symptoms were expected to be higher by larger care receiver emotional troubles, low care receiver social support, and weak caregiver wellbeing.

Siebert and Seibert (2010) demonstrated that higher personal distress (e.g., depression, burnout) is associated to caregiver role identity and this distress can negatively affect practitioners' professional work. Among 751 respondents in a representative sample of practicing social workers, they extended the conceptualization of role identity theory and expanded its application to help-seeking attitude. Results suggest caregiver role identity may be an important risk factor for depression.

Rodrigo et al. (2013) explored the symptoms of depression, caregiver strain and dissatisfaction with life in caregivers of patients with schizophrenia and bipolar affective disorder on 80 caregivers. Symptoms of depression were significant in 37.5%. It was observed that spending more time with the patient, disturbance to work, conflicts with relations, being battered by patient and self-admission of wanting professional aid to defeat mental stress. Depression and higher caregiver strain were found to be associated. This study identified several associations for depression and increased caregiver strain among caregivers in a subset of patients with mental disorders. These can be seen as indicators to monitor and enhance pretest probability to identify caregivers requiring help.

Lander, Howsare, and Byrne (2013) used family systems theory and attachment theory as theoretical models that provide a framework for understanding how SUDs affect the family. They also explored the current developmental stage a family is in to understand the assessment of impairment and determination of appropriate interventions. SUDs were found to be distressing emotional and behavioral guide from the beginning of the family, resulting in weak outcomes for the children and adults with SUDs.

Li, Mak, and Loke (2013) reviewed recently published research on the stress process of spousal caregiving experience for cancer patients to identify any gender differences in the caregiving experience. It was discovered that female spouse-caregivers identified higher level of negative occurrence in caregiving, such as lower mental wellbeing, lower physical fitness, inferior health-related quality of life, lesser life satisfaction and diminished marital satisfaction than male spouse-caregivers. However, female spousal caregivers have more likelihood to experience individual growth than male spousal caregivers.

Adejumo et al. (2019) assessed the psychosocial well-being and quality of life (QoL) of caregivers of chronic kidney disease (CKD) patients in two hospitals in Southern Nigeria. Depression was found significantly higher in caregivers. Depression, anxiety, and burden were common among caregivers of CKD patients especially females compared to controls.

## **CHAPTER III**

### **THE PRESENT STUDY**

#### **3.1 Need and Justification of the Study**

One of the worst psychosocial hazards being faced by any society today is addiction to alcohol and psychotropic drugs. The use and abuse of various licit and illicit substances and its negative consequences is increasingly becoming a major public health concern. One worrisome factor is the progressive decline in the age of initiation (United National International Drug Control Programme, 1994). Living with spouse with severe mental illness is stressful. A global issue affecting family caregivers is the burden of care, in both developed and developing countries. The aim of this study is to study the relationship between care burden, perceived social support and depression of the spouse-caregivers of individuals with single and poly-substance abusers of Assam. This study will also aim to compare the care burden, perceived social support and depression in spouse-caregivers of patients with single and poly- substance use disorder and study the common between wife caregivers of patients with single and poly- substance use disorder of Assam.

#### **3.2 Significance of the Study**

In marriages where one partner struggles with substance abuse disorder, the non-addicted spouse carries the responsibility for two people, including care of the children, finances and is often the primary breadwinner for the family. It often becomes overwhelming to find support and appropriate treatment for the addicted love ones. The

deterioration of patient's condition can increase care burden and cause a vicious cycle, and if timely intervention is not done, it may lead to a gradual exhaustion of the caregivers. Also, social support is becoming recognized as a positive influence on health and health maintenance. Therefore, timely identification of these pressures in caregivers plays a decisive role in promoting their physical and mental health. Little attention has been paid to the relationship between caregiver burdens and perceived social support in spouse-caregivers of patients with substance use disorder. Thus, conducting a study on the care burden and perceived social support of the spouse-caregivers of patients with single and poly-substance use disorder seems necessary. Considering the unavailability of sufficient knowledge on the level of care burden and social support in the spouse-caregivers of patients with single and poly-substance use disorder in Assam, and since reviewing this problem is the first step towards providing a solution for this issue, the present study will be conducted to determine the level of care burden and its relationship with the social support received by spouse-caregivers of patients with single and poly-substance use disorder. It will also explore how care burden in the spouse-caregivers may lead to depressive symptoms. The present study will examine the care burden, social support received by the spouses and its effects on depressive symptoms in spouse-caregivers experienced by caring for their male spouses with single and poly-substance use disorder.

### **3.3 Objectives**

**01.** To find out burden, social support, depression and their relationship among spouse-caregivers of male patients with single and poly-substance use disorders.



**O2.** To determine the effect and level of significance of burden, social support and depression among spouse-caregivers of male patients with single and poly-substance use disorders.

**O3.** To evaluate the main effect of the selected demographic variables on depression among spouse-caregivers.

### **3.4 Hypotheses**

**H1:** A significant correlation would exist between burden, perceived social support and depression among spouse-caregivers of male patients with single and poly- substance use disorder.

**H2:** Burden and social support would contribute significantly in predicting depression among spouse-caregivers of male patients with single and poly- substance use disorder conjointly as well as independently.

**H3:** Spouse-caregivers of male patients with poly- substance use disorder would score high on burden compared to spouse-caregivers of male patients with single substance use disorder.

**H4:** Spouse-caregivers of male patients with single and poly- substance use disorder with low social support would experience more burden compared to spouse-caregivers of male patients with single and poly- substance use disorder with high social support.

**H5:** Spouse-caregivers of male patients with multiple substance abusers would score high on depression compared to spouse-caregivers of male patients with single substance abusers.

**H6:** There would be significant effect of selected socio-demographic variables on depression among spouse-caregivers of male patients with single and multiple substance abusers.

## CHAPTER IV

### METHODOLOGY

This chapter deals with the research approach method and procedure followed in this study, the sampling design, a brief discussion of tools in the study and statistical design employed for analysis and interpretation of data. A research is equally important as reading books. Both scientific and non-scientific fields of study require research for a better reality with knowledge. The everyday problems those arise seek for their solutions and suggestions. Scientists are among several ordinary people who take initiatives to find their causes, explanations and implications. The effective yet abstract phenomena are undertaken to both understand and realize by a research. Avenues of research open a door for the readers to know about the phenomena in a systematic way. The foremost aims of a research are to invent new and relevant facts, to verify and test them and to analyze an event in order to see its cause and effect relationship, to develop new scientific tools, concepts and theories to solve and understand problems, to find solutions to them and to overcome upcoming ones (Rajasekar, Pitchai & Veerapadran, 2013). Research is a technical term which is priory used as an academic activity. According to Clifford Woody a research comprises of defining a problem, originating hypothesis, gathering, systematizing and analyzing data, making inferences, coming to a conclusion and finally testing if they are parallel to the formulated hypothesis (Fisher, 1930). Adding to these, research is a scientific study focused to an inquiry aiming to learn new facts, idea with a systematic collection, analysis and interpretation of data. All of the activities lead us to generate a new knowledge and solve problems (Degu & Yigzaw, 2006).

**Table 4.1:** *Variables used in the Study*

<i>Sl. No.</i>	<i>Independent Variables</i>		<i>Dependent Variable</i>
1.	Gender	Male	Depression
		Male	
2.	Sociodemographic variables	Age	
		Religion	
		Social group	
		Family type	
		Education	
		Income	
3.	Psychosocial variables	Burden and <i>Social Support</i>	

***Geographical Area***

Stretching 600km alongside the Brahmaputra River Valley, with a drive down to the hilly southeast, Assam is the biggest and most accessible of the Northeast States. An administrative district in the state of Assam is the Kamrup district. Today Kamrup has its headquarters located at Guwahati city. The district is bounded by Udalguri and Baska district in the north, Meghalaya state in the south, Darrang district and Kamrup

Metropolitan district in the east and Goalpara district and Nalbari district in the west.

Kamrup district occupies a total area of 4345 sq. km and has a population of 15,17,202 (as of 2001).

The menace of drug abuse is alarmingly on the rise in Assam. The increasing number of de-addiction and rehabilitation centers in the city of Guwahati over the years bears testimony to this fact. Due to the proximity of the North-east region to the Golden Triangle – the tri-junction of Myanmar, Thailand and Laos – it is one of the worst-affected areas. The geographical location and accessibility to drugs plays a crucial role with Assam being a transit point and the gateway to other northeastern states.

Considering all these factors and data, Assam and particularly, Kamrup district is chosen as an area to observe the effect of burden and social support on depression among the spouse-caregivers of substance users in the present study.

**Figure 4.1:** *Map of Assam (www.pinterest.com)*



The data was collected from various Rehabilitation Centre located in Kamrup districts of Assam, India.

#### **4.1 Research Design**

The function of research design is to provide for collection of relevant data with minimum expenditure of effort, time and money. Preparation of research design involves usually the means of obtaining information. For this study of “psycho-social determinants of depression among spouse- caregivers of male patients: a comparative study of single and poly-substance use disorder” data has been collected from different hospitals and rehabilitation centers of Assam. The most popular and widely used components of substance use disorder i.e. physiological variables were measured. The present study of examining and analyzing the selected spouse-caregivers of male patients with single and poly substance use disorder of Assam, is exclusively based on primary data which has been collected from various participants as respondents from time to time; hence this study is purely practical and analytical. The analytical research of burden, perceived support and depression among spouses of male patient with single and poly-substance use disorder of Assam was done by calculating Mean, Standard Deviation, “t” test and regression. For the qualitative data, narrative analysis has been used. The interpretations of schemes had been tried to be classified in tabular form and explained with the help of graphical databases.

Study was conducted on spouse caregivers of male in-patient single and multiple substance abusers from different psychiatric hospitals/ rehabilitation centers of Assam.

Data were collected from the following five hospitals/Rehabilitation Centers of Assam:

SI No.	Name of the Hospital/ Institute	District	State
1.	Guwahati Medical College and Hospital	Kamrup	Assam
2.	GNRC Hospital	Kamrup	Assam
3.	Serenity Foundation	Kamrup	Assam
4.	Medicity Hospital	Kamrup	Assam
5.	Borthakur Clinic	Kamrup	Assam
6.	Al Anol Family Group	Kamrup	Assam

#### 4.2 Sample of the Study

A total number of 60 spouse-caregivers (30 spouse-caregivers of male in-patients with single and 30 spouse-caregivers of poly-substance use disorders) of age range of 18 years to 40 years were selected for the study from different psychiatric hospitals and rehabilitation centers of Assam. Both quantitative and qualitative research method (mixed method) was employed for collection of data. Five spouse-caregivers of male in-patients with single substance use disorder and 5 spouse-caregivers of male in-patients with poly-substance use disorder were interviewed individually by using in-depth interview technique for in-depth understanding of their problems. Methods for data collection include self-report inventories and scales by the technique of purposive random sampling. The present sample consists of 60 participants, 30 spouses of patients with single-substance use disorder and 30 spouses of patients with poly-substance use disorder. The spouses include were in the age range of 18-40 years. The mean age of the participants is 31.96 and SD is 5.96.

**Participant Inclusion Criteria:**

- Spouse-caregivers of admitted male patients with single and poly-substance use disorders.
- Patients should be diagnosed under ICD 11 (2018) or DSM 5 (2013) criteria at least six months prior to the date of interview.
- Spouse-caregiver who is defined as the wife of the patient and who has been the most involved in the care of the patient will be selected.
- Spouse caregiver should have lived with the patient for at least a period of 12 months.
- Spouse-caregiver primarily takes active responsibility for meeting the patients' needs.
- In-patients who are male and married.
- Primary caregivers should be able to read and write English.

**Participant Exclusion Criteria:**

- Spouse-caregivers suffering from major psychiatric and/or physical disorder.
- Spouse-caregivers who will not give their consent.
- Participants having previous knowledge or exposure to the test.

**4.3 Ethical Considerations**

- Permission will be taken from the Director/Head of the hospitals/institutions for data collection
- Consent form: Informed consent of the interviewee
- Confidentiality: Ensuring privacy and confidentiality of personal information.
- Non-inclusion of subject's personal information in data files.



- Presentation of results in aggregate; form, without individual identification

#### **4.4 Design and Variable Involved**

The present study is concerned with psycho-social determinants of depression among spouse- caregivers of male patients of single and poly-substance use disorders There are three types of variable in the study: -

1. Independent Variable: Burden and Social Support
2. Dependent Variable: Depression

#### **4.5 Tools Used**

Keeping in view of the objectives of the present study, the selected sample were assessed using the following measures:

- 1. Socio-demographic Datasheet (Self, 2019):** Socio-demographic data sheet consists of the personal record of the spouse-caregivers like age, sex, name, education, religion, residential address, ethnicity, socio-economic status like employment, income of the spouses, etc. It helps in acquiring the characteristics of the caregivers and the patients and to check the difference with any previous studies or theories.
- 2. The Burden Assessment Schedule (Sell et al., 1998):** The Burden Assessment Schedule (BAS) has been developed by Sell, Thara, Padmapati and Kumar (1998) with the support of the WHO. The burden assessment schedule (BAS) intends to evaluate both subjective and objective burden experienced by the primary care givers of chronic mentally ill patients. BAS is a 20-item instrument rated on a 3-point scale, marked 1-3, covering five domains:

Factor 1: Impact on well being – This factor contains items describing the impact on the presence of the chronic psychotic on the caregivers in terms of feelings of exhaustion, frustration, depression and impact on health in general

Factor 2: Impact on marital relationships – The items reflects the ability of the mentally ill patients to give adequate attention and affection to other members of the family and satisfy the emotional needs of his/her partner.

Factor 3: Appreciation for caring – This is a positive factor that reflects the satisfaction caregivers receive from the appreciation and acknowledgement of their good care from their friends and family members and the pride of still being able to take good care of the rest of the family. This factor gives hints at a very important component of support to caregiving families.

Factor 4: Impact on relations with others – This factor includes items which refer to the disruption of family and other social relations as a consequence of the presence of the mentally ill person.

Factor 5: Perceived severity of the disease – The items here represent the severity of the disorder, such as disturbing or unpredictable behavior rendering the caregiver unable to hold or take up a regular job.

Burden Score	Range
0-20	Low
21-40	Mild
41-60	High

The inter-rater reliability between the interviewers was good (Kappa, 0.80). For every 10th interview reliability exercise were also done all the way through the process of instrument development and standardization to make sure that reliability was preserved. Criterion validity has been established by comparing with the Family Burden Schedule (Pai & Kapur, 1981).

### **3. The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) -**

The Multidimensional Scale of Perceived Social Support (MSPSS), developed by Zimet, Dahlem, Zimet and Farley (1988) is a short instrument designed to measure an individual's perception of support from 3 sources: family, friends and a significant other. Each section consists of 4 items. This instrument contains 12 questions items, rated on 12-point Likert type scale ranging from very strongly disagree to strongly agree.

A separate subscale is formed by each of these involving to perceived support from a significant other, from friends and from family. We can also calculate a total score.

To calculate subscale scores:

Significant Other Subscale: We add together items 1, 2, 5, & 10, and then divide by 4.

Family Subscale: We add together items 3, 4, 8, & 11, and then divide by 4.

Friends Subscale: We add together items 6, 7, 9, & 12, and then divide by 4.

Total Scale: Add together all 12 items, and then divide by 12.

Low support could be considered by any mean total scale score ranging from 1 to 2.9; moderate support could be considered by a score of 3 to 5; high support could be considered by a score from 5.1 to 7.

<i>Total score</i>	<i>Range</i>
1-2.9	Low support
3-5	Moderate support
5.1-7	High support

The MSPSS consists of good internal and test-retest reliability and also moderate construct validity. Strong factorial validity was established, verifying the three-subscale makeup of the MSPSS: Family, Friends, and Significant Other. Also, strong support was also found for the validity of the Family and Significant Other subscales.

**4. Beck Depression Inventory II (Beck et al., 1996):** The Beck Depression Inventory (BDI II) is a 21-item self-reporting questionnaire for evaluating the severity of depression in normal and psychiatric populations. The BDI-II was designed to act as an indicator of depressive symptoms based on diagnostic criteria in the DSM IV. According to the authors, the 21 items in the BDI-II are representative of the DSMIV criteria for depression. Administration of the BDI-II is usually completed in 5-10 minutes; the BDI-II is a paper and pencil completed questionnaire and can be self administered or presented orally. The BDI-II is a single test that is intended to

measure all aspects of depressive symptoms based on diagnostic criteria in the DSM-IV.

The BDI-II contains 21 items on a 4-point scale from 0 (symptom absent) to 3 (severe symptoms). Scoring is achieved by adding the highest ratings for all 21 items. The minimum score is 0 and maximum score is 63.

Total raw scores can range from 0 to 63, and are then converted into descriptive classifications based on cut scores. Total score of 0-13 is considered having the minimal range, 14-19 having mild depression, 20-28 having moderate depression and 29-63 having severe depression.

<i>Total scores</i>	<i>Range</i>
0-13	Low
14-19	Mild
20-28	Moderate
29-63	Severe

An evaluation of internal consistency found a Cronbach's alpha of .92. The test-retest reliabilities were measured, and found an average correlation of .93. Internal reliability was found to be moderate to high for all subscales and for the total scale.

Scores on BDI-II differentiated between clinical and general population, sustaining for external validity.

## **4.6 Procedure for Data Collection**

### ***a. Quantitative Data***

Primary data was collected on 60 spouse-caregivers of inpatient with single substance use disorder and poly substance use disorder (30 spouse-caregivers of in-patient with single substance use disorder and 30 spouse-caregivers of in-patient with poly- substance use disorders). Data were collected from the various institutes of Assam (List is given). Prior information was taken from the hospital authorities / organizations about the data collection. Once the appointment was confirmed informed consent for participation in the study was taken. The spouse-caregivers attending the patients regularly were screened and were considered for the study. An initial rapport with the participants was developed, after which they were assured of confidentiality of their responses as the collected data (only quantitative data) was used for academic and research purpose only. All the questionnaires were given to the spouse-caregivers individually with instructions for their response.

### **b. Qualitative Data**

Qualitative data was collected from 5 spouse-caregivers of in-patients with single substance use disorder and 5 spouse-caregivers of in-patient poly-substance use disorder. They were interviewed individually by using in-depth interview technique for in-depth understanding of their problems. The following probable questions were asked at the time of interview:

- How is your relationship/life with your husband on financial and emotional aspects?

- How do you take care of yourself? Can you please explain what kind of support you get from your relatives or significant others and what kind of support do you expect?
- Can you please tell us about your experience when you feel low?

#### **4.7 Statistical Techniques**

The collected data were analyzed by using the various statistical techniques using SPSS.

The scores of the psycho-social determinants of depression among spouse- caregivers of male patients: a comparative study of single and poly-substance use disorder was

evaluated by means of descriptive statistics such as percentage, mean, frequency, and

standard deviation. Collected data was tabulated and t-test and regression were used to

find out the significant difference between spouse- caregivers of male patients with single

and poly-substance use disorder. The comparisons between the two groups were

calculated. The correlation was used to measure the relationship between the t variable.

The comparisons between the different groups were made on the basis of 0.05 and 0.01

levels of confidence considered significant.

## CHAPTER V

### RESULTS AND DISCUSSION

After collecting data, it has to be analyzed. It is a crucial step in psychological research after which the results can be out-streamed. The data may be adequate, valid and reliable to any extent, it does not serve any worthwhile purpose unless it is carefully and systematically classified, tabulated, scientifically analyzed, intelligently interpreted and rationally concluded. Analysis of data means studying the tabulated material in order to determine inherent facts or meanings. It involves the breaking up of complex factors into simpler parts and putting the parts together in a new arrangement for the purpose of interpretation. So the process of interpretation is also very essential in order to state, what do the results show? What do they mean? What is their significance? What is the answer to original problem?

In this study, an attempt has been made to ascertain the influence of different dimensions of burden and social support on depression in spouse-caregiver of male patients with single and poly substance use disorder. Different dimensions of burden and social support have been studied as predictors of depression in spouse-caregiver of male patients with single and poly substance use disorder. Data obtained from the respondents of different hospitals and rehabilitation centers of Assam has been analyzed by means of SPSS package. The data were arranged and analyzed in six sections. The socioeconomic characteristics of the school going adolescent boys and girls selected for the study are profiled in Section I. In Section II, the results of inter-correlations carried out for all the variables have been presented. Section III deals with multiple regression equations for



burden and social support where as Section IV deals with t-test analysis to measure the significant difference between spouse-caregivers of male patients with single and poly substance use disorder have been presented. In Section V multiple regression equations for the sociodemographic variables have been discussed. In Section VI narrative analysis of the 5 spouse-caregivers of male patients with single substance use disorder and 5 spouse-caregivers of male patients with poly substance use disorder has been discussed.

This chapter deals with comparative results of the participants in psycho-social determinants of depression among spouse- caregivers of male patients with single and poly-substance use disorders. The data obtained by the standard questionnaires were tabulated. To compare the data of selected psychological variable namely burden, social support and depression in spouse caregivers of male patients with single and poly-substance use disorders. The level of significance chosen was 0.001, 0.01 and 0.05.

## 5.1 Quantitative Analysis

### SECTION I: *Socioeconomic Characteristics of Spouse-caregivers of Male Patients with Single and Poly-Substance Use Disorder*

#### Age-wise Distribution

**Table – 5.1**

*Age Category of Spouse-caregivers of patients with single and poly substance use disorder (N=60)*

<b>Age category</b>	<b>Spouses of patients with single substance use disorder</b>	<b>Spouses of patients with poly substance use disorder</b>	<b>Spouses of patients with single and poly substance use disorder</b>
<b>18 years -25 years</b>	6(20%)	2(6.67%)	8(13.33%)
<b>26 years -35 years</b>	14(46.67%)	24(80%)	38(63.33%)
<b>36 years – 45 years</b>	10(33.33%)	4(13.33%)	14(23.34%)
<b>Total</b>	30(100%)	30(100%)	60(100%)

The Table 5.1 shows the sample of the study. As mentioned above the total numbers of participants is 60 including 30 spouse-caregivers of male patients with single substance use disorder and 30 spouse-caregivers of male patients with poly substance use disorder. The mean age is 31.96. 20% spouse-caregivers of male patients with single substance use disorder were in the age group 18 years – 25 years, 46.47% spouse-caregivers of male patients with single substance use disorder were in 26 years - 35 years and 33.33% spouse-caregivers of male patients with single substance use disorder were in the age

group 36 years - 45 years. For spouse-caregivers of male patients with poly substance use disorder, 6.67% were in age group 18 years – 25 years, 80% in age group 26 years – 35 years and 13.33% in age group 36 years – 45 years. In both single and poly substance use disorder it is seen that maximum number of spouses were in age group 26 years – 35 years and minimum number of spouses were in age group 18 years – 25 years..

Therefore, 13.33% spouses were from age group 18 years – 25 years, 63.33% were in age group 26 years – 35 years and 23.34% were in age group 36 years – 45 years.

### Religion-wise Distribution

**Table 5.2**

*Religion of spouse-caregivers of patients with single and poly substance use disorder (N =60)*

<b>Religion</b>	<b>Spouses of patients with single substance use disorder</b>	<b>Spouses of patients with poly substance use disorder</b>	<b>Spouses of patients with single and poly substance use disorder</b>
<b>Hindu</b>	25(83.33%)	18(60%)	43(71.67%)
<b>Muslim</b>	3(10%)	6(20%)	9(15%)
<b>Christian</b>	2(6.67%)	6(20%)	8(13.33%)
<b>Buddhist</b>	0	0	0
<b>Total</b>	30 (100%)	30 (100%)	60(100%)

Table 5.2 depicts that 83.33 percent spouses of patients with single substance use disorder and 60% spouses of patients with poly substance use disorder were Hindu, 10% spouses of patients with single substance use disorder and 20% spouses of patients with poly substance use disorder were Muslim, 6.67% spouses of patients with single substance use disorder and 20% spouses of patients with poly substance use disorder were Christian and none were Buddhist. Maximum numbers of participants were Hindu. Therefore, 71.67% spouses were Hindu, 15% spouses were Muslim, 13.33% spouses were Christian and there were no spouses from Buddhist religion.

### **Family type-wise Distribution**

**Table 5.3**

*Family Type of Spouse-caregivers of patients with single and poly substance use disorder (N=60)*

<b>Family Type</b>	<b>Spouses of patients with single substance use disorder</b>	<b>Spouses of patients with poly substance use disorder</b>	<b>Spouses of patients with single and poly substance use disorder</b>
<b>Joint</b>	22(73.3%)	8(26.7%)	30(50%)
<b>Nuclear</b>	8(26.7%)	22(73.3%)	30(50%)
<b>Total</b>	30 (100%)	30 (100%)	60(100%)

It can be observed from Table 5.3 that 73.3% spouses of patients with single substance use disorder and 26.7 % spouses of patients with poly substance use disorder were from

joint family and 26.7% spouses of patients with single substance use disorder and 73.3% spouses of patients with poly substance use disorder were from nuclear family. Therefore, 50% spouses were from joint family and 50% spouses were from nuclear family.

### Education-wise Distribution

**Table 5.4**

*Education of Spouses of patients with single and poly substance use disorder (N=60)*

<b>Education</b>	<b>Spouses of patients with single substance use disorder</b>	<b>Spouses of patients with poly substance use disorder</b>	<b>Total Spouses of patients with single and poly substance use disorder</b>
<b>None</b>	2(6.7%)	0	2(3.3%)
<b>Primary</b>	5(16.7%)	5(16.7%)	10(16.7%)
<b>Matriculation</b>	8(33.3%)	12(40%)	20(33.3%)
<b>10+2</b>	6(20%)	6(20%)	12(20%)
<b>Graduation</b>	9(26.7%)	7(23.3%)	6(26.7%)
<b>Total</b>	30(100%)	30(100%)	60(100%)

It can be observed from Table 5.4 that 6.7% spouses of patients with single substance use disorder and none of the spouses of patients with poly substance use disorder had no education background. 16.7% spouses of patients with both single and poly substance use disorder had completed their primary education, 33.3% spouses of patients with single substance use disorder and 40% spouses of patients with poly substance use disorder had

completed their matriculation. 20% spouses of patients with both single and poly substance use disorder has done their 10+2 and 26.7% spouses of patients with single substance use disorder and 23.3% spouses of patients with poly substance use disorder has completed graduation. Therefore, 3.3% spouses had no education, 16.7% spouses had primary education, 33.3% spouses had done matriculation, 20% spouses had done their 10+2 and 26.7% spouses were graduated.

### Social group-wise Distribution

**Table 5.5**

*Social Group of Spouses of patients with single and poly substance use disorder (N=60)*

<b>Social Group</b>	<b>Spouses of patients with single substance use disorder</b>	<b>Spouses of patients with poly substance use disorder</b>	<b>Spouses of patients with single and poly substance use disorder</b>
<b>General</b>	17(56.7%)	7(23.4%)	24(40%)
<b>OBC</b>	6(20%)	10(33.33%)	16(26.7%)
<b>ST</b>	5(16.7%)	10(33.3%)	15(25%)
<b>SC</b>	2(8.3%)	3(10%)	5(8.3%)
<b>Others</b>	0	0	0
<b>Total</b>	30(100%)	30(100%)	60(100%)

It can be observed from Table 5.5 that 56.7% spouses of patients with single substance use disorder and 23.4% spouses of patients with poly substance use disorder were from

general category. 20% spouses of single substance use disorder patients and 33.33% spouses of poly substance use disorder patients were from OBC, 16.7% spouses of patients with single substance use disorder and 33.33% spouses of patients with poly substance use disorder were from ST and 8.3% spouses of patients with single substance use disorder and 10% spouses of patients with poly substance use disorder were from SC. Overall, 40% of total spouses were from general, 26.7% were from OBC, 25% were from ST and 8.3% were from SC.

### **Income-wise Distribution**

**Table 5.6**

*Income of Spouses of patients with single and poly substance use disorder (N=60)*

<b>Income</b>	<b>Spouses of patients with single substance use disorder</b>	<b>Spouses of patients with poly substance use disorder</b>	<b>Spouses of patients with single and poly substance use disorder</b>
<b>Rs.0-Rs.10000</b>	24(80%)	21(70%)	45(75%)
<b>Rs. 10000-Rs. 30000</b>	4(13.3%)	6(20%)	10(16.7%)
<b>Rs.30000 and above</b>	2(6.7%)	3(10%)	5(8.3%)
<b>Total</b>	30(100%)	30(100%)	60(100%)

It can be observed from Table 5.6, among spouses of patients with single substance use disorder, 80% were from income group Rs.0- Rs.10000, 13.3% were from income group Rs. 10000-Rs.30000 and 6.7% were from income group Rs.30000 and above. Among

spouses of patients with poly substance use disorder 70% were from income group Rs.0-Rs.10000, 20% were from Rs.10000-Rs.30000 and 10% were from Rs.30000 and above. Overall, 75% spouses were from income group Rs.0-Rs.10000, 16.7% spouses were from Rs.10000-Rs.30000 and 8.3% were from income group Rs.30000 and above.

## **SECTION II:** *Correlation Coefficients among Different Variables*

**Hypothesis 1:** A significant correlation would exist between burden, perceived social support and depression among spouse-caregivers of male patients with single and poly-substance use disorder.

From the Table 5.7, it was found that the mean depression score of caregivers was 43.4 (SD =14.11) which indicate severe depression in caregivers, the mean burden score was 42.2 (SD = 8.37) which indicate high burden in caregivers and the mean support score was 5.32 (SD = 1.07) which indicate high level of support in caregivers.

Burden and all its five factors, F1, F2, F3., F4 and F5 have significant relationship with depression.

- F2 i.e. marital satisfaction of burden have significant relationship with total burden and F1, F3 and F4 of burden.
- F3 i.e. appreciation for caring of burden have significant relationship with total burden, F1, F2, F4, and F5.



**Table 5.7**

*Mean, SD and Coefficient of Correlation of different dimension of depression, burden and social support among Spouse-caregivers of Male Patients with Single and Poly Substance Use Disorder (N=60)*

	Mean	SD	BDI	TBAS	F1B	F2B	F3B	F4B	F5B	TSUP	SSUP	FSUP	FRSUP
<b>BDI</b>	43.4	14.11	1										
<b>BAS</b>	42.2	8.37	.680*	1									
<b>F1B</b>	8.15	2.14	.607**	.926**	1								
<b>F2B</b>	8.95	1.77	.580**	.485**	.314*	1							
<b>F3B</b>	8.55	1.85	.569**	.808**	.626**	.659**	1						
<b>F4B</b>	8.33	2.3	.584**	.860**	.788**	.145	.567**	1					
<b>F5B</b>	8.26	2.38	.388**	.835**	.840**	.063	.464**	.757**	1				
<b>TSUP</b>	5.32	1.07	.390**	.278*	.211	.092	.109	.430**	.203	1			
<b>SSUP</b>	5.82	1.34	.381**	.152	.033	.189	.102	.299*	.001	.782**	1		
<b>FSUP</b>	5.31	1.43	.232	.150	.145	.041	-.023	.210	.188	.780**	.616**	1	
<b>FRSUP</b>	4.76	1.58	.268*	.298*	.271*	-.03	.148	.432**	.267*	.701**	.262*	.226	1

\*\* Correlation is significant at the 0.01 level (2-tailed)

\*Correlation is significant at the 0.05 level (2-tailed)

- F4 i.e. impact on relations with others have significant relationship with total burden, F1, F2, F3, F5, total support, support from significant others and support from friends.
- F5 i.e. perceived severity of the illness have significant relationship with total burden, F1, F3, F4 and support from friends.
- Total support have significant relationship with depression, total burden and F4 of burden
- Support from significant other have significant relationship with depression and total support.
- Support from family have significant relationship with total support and support from significant other.
- Support from friends have significant relationship with depression, total burden, total support and support from significant other.

**Burden** - Burden is a multidimensional reaction to psychological, physical, emotional, financial, and social stressors linked with the caregiving experience. The demands of caregiving can be exhausting and overwhelming. Caregiver burden has been explained as both perceived and observable. The caregiver's awareness of the burden, other than the awareness of other family members or healthcare contributor, estimates the impact on his or her life. The level of perceived burden has been correlated with higher risks of depression and lower quality of life for caregivers (Aronson, 1997). In the present study, burden has been found to be positively correlated to depression. In the present study it was found that, a dimension of burden, appreciation for caring is positively correlated to

depression. In the present study it was found that all the dimensions of burden, impact on wellbeing, impact on marital satisfaction was appreciation for caregiving, impact on relationship with others and, perceived severity of the illness were found to be significantly related to depression.

Adelman and colleagues found that caregiver burden was greater in caregivers who were female, had less education, resided with the care recipient, had depression, were socially isolated, incurred financial stress, spent more time caregiving, and lacked the choice to be a caregiver. Caregivers time and again have feelings of obvious isolation and in effect are distressing for their earlier vibrant and active lifestyles. Lack of time for self-care and continued focus on the care recipient's well-being typically deplete their energy and contribute to an increased caregiver burden (McLaughlin et al., 2011).

Studies illustrated those caregivers who feel valued experience greater physical and emotional wellbeing. But in the present study an opposite relationship is seen between burden and social support. A significant positive relationship is found between burden and social support. But findings report negative correlation between burden and social support. Rodakowski, Skidmore, Rogers and Schulz (2012) found negative social support as significant independent predictors of caregiver burden. Caregiver burden was found to be significantly associated with informal support. Informal support, particularly aid from family members, was significantly linked with a lesser burden perceived by the caregivers. However, the study shows that formal support such as assistance from maids and private nurses did not alleviate the burden of caregivers (Choo et al, 2013).

Therefore, the effects on the caregivers' well being are mediated by appraisal of burden. A higher frequency of disturbing behavior, caring for the patient and support were related to higher burden in caregivers which in turn led to depressive symptoms in caregivers.

**Social support** – Cohen and Wills (2000) argued that social support may play a role at two different points in the causal sequence, linking stress to its consequences. First, the perception that others can offer required resources could guide to appraising a condition as less stressful. Second, the actual receipt of support may alleviate the impact of stress by providing a solution to the problem, by reducing the perceived importance of the problem, by providing distraction from the problem or by facilitating healthful behaviors. Consequently, social support could reduce the impact of stressors on caregiver's emotional state.

The caregiving not only offers physical and emotional support for patients but also plays a large economic role and prevents early nursing home placement (Schrag et al., 2006). In order to support caregivers in this role, it is necessary to understand the extent of caregiver-burden and factors associated with increased caregiver-burden and distress. Depression, caregiver burden and anxiety were positively associated with each other, and every variable had a negative correlation with social support (Pagnini et al., 2010). But in the current study, a positive relationship is found between depression, burden and social support which are contradictory to the previous researches.

**Depression** - The distress resulting from assuming the role of caregiver can be manifested as anxiety, depression, helplessness, burden, and fear (Given et al., 2004). Caregivers often report high levels of stress and burnout and are more likely than non-

caregivers to experience depression. Caregivers who must help with several tasks, or with responsibilities they find complicated or unpleasant (such as performing medical procedures at home or toileting) may have higher levels of distress (Given, et al., 1992). The patient's symptom status (including number, type, and severity of symptoms) can also affect caregiver distress (Given, Given & Kozachik, 2001). As patients' symptom suffering rises and results in depressive symptoms and worsening in quality of life for the patient functional boundaries may increase and caregiver tasks to help manage symptoms and support with functional boundaries may increase (Sarna & Brecht, 1997). Patient symptom status involve caregiver assistance not only with identifying rising and altering patient symptoms connected to the disease and its treatment, but also with the supervision of those symptoms (Williamson, Schaffer, & Schulz, 1998).

Cameron, Franche, Cheung, and Stewart (2002) observed family caregivers of patients with advanced cancer and found that in spite of the amount of care make available caregivers feel emotional distress when given care limited caregivers' capability to take part in usual daily activities (work, recreation, and social activities). This finding suggests that emotional distress may occur somewhat independently of the objective tasks and potential burden imposed by the demands of caregiving.

A dispute in the caregiving literature centers on the associations between caregiver burden and depression (Schultz et al., 1995). Some researchers argue that burden and depression are virtually identical (Stommel, Given, & Given, 1990), while others assert that they are exclusive constructs (Gitlin et al., 2003; Schultz et al., 1995). This study favors the former argument; the five dimensions of caregiver burden explored here—impact on wellbeing, impact on marital satisfaction, appreciation for caring, impact on

relation with others and perceived severity of the illness are related to caregiver depression. Thus, although depression and burden may both be outline of caregiver distress, interventions meant at lessening burden and depressive symptoms should vary.

Therefore, based on the values depicted in Table 4.7 it can be said that the hypothesis 1 that states “A significant correlation would exist between burden, perceived social support and depression among spouse-caregivers of male patients with single and poly-substance use disorder” is accepted.

**Hypothesis 4:** Spouse-caregivers of male patients with single and poly- substance use disorder with low social support would experience more burden compared to spouse-caregivers of male patients with single and poly- substance use disorder with high social support.

From Table 5.7, it is found that social support is positively significant to burden which is contradictory to the above-mentioned hypothesis which states that burden and social support will negatively correlate. The above hypothesis states that in presence of low social support burden there will be more burden and in presence of high social support will predict less burden. But in the present study it is seen that low social support will lead to low burden and high social support will lead to high burden.

In the face of the commonly accepted belief that social support enhances caregiver adjustment in general and subjective burden specifically, the reviews shows mixed conclusion. A recent literature concluded that the predictive power of caregiver social support in deciding caregiver burden is less obvious, due to the abstract range of this determinant (Smerglia, Miller, Sotnak, & Geiss, 2007). A recent literature suggest that

the predictive power of caregiver social support in evaluating caregiver burden is less obvious among dementia caregivers, due to the theoretical mixture of this determinant (van der Lee, Bakker, Duivenvoorden, & Droes, 2014).

In the present study, social support is positively related to burden, which indicates high support will lead to high burden and vice versa. One dimension of social support, support from friends is found to be positively related to burden. Also social support is found to be positively related to depression. Other two dimensions, support from family and significant others does not show any relationship. Chang, Brecht and Carter (2001) found social support to be positively related to burden and depression. Casado et al. (2018) found that the relationships between social support and subjective burden depend on whether the social support is measured as perceived or received. This study may explain the mixed results found by Smerglia and colleagues. Study conducted by Casado and colleagues (2018) may contribute to explain these mixed results, demonstrating that the relationships between social support and subjective burden can vary according the type of support measured i.e., perceived social support is more consistently related to subjective burden than received social support. Therefore, the study supports the consideration of perceived social support as a possible good predictor of subjective burden in caregivers. Study by Thompson et al. (1993) demonstrated that all types of social support for caregivers are not equal. Engaging in social relations for entertainment and pastime appears to be the most important in diminishing the burden of caregiving.

Reviews almost 30 years of research that directly examined the evidence for models that propose psychological pathways linking social support and health found no evidence that psychological factors were mediators of links between social support and health (Uchino, Bowen, Carlisle, & Birmingham, 2012).

Therefore, the hypothesis stating “Spouse-caregivers of male patients with single and poly- substance use disorder with low social support would experience more burden compared to spouse-caregivers of male patients with single and poly- substance use disorder with high social support” is not accepted

### **SECTION III:** *Multiple regression equations for burden and social support*

**Hypothesis 2:** Burden and social support would contribute significantly in predicting depression among spouse-caregivers of male patients with single and poly- substance use disorder conjointly as well as independently.

**Table 5.8**

*Factors significantly predicting depression (individually)*

Variables	B	$\beta$	R Square	P
Burden	1.146	.680	.452	<0.001
Social Support	5.135	.390	.152	<0.01



**Table 5.9**

*Factors significantly predicting depression (conjointly)*

<i>Variables</i>	<i>B</i>	<i>B</i>	<i>R Square</i>	<i>P</i>
Burden and Social Support			.506	<0.001
Burden	1.043	.619		<0.001
Social Support	2.867	.218		<0.05

In the Table 5.8 and Table 5.9, it is seen that burden and social support both significantly predict depression individually and conjointly.

Family caregivers of patients often experience tremendous financial and social distress, emotional burden and mental distress. These challenges may increase caregivers' vulnerability to serious mental health problems, and caregivers may experience serious mental health problems. Depression has been cited as one of the main psychological consequences of caregiving (Greenwood, Mackenzie, Cloud & Wilson, 2010). Studies have found that the depression rate among caregivers of severe mental illness patients was more than two times higher than that of the general population (Heru, Ryan, & Madrid, 2005). As a common mental disorder, depression can be chronic or recurrent, thus substantially impairing an individual's ability to function in their daily life. Mental disorders have also been identified as significant risk factors for both suicidal behavior and suicidal ideation, especially among depressed patients.

Pearlin et al. (1981) proposed and developed the stress process model of depression. Based on the model, far-reaching research had explored the controlling factors of depression not only in the common residents but also in the caregiver residents. Factors associated with caregivers' depression mainly include behavioral problems of care recipients, social support and care burden. Different combinations of these factors were often incorporated in studies to explore the combined effect on depression.

Care burden usually refers to the physical, psychological, financial, and social discomfort that are experienced by the principal caregiver of a disabled family member. Care burden could be objective, measured by the impact of caring for patients on family resources. It could also be subjective, that is, the mental health and emotional impacts that were felt while caregivers care for ill relatives. Family caregivers of patients experienced a high-level of care burden. Care burden has been frequently considered as a strong predictor of depression in family caregivers who care for individuals with severe mental illness (Perlick et al., 2016) as well as a mediator of the relationship between other factors and depression (Kim & Yi, 2015). For example, care burden fully mediated the effect of social support on levels of depressive symptoms among caregivers of lung cancer in a study by Kim and Yi. (2015).

Given that depression is one of the main causes of disability and disease burden worldwide (Mathers and Loncar, 2006), higher levels of depression will influence family caregivers' ability to care for SUD patients. Analyzing how social support and care burden affect depression of caregivers of SUD patients is important for promoting the

health of caregivers and even SUD patients. However, very little is known about the interrelationships and potential mechanisms of social support, care burden and depression among caregivers of SUD patients.

Social support is defined as the interpersonal resources that individuals accessed and mobilized when they attempt to deal with the daily stresses and strains of life. Previous studies demonstrated that increased risk of depression status was associated with the lack of social support among different groups (Han et al, 2007). Hobbs (1997) found that social support was a significant predictor of depression among caregivers of severe mental illness patients. Saunders (2003) showed that insufficient social support was the most significant predictor of depression among caregivers, care burden followed. Social support also could reduce the care burden.

The model showed that social support was a significant and direct predicting factor for depression among caregivers of SUD patients. A one-year community-based prospective cohort study in Japan showed a significant increase in the risk of depression status associated with the lack of social support among the elderly (Koizumi et al, 2005). One possible explanation may be that caregivers who received insufficient social support could not buffer caring stress effectively and the incidence of various kinds of related psychic disturbances, including depression, would be increased. This suggests that providing sufficient social support represents a useful strategy for reducing depression of caregivers of SUD patients.

Based on the above, social support not only influences depression directly but also exerts an influence on depression indirectly through the role of care burden. This reveals that

social support is essential to decrease depression and that interventions to reduce depression in caregivers should be inspired by this path. One possible approach is to enhance caregivers' ability to acquire and use social support from family and friends. In addition to informal support from families and friends, formal mental health services are also of great importance for SUD patients and their caregivers.

Therefore, based on the results, it can be said that the hypothesis "burden and social support would contribute significantly in predicting depression among spouse-caregivers of male patients with single and poly- substance use disorder conjointly as well as independently" is accepted.

#### **SECTION IV:** *t-test analysis to measure the difference between the two groups*

**Hypothesis 3:** Spouse-caregivers of male patients with poly- substance use disorder would score high on burden compared to spouse-caregivers of male patients with single substance use disorder.

From the Table 5.10, it is observed that mean of burden in spouse caregivers of male patient with single substance use disorder is 34.7 and in spouse caregivers of male patient with poly substance use disorder is 49.7.

**Table 5.10**

*Mean, SD and t-value of burden and its dimensions among spouse-caregivers of male patients with single and poly substance use disorder (N=60)*

<i>Variables</i>	<i>Participants</i>	<i>Mean</i>	<i>SD</i>	<i>t-value</i>	<i>df</i>	<i>Sig.</i>
Total burden	S	34.7	3.6	39.02	29	<0.001
	P	49.7	3.6			
F1	S	6.4	1.42	29.42	29	<0.001
	P	9.9	.99			
F2	S	8.1	1.97	39.17	29	<0.001
	P	9.8	.99			
F3	S	7.1	1.34	35.71	29	<0.001
	P	10	.90			
F4	S	6.5	1.73	28.01	29	<0.001
	P	10.1	1.04			
F5	S	6.67	2.23	26.84	29	<0.001
	P	9.87	1.13			

The mean score five dimensions of burden of spouse-caregivers of male patients with single substance use disorder are F1 = 6.4, F2 = 8.1, F3 = 1.34, F4 = 6.5 and F5 = 6.67.

The mean score five dimensions of burden of spouse-caregivers of male patients with poly substance use disorder are F1 = 9.9, F2 = 9.8, F3 = 10, F4 = 10.1 and F5 = 9.87.

Burden in spouse-caregivers of male patients with poly substance use disorder is higher than burden in spouse-caregivers of male patients with single substance use disorder.

Also all the five dimensions of burden, impact on wellbeing, impact on marital satisfaction, appreciation for caring, impact on relations with others and perceived severity of the illness are higher in spouse-caregivers of male patients with poly substance use disorder than in spouse-caregivers of male patients with single substance use disorder. Burdens as well as all its five dimensions are significant at 0.001 level.

Substance use and addiction have long been recognized as major public health and clinical problems with concern about opiate use becoming a focus of special urgency in recent years. Although most research on addiction has focused on one or another substance of abuse, many people use more than 1 substance. Empirical research on people who have problems with multiple substances has been limited, although some evidence suggests that poly substance use may be increasing. As there are no comparison studies done on caregivers of single and poly substance users, based on study done by Bhalla, Stefanovics, and Rosenheck (2017) it can be said that caregivers of poly substance users are associated with higher rates of lifetime suicide attempts, infection, incarceration, deviant behaviors, medical, financial, and legal problems, and depression. Bhalla et al. (2017) reported that use of multiple substances results in more severe medical and psychiatric comorbidities as well as more risky social behaviors. One study specifically showed that veterans who used alcohol and another substance concurrently were at a higher risk for homelessness than those with alcohol problems alone (Tsai, Kaspro, & Rosenheck, 2014). Also previous studies results suggest that PSUD is associated with more severe medical and psychiatric comorbidities (Mertens et al.,

2003). Intoxication with cocaine can lead to seizures (Pascaul-Leone et al.,1990) and use of alcohol is strongly associated with hepatic disease (Ghabril, Chalasani, & Bjornsson, 2010). Intravenous drug use is a well-known risk factor for blood borne infections such as HIV and viral hepatitis (Garfein et al., 1996). Practices relating to the use of multiple substances with medical illness are well documented. It is obvious from the above mentioned studies that spouses of those poly substance users will experience more burden compared to the ones with single substance use. Veterans with PSUD use substantially more mental health services than those with a single SUD across all types of services including inpatient and residential care, and a wide range of specialized and subspecialized rehabilitative mental health services and psychotropic medications. Previous studies found that substance abuse is a considerable risk factor for suicide and violence (Hall, Platt, & Hall, 1999) and those high risks may account for the increased use of residential and inpatient treatment. Treating each SUD, its medicinal and psychiatric associate, and social dysfunction in loneliness through an uneven example of service delivery, nevertheless, may fail to satisfactorily address these demanding clinical states of affairs in their full density. Therefore, caring for patient with PSUD leads to more burden in spouse-caregivers than caring for patient with SSUD in the spouses. The care provided by the wives and in addition taking care of the family member of patients with PSUD is an extra burden for the spouse caregivers. It affects their well being as well as impacts their relationship with the others. Also it is more like to impact their marital relationship.

Therefore the hypothesis stating “Spouse-caregivers of male patients with poly-substance use disorder would score high on burden compared to spouse-caregivers of male patients with single substance use disorder” is accepted.

**Hypothesis 5:** Spouse-caregivers of male patients with multiple substance abusers would score high on depression compared to spouse-caregivers of male patients with single substance abusers.

**Table 5.11**

*Mean, SD and t-value of depression among spouse-caregivers of male patients with single and poly substance use disorder (N=60)*

	Types	Mean	SD	t-score	df	Sig.
Depression	S	32.33	11.33	23.83	29	<0.001
	P	54.46	4.82			

In table 5.11, it is observed that mean of depression in spouse caregivers of male patient with single substance use disorder is 32.33 and in spouse caregivers of male patients with poly substance use disorder is 54.46 which indicate depression in spouse-caregivers of male patients with poly substance use disorder is high than depression in spouse-caregivers of male patients with single substance use disorder. Depression in spouse-caregivers of male patients with single and poly substance use disorder is significant at 0.001 level.



Substance abusing patients who exclusively abuse a single substance have become progressively scarce and unrepresentative of the general population of substance abusers in community and clinical settings. Both population and clinical surveys (Ball & Ross, 1991; Caetano & Weisner, 1995; Helzer & Pryzbeck, 1988) indicate that the majority of those with a current substance use disorder use multiple psychoactive substances and meet current or lifetime criteria for a number of substance use disorders. For example, estimates indicate that 30–60% of alcohol-dependent individuals abuse cocaine (Caetano & Weisner, 1995; Martin et al., 1996; Tsuang et al., 1994), 0–50% abuse marijuana (Caetano & Weisner, 1995; Martin et al., 1996; Tsuang et al., 1994), 12–20% abuse benzodiazepines (Ciraulo et al., 1988; Ross, 1993) and 7–10% abuse heroin (Caetano & Weisner, 1995; Martin et al., 1996; Tsuang et al., 1994). Prevalence of marijuana abuse in cocaine-dependent patients ranges from 25 to 70% (Higgins et al., 1994; Schmitz et al., 1991), and lifetime prevalence of alcohol dependence exceeds 65% in both treatment-seeking cocaine users as well as those not seeking treatment (Carroll et al., 1993). Fifty, 33, 47 and 69% of heroin-dependent patients are regular users of alcohol, benzodiazepines, cocaine, and marijuana, respectively (Ball & Ross, 1991). Cigarette smoking is also common, with up to 63–90% of treatment-seeking substance abusers reporting daily nicotine use (Budney et al., 1993; Burling and Ziff, 1988; Cunningham-Williams et al., 2000).

People who use multiple substances are increasingly seen as a subpopulation exhibiting a unique risk profile, with concerns regarding parallel use superseding interest in the exact sequence of initiation. Such substance co-use is linked with

dangerous behaviours and harmful health outcomes over and further than the use of each individual substance in loneliness (Connell et al., 2009; Connor et al., 2014; Moss et al., 2014). Those who report wide-ranging co-use are also more likely to report poor mental health, high-risk sexual behaviours, and substance use disorders, including opioid dependence in adulthood, all of which synergistically contribute to negative outcomes and lifelong harm (Arterberry, Horbal, Buu, & Lin, 2016; Fiellin, Tetrault, Becker, Fiellin, & Hoff, 2013). By 2017/2018, over 50% of substance users were using more than one substance and reports of single substance use had dropped accordingly. Together, these results suggest that poly-use is on the rise. The burden of caring for the caregivers too increases as increase in rise in mental issues, physiological changes, withdrawal, emotional disturbances, and abusive and violent nature of the poly substances users than in the single substance users.

Gupta and his colleagues (2014) intended to determine the psychiatric morbidity in wives of substance dependent men and to review social support and coping as its associates. The psychiatric diagnosis was present in 16 percent and 20 percent of the wives in alcohol and opioid dependence groups, respectively, depression and dysthymia being the commonly encountered diagnoses. Psychological morbidity is common in wives of patients with substance use disorders. Also, Codependence in family members of substance users seems to be a culturally influenced construct. Codependence was found to be present in 56 and 64% of the spouses in the alcohol and opioid dependence groups, respectively (Sarkar, Mattoo, Basu, & Gupta, 2013).

Although the majority of the wives agreed that codependency engage them in caretaking behavior and live by virtue of their relationship with an alcoholic, they oppose widely as to its impact on the self, its locus as private or societal, its disease condition, its prolonged existence, and whether or not it is typical to alcohol-complicated marriages. Self blaming and recognition of self occur through retrospective reinterpretation of their lives with their alcoholic husbands, directed and legitimated by therapeutic human resources. These reconstructions then serve as self-evidence of codependency (Asher & Brissett, 2009).

From the above mentioned statistics of single substance use and poly substance users, therefore it can be derived that spouse caregivers of poly substance users will be more distress, burdened and is more likely to experience fatigue and prevalence of mental illness, particularly depression is common than spouse caregivers of single substance users.

Therefore, the hypothesis stating, “Spouse-caregivers of male patients with multiple substance abusers would score high on depression compared to spouse-caregivers of male patients with single substance abusers” is accepted.

**SECTION V: Multiple regression equations for the sociodemographic variables**

**Hypothesis 6:** There would be significant effect of selected socio-demographic variables on depression among spouse-caregivers of male patients with single and multiple substance users.

**Table 5.12**

*Socio-demographic variable predicting depression among spouse-caregivers of male patients with single and multiple substance abusers.*

<i>Variables</i>	<i>B</i>	<i>SE</i>	<i>β</i>	<i>P</i>
Age	-.157	.282	-.066	> 0.05
Religion	2.582	2.702	.132	>0.05
Social group	.001	2.043	.000	>0.05
Family type	13.109	3.506	.468	<0.001
Education	-.408	1.720	-.033	>0.05
Income	.526	2.810	.023	>0.05

**Table 5.13**

	<b>R Square</b>	<b>F</b>	<b>P</b>
Sociodemographic data	.271	29.21	<0.001

From table 5.13, it can be observed that R Square for sociodemographic variables is 0.271 which is significant at 0.001 level. Also considering the variables, from Table 4.12

it can be seen that except family type, none of the variables are significant in predicting any effect on depression. It can be concluded that except family type, the other variables, age, religion, social group, income and education of the spouse caregivers of male patients with single and poly substance use disorder does not have any effect on depression. No relationship is found between social group and depression in spouse caregivers of male patients with single and poly substance use disorder.

Socio-demographic variables included in this study are age, religion, social group, family type, education of the spouses and income of the spouses. It can be observed from the above tables from the analysis of socio-demographic variables, most of the spouses (63.33%) are of age 26 years – 35 years and 71.67% of the spouses is Hindu. Covinsky (2003) found that patient characteristics that predicted caregiver depression included younger caregiver's age and low levels of financial resources (income). The age of the caregiver was found to have an impact on the caregiver's stress where younger caregivers are more likely to experience caregiver stress in a study by Markey, in 2015. Pinquart and Sorenson (2007) found that there was a higher rate of depression in older caregivers. About 33.3% spouses-caregiver have completed matriculation, 26.7% had completed graduation, 20% has done their 10+2, 16.7% has done primary education and about 3.3 % spouse-caregivers had no education at all. Sociodemographic characteristics have been less likely to be associated with emotional distress; although Cameron and colleagues (2002) found that those caregivers with less than a high school education were more distressed than those with higher levels of education. The effect of the socio-demographic variables on the caregiver's quality of life is unclear as findings from previous studies (Wilder, Oliver, Demiris, & Washington, 2008) have been mixed.

If we compare the social group, maximum (40%) are General category and rest 60% were OBC, ST, SC or others. Also income of most the spouses (75%) were between Rs. 0 – Rs.10000 and only 25% of the spouses are of the income group Rs.10000-30000 and Rs.30,000/- and above. Equal numbers of spouses (50% each) were found to be from both nuclear and joint family.

Findings from the study also revealed that two other socio-demographic characteristics of caregivers were associated with depression: education and income level. (Sun et al., 2019). Caregivers with higher income and education level were less likely to be depressed was reported by Cummings and Kropf (2015) and Magana et al. (2007). These studies are contradictory to the present finding which does not indicate income and education as a predictor of depression in spouse-caregiver of male patients with single and poly substance use disorder.

Studies by Zhou et al. (2011) and Geriani et al. (2015) defends the relationship between the sociodemographic variables of the caregiver and the person cared for and the illness characteristics with the level of burden and risk factors. The most prominent variables - age, religion, income, and education. However, given the high levels of depression found in most subjects under study, the statistical tests performed for quantitative data analysis indicate that in this sample, the depression had no significant relationship with any of these variables.

In this study, the impact of age on the occurrence of depressive disorder was in contrast to previous research. Pinquart and Sorenson (2007) suggested that older people had a high degree of depression and younger people had high degree of anxiety. Our study found that that being

younger significantly increased the likelihood of suffering from a depressive disorder whereas age was not a significant predictor of suffering from depressive disorder. One could deduce that younger people have more stress and other roles to conform depicting them more vulnerable to suffering from an anxiety disorder (Pinquart & Sorenson, 2007).

Contrast to previous findings of Dew et al. (2004), in this study employment status significantly affected the likelihood of suffering from a depressive disorder. Not being in the labor force increased the likelihood of suffering from a depressive disorder twofold. Dew et al.'s (2004) study indicated that depressive disorders were elevated by unemployment (Dew et al., 2004). Our study did not find that unemployment or income predicted elevated rates of depressive disorders. The sole socio-demographic variable that held significant predictive value for depressive disorders was family type, more specifically, both being equal.

Therefore the hypothesis stating “There would be significant effect of selected socio-demographic variables on depression among spouse-caregivers of male patients with single and multiple substance abusers” is not accepted.

## **5.2 Qualitative Analysis**

### **SECTION VI: *Narrative Analysis of Spouse-Caregivers***

The exercise of a narrative analysis and the expansion of case stories offer multiple outlooks in understanding a community-based literacy course. These sorts of method offer meaning to the learners' own lives; it brings out history, literature and saga. Hopkins (1994) writes that because the recounted experience is central to the development of a social and personal identity - it has a lot to do with education and learning. Connelly and Clandinin (1990) put in the picture that stories can permit individuals to reflect upon life

and enlighten themselves to others - in order to study 'life narratives' as a framework for making meaning. A life story can be a work of fiction but as Lauritzen and Jaeger (1997) write it can also be factual as in the telling of a real life incident. They point out that this factuality reflects the learner's point of view, not actual reality.

A typical narrative framework focuses on the 'core narrative' or skeleton plot through four categories (Mishler, 1986):

- Orientation - describes the setting and character
- Abstract - summarizes the events or incidents of the story
- Complicating Action - offers an evaluative observation on conflicts, events and themes
- Resolution - describes the outcomes of the story or conflict

The resulting investigation moves towards a deduction of the recitation to answer the question "What is the point of this story?" This kind of analysis is rather formal and ordered and its authority lies in its generalizability.

The narrative analysis of the stories applies phrases from literary study. The word "story" is used in exchange with "narrative" all the way through the study. I have developed a 'story-map' for each spouse-caregivers whose story has been part of the research. The story-map organizes the spouses' recounting of past and present experiences and future intentions under the rubric of character, setting, events, conflicts, incidents, themes and resolutions (or outcomes). There are stories of 5 spouse caregivers of male patients with single substance use disorder and 5 spouse-caregivers of male patients with poly substance use disorder. This "map" presents a silhouette to individual stories and allows



for a more insightful analysis in relation to the objectives of the study. The shape of a story is a blueprint acknowledged by both storytellers and listeners, allowing the mind of both to renovate and create sense of what is being heard or told. The story is a meaningful way of organizing thinking and is useful for this study.

The following questions were asked to the spouse-caregivers of male patients with single and poly substance use disorder:

- How is your relationship/life with your husband on financial and emotional aspects?
- How do you take care of yourself? Can you please explain what kind of support you get from your relatives or significant others and what kind of support do you expect?
- Can you please tell us about your experience when you feel low?

**Case studies of spouse-caregivers of male patient with single substance use disorder-**

*Case Study 1: My relationship with my husband is not good. He does not care how I feel. He does not care about the family. Ours was a love marriage. He loved me very much. He cared for me. But when he gets to drinking, he becomes abusive. I use to stand outside the house till midnight because he scares me. He tries to get intimate with me forcefully. I only come inside when I see that he has stopped drinking and slept.*

*He was doing well with his business but due to his drinking habits. He lost everything. He takes that frustration on me. I am a nurse. I have to stop working because he would otherwise disturb the family.*

*I do not want to take care of myself. The person I love does not care about me or my feelings. For whom shall I dress up? I always get worried about his doings and want to help him.*

*My mother-in-law is very supportive. She helps me a lot. She supports me. My parents understand too. But I cannot expect help from my friends.*

*When I feel low I do not want to talk to anybody. I feel lonely and helpless. I think of leaving my husband but I love him. Whenever I feel low I go to my sister's place and spend some days with her. I often think it is better to die than to live this way and face this every day.*

**Past history:** In the case story, it can be understood that husband was caring and loving and was doing well with his business. Theirs was a love marriage. After he started drinking, he lost his business and got abusive.

**Present history:** In the present, the wife is not happy with her husband. He is scared of her husband. She has to face his anger and frustration. Also after he starts drinking he become abusive and tries to get intimate with her without her consent. She has to stay outside her house till midnight to avoid him. This shows that there is a fear in her because of her husband's addiction. She also stated she do not want to take care of herself as her husband does not care for her anymore. she also has o quit her job because of her husband's situation which makes her lonelier and more helpless. All she does is keep worrying about him and how she can help him. Worry and anxiety can be observed in this case. Also not wanting to take care of self can be taken as a sign of feeling of worthlessness and self dislike. Also she stated that when she feels low she do not feel like talking to anyone and goes to her sister's place for few days. It can be noticed that she is trying to avoid the situation when she feels depressed. Burden and depression are

prominent in her case. She even thinks of leaving her husband and often gets suicidal thoughts. The burden of facing the abuse everyday made her wish for death.

**Future plan:** Though her parents and mother-in-law are support there is not much hope in her. She wants to leave her husband but is not to leave because she loves him. She often gets suicidal thoughts and expects death than facing the same things every day. In future, she is more likely to carry out her suicidal thoughts if she ever gets any chance.

*Case Study 2: My relationship with my husband is not at all good. He does not care for me. He was very understanding before but now he would fight with me for everything. He does not like anything I do. He always uses to say that I can do nothing. He does not even allow me to go my parents' place. Even when he was admitted to the hospital, he would scold me in front of everyone. He even tried to slap when I asked him not to go out of the hospital. Whatever he earns he spends it on alcohol.*

*Talking of self care, what would I do take care of myself? Again I have to hear all those scolding. Who would like to take care of themselves when you keep hearing all the bad and abusive words about you?*

*Before my in-laws used to support him but now even they do not care about him. They have left us on our own. I do not have any schooling to get a good earning job but my husband earns god money. Even though he earns good we still have financial crisis. He does not give me any money and would spend everything on his drinks.*

*I do not want to live. I do not feel like living. I have also attempted suicide but it was unsuccessful. Whenever I fell low I do not want to talk to anybody. I prefer to be alone. I*

*want to cry but I cannot. It's just because of my children I am with him otherwise I would have left him years ago.*

**Past history:** The wife stated that her husband used to understand her and would help her before but now he does not care for her. Lack of attention and love is being reported by the wife.

**Present history:** The wife is mentally disturbed and has strong suicidal ideation. Also she has attempted suicide once. Self care is totally absent in her and she blames her husband for that. The scolding and the humiliation faced by her from her husband has left her shattered and she does not even wants to take care of herself. Depression is severe as she stated *"I do not want to live. I do not feel like living."*

**Future plan:** The wife is likely to attempt suicide again because of the high level of mental and physical burden experienced by her and depression is also severe. Proper treatment of the spouse caregiver is necessary.

*Case Study 3: When I married my husband, he promised that he would stop taking drugs. He uses to take heroine. Whenever he is in hospital, he would stop taking the drug. After treatment he would be fine for few days but again when he meets his friends he would start again. He loves me, cares for me but when he gets back to taking heroine he forgets that I am his wife. I am just another person for him.*

*Most of our earnings are spent on his treatment. When not under treatment, it is spent on his drug. Whatever is left I try to run the household with that. I refuse to give him money for drugs but he gets violent and beats me up.*

*I do not feel like getting dressed up. Sometimes I do not even feel like cleaning my face. Anyway, I have to face the usual, so what the use of keeping myself clean. My in-law and other relatives often blame me when I cannot stop him. I cannot stop him even I try. My in-laws won't even understand I have lost all my friends.*

*I feel low almost all the time. I do not want to do anything. Sometimes I do not even feel like doing the households work. I feel lethargic. I want to sleep all the time. I sleep most of the time. Also I do not want to eat. I think about suicide but do not carry it out on the hope that things will change.*

**Past history:** The husband used to take heroine even before their marriage. His spouse married him as he promised that he would leave taking drug after their marriage. But he did not keep his promise.

**Present history:** The wife stated that the husband is caring and affectionate but when he takes the drug, he gets abusive and does not even remember. He starts getting abusive and would often fight for money. The wife stated that she does not even feel like cleaning her face. Lack of self care clearly visible in her. She sleeps most of the time and also does not feel like eating. This indicates the presence of depression in her. Also support is absent in her situation, this may be the reason for increased burden.

**Future plan:** She has hope for the future that things will change. Although she has suicidal ideation, she does not carry that out. She hopes things to change.

**Case study 4:** *My relationship with my husband was okay. We were fine with each other. Before we used to discuss stuffs with each other but after started drinking he is always*

*busy with his friends who drinks too. I often feel left out. Our relationship is not strong as before. We fight more now, actually most of the time. We are losing peace in our family.*

*He even left his job and often comes home late. He is not even trying to get another job due to which we are facing financial problems. I think we still connect and he wants to recover but is not being able to. Hope if I can do something.*

*I try to take care of myself as much as I can. I keep myself busy. I watch YouTube videos about how to adjust to such problems. I also ask him to watch such videos for motivation. My in-laws and parents are supportive and I can really ask help from my friends if need arises. I cannot say much about my relatives.*

*I cry when I feel sad or lonely. I do not want to out with friends sometimes but my mother-in-law force me to go. She treats me like her daughter. I never had any suicidal thoughts. Maybe because I always have support when I need.*

**Past history:** The relationship between the husband and the wife was working well before the husband's addiction to alcohol started. There used to be discussion between them on issues and it was a pleasing relationship. After he started drinking he stays out most of the time with his friends and comes home late.

**Present history:** The wife although depressed is able to cope with the situation. Though she reported being lonely and crying when upset she also stated that because of the availability of all needed support she is able to cope with the situation. Self care is also present in this case. She does not report any suicidal thoughts and also refuse of ever having them.

**Future plan:** There is hope of recovery in her and she also try to motivate her husband in any way she can. No suicidal tendency is noticed.

*Case study 5: My husband is a loving and caring person. He still cares for me but not like before. He is not attentive at all now. He does not even listen to important things I say. He takes marijuana. When he takes that stuff he is not aware of what is going on the world. I have to do all the things alone starting from household chores to official work. If asked he would do the works but would mess things up and I have to do the same work anyway.*

*I get no time for me. I feel so loaded. I always leave for work in hurry and is often late. If I could get some help. My in-laws are not at all supportive. My parents do not stay near so no help can be expected from them too. Taking care of me is like a impossible thing. With so much work to do there is never time left for me to do anything for me.*

*I feel like crying for no reason. I feel so tired looking after the husband and the kids and no one is even there to help me. I feel like a sick person always attending to others and when needed getting not even a glass of water. I do not want to live this way. Sometimes I feel like leaving the entire thing behind but again thoughts of my children does not let me do that.*

**Past history:** The husband is a caring and loving person who was attentive and helpful before he started taking on the drug. He is not aware of his surroundings.

**Present history:** The whole burden of the house is borne by the wife. From doing household chores to taking care of the children to doing her job the burden is on her with no one to support. It is noticed that she is depressed and want to leave the situation but is

holding on just because of her children. Self care is totally absent and the wife also reported being tired and having crying spells. Depression is clearly visible in this case.

**Future plan:** The only hope that the wife is holding on is her children. There is likelihood of the wife leaving her husband if someday she gets the opportunity. Though no suicidal tendencies reported it is likely to occur if proper intervention is not taken.

### **Case studies of spouse-caregivers of male patient with poly-substance use disorder-**

*Case Study 1: When I married everything was fine for a year or two. He doesn't not have any drinking habits or did not take any other substance. everything was going perfect. He used to go to work in the morning and return home in the evening. Sometimes he used to go out with his friends. Gradually his outing with his friends became regular and he started coming home drunk. It happened a couple of times so I did not pay any attention to it. When it became a regular thing, I got worried. I tried talking to him about this habit. For few days he would stop taking alcohol but again he would start. After few months I came to know that he also takes other substance along with alcohol. When I confronted him he shouted at me and even threatened to beat me if I interfere in his life. He started ignoring me. I did not know what to do. I approached my in-laws and my parents. They tried to talk to him but it was of no use. We thought of getting him admitted in a rehab as well but could not. He initially used to take alcohol and all those substances but did not create a problem in the house but slowly he started getting violent. He ignored me and also became irregular in his job due to which he was fired. Now I am the only earning member in the family. I have to support the whole family. My salary is not enough*



*to manage the whole family. I often run short of cash and has to burrow from my parents or friends. Though my in-laws supports me I do not feel any less stress.*

*I try to keep myself busy. I work extra shift to distract myself as well as for the money. I try to come home as late as possible to avoid him. I do not feel like facing him.seeing him in that condition makes me feel sad and angry. Nowadays I get irritared at small things.*

*Whenever I feel low I want to cry out loud but I cant. I lock myself in the room and cry. I often think of suicide.i do nt see anything good coming out of it. There is no hope for me.*

**Past history:** Before marriage the husband was not into any substance but it started after a year or two. He was doing ell with his job and was even regular in his work. He used to usually hang out with friends. The married life was good and there was no such worrisome issues for the wife. It started when he increased his hangouts and often come home late, most of the time drunk. It became a problem for the wife when it became a regular thing and also started taking other substances. He became abusive and violent.

**Present history:** The wife has high level of burden and often would have crying spells. The burden experienced by the wife has led her to live a life of issolation even in the presence of support. Depression is clearly visible in the wife. Self care is absent and load of extra work is perceived as an excuse from the tiring role of careging for the wife. Suicidal ideation is present in the wife.

**Future plan:** The wife does not see any hope in the future. She does not think her husband will ever listen to her or visit a rehab. She sees no signs of recovery in her husband. If ever she gets any chance there is high probability of attempting suicide.

*Case Study 2: When I got married I was not aware of the drinking habits. About taking other substance I got to know only after a year of marriage when he started taking those stuffs again. I was not told about his substance addictions before marriage. Even my parents weren't aware of it. When we confronted we were told that he was an addict many years before we got married but he went through treatment and after staying at a rehab for 6 months, he stopped taking those substances. He was treated totally and he did not know that he will start again. They thought he would never drink again and that would not be a problem. So they did not inform the wife and her family about his drinking habits or about him taking other stuffs. I do not know what to do. He is not a bad person but when he gets drunk no one knows what will be his behavior then. He said I could leave him but I do not want to leave him. Only when he is under the effect of those substance he reacts violently. He doesn't physically abuse me or beat me but when he gets angry he uses to say such things which make me feel it was better if he would have beaten me. The harsh words were enough to burden me mentally. Those words run in my head all day and I could not stop thinking about it. That bothers me. I want to cry and I do cry sometimes. My mother-in-law is not supportive of me doing job but rest of the family does not have any problem with it. Self care is like a alien term for me now. I am being called an addict's wife. I do not want to take care of myself. I think he was cured once before, so, this time too he will be cured.*

*I feel sad all the time. I am not even able to sleep or eat properly. Only if things were different. May be its my fault I am not being able to take care of my husband.*

**Past history:** The wife and her family not being aware of husband's addiction is a case of betrayal for them. The husband was a recovering addict and though he has not taken any alcohol or substance prior marriage, starting all over again is a possible sign of withdrawal. Her husband not telling her about his issues has created a sense of anger in her.

**Present history:** Mentally the wife is suffering a lot and the burden of being called a addict's wife is taking on her mind and health. Also the burden of taking care of rest of the family, her job has put extra burden in her. The wife is clearly depressed as she mentioned of not being able to sleep or eat and her mind being constantly worried about her husband and his harsh words has created a wall of silence around her. Lack of self care and self blame is visible in her.

**Future plan:** No suicidal ideation or attempt is present but if it continues there is likelihood of suicidal ideation. There is hope in her and she want him to get cured. She also wishes if things would have been different.

*Case Study 3: I got married when I was 17 years. Ours was love marriage. We did not marry with our parents consent. We eloped and got married. I have a son who studies in college. Our world was perfect until he started taking bhang (cannabis). It was not much initially but then he started taking it from the morning till night. He use take while going to work and then again after coming back from office. It was fine when he was taking*

*only the bhang but after he started taking the other stuffs like heroine and all he got abusive. He use to lose money in gambling and then would fight with me for money. I do not have much qualification for a good job to earn enough. I got a job of a receptionist but again due to his abusive nature and the thought of him and my son alone at time would not let me concentrate on my job. I left the job and now I bake at home and take orders.*

*When I do not give him money for his stuffs he steal from me. I hide the money so that he could not steal but again then he would sell all the houshold items, like TV, heater and all. I tried talking to him about getting treatment, he aggreed but again he would try to make excuses when asked to visit a doctor or rehab. I now do not care what happens to him. I just do not want any harm on my son because of him.*

*My parents would support me but again they would make me listen how I made a mistake eloping and marring him. I do not want hear all that, what I have is enough so I refused their help. My in law are supportive and I can trust my son with them. Its only because of my in laws that now I can bake at ome. Also my son has grown up now. He hekps me too.*

*I get so busy in baking, taking order, cooking for the family, taking care of my husband and my son that I do not get time for myself. I do not want any free time. Otherwise my mind would be thinking of all the negative stuffs.*

*I feel sad but what can I do. I cannot change anything. Suicide was an option for me before but now when I think of my son it seems like a foolish idea. I am used to my life now.*

**Past history:** It was a love marriage. They eloped and married against the wishes of their parents. They were happy before. As mentioned by the wife everything perfect. They were happy as a couple until the husband started taking cannabis and other stuff. There was no other illness present in the husband as well as the wife.

**Present history:** Presently, the wife is fed up with her husband's situation. He does not take any help from her parents even if they are offering because of her rants. He is only worried about her son and him getting a good life. The mental pressure of caring for the husband, cooking for the family and taking care of her son and also with all the orders and baking she is quite occupied. Depression is visible in her as she feels sad but she cannot do anything to change that. She has lost hope of her husband getting any help or being recovered. Her husband selling the household stuff and stealing money from her has created an extra burden for her and the thought of her son being affected because of her husband's situation or behavior is mentally pressuring her to leave her job. It can be concluded that the burden of caring is taking a toll on her and has led to depression.

**Future plan:** She does not hope for any recovery of her husband. There is no hope in her. Loss of hope and suicidal thoughts may affect her in the future. If her son leaves for higher studies or job she would even carry out the suicidal thoughts.

*Case study 4: I was very young when I married my husband. I did not know much about the illegal substance such as heroine, cocaine and other such stuff. My husband was 10 years older than me. When I married I did not know that he was an addict. I knew he used to drink but did not know about the other substances. But his addiction did not create*

*any problem but when his bussiness went down he started taking all the drugs in large amount and that's when financial problems, marriage problem and all this started. He use to come home and blame me and the children for his loss in business. He would beat the children if theymake moises. They are children, they do not know anything. He also beat me if I try to stop him. he would not give us any money, the little he gives is very difficult for me to manage. My cildren are small now otherwise I would have looked for some job.*

*I feel tired all day. More than physical work I have mental pressure. I have to live in fear. I do not care what he does to me but I am afraid he will harm my children.may be I have done something bad in my previous life so I am punished for it. I feel like sleeping and do not want to get out of the bed. I get tired too easily. Now even my eyes drops have dried. I cannot even cry.*

*I do not have any in-laws. They passed away before our marriage.but my neighbors are good. They have helped me wih food and money when needed. I do not have any friends. My neighbors are my friends now. I do not want this life for my children. If I am able to get some good job I will leave my husband and will raise my children myself. I do not want to live with him. He won't even care if he dies. He is not getting well anyway.*

**Past history:** The husband was an addicted even before their marriage. Although he was an addict he was not creating any problem for the wife and his children. Its only after he started losing in his business he increased his doses and became abusive.

**Present history:** Clearly the wife is not happy. She reported being more mentally burdened than being physically burdened. She is depressed because of the burden she has to face. He sleeps most of the time and still gets tired easily. She lives in fear that her husband will harm her children and her. Also she blames herself and her previous life. She believes she has done something bad in her previous life that she is being punished now.

**Future plan:** The wife does not hope or wish for any recovery. She wants to leave her husband and raise her children herself. She is more likely to live with her husband if she gets any opportunity. She is vulnerable to suicide though no suicidal tendency was reported.

*Case study 5: I am married to my husband with 2 children. Both are girls. They are teenagers. My husband was a very caring husband and father. He used to think about his family. Few years back his parents and sister died in a car accident. It was too much for him to bear. He went into depression. Then when he started drinking. He used to come home from work and would not talk to anybody and start drinking. But gradually he started taking other stuff like marijuana. He said it makes him forget the traumatic incident. And then he started taking other stuffs too. When he started taking all those stuff he forgets he has a family and gets violent and would make a scene out of anything. It's unpredictable when he will again create a scene and we have to be ashamed in front of all the relatives. I cannot even say anything. He has lost his whole family and I do not want him to go through any more trouble again. I want him to get well soon. He has agreed to go to rehab with me. Though he is violent towards me he never mistreats his daughters.*

*I do not want to take care of myself. I just want him to get well. I will take care of myself once he gets well. I do not fee like enjoying life withou him. He is a good prson. What happened to him was not good. I cannot see him suffer.*

*My parents are a great help to me. Its only because of them he has agreed to go to a rehab. We have lots of common friends. Thy are supportive too. They always try to cheer him up. I think if we go to a rehab he will be fine.*

**Past history:** The husband was not an addict before. But after a traumatic incident where he lost his parents and sister he went into depression and started drinking. Gradually he started taking other stuffs like marijuana. he acts violent he start taking all these drugs and abuse his wife. Though he abuses his wife he never mistreats his daughters.

**Present history:** He wife is considerate of her husband and wishes him to get well soon. She also encourage him to visit a rehab. She convinced him to visita rehab with the help of her parents. Though she is unwilling to take are of self she stated she would once he gets well. There is hope in her. Though there are less signs of burden she is still depressed to an extend. Her lack of self care and her worry for her husband's wellbeing point towards depression. In this case, social support from friends and family has helped in lessing the burden in the spouse-caregiver.

**Future plan:** The wife is hopeful of the future. She convined her husband to visit a rehab and hopes he gets well soon. She looks forward a bright future though she is worried about her husband 's wellbeing. No suicidal tendency is seen in this case.



### **Discussion of Narrative Analysis**

More deterioration in a marital relationship as perceived by wives may be because of the fact that substances used by their husbands is the illegal drug and time spent in the procurement of the heroin and other substances through illicit sources is quite high. A number of sources of stress for spouse-caregivers who provide care for their husband with a substance use disorder have been identified. Those most reported often include isolation, coping with behavioral problems, not having enough help in providing care for their relative, and financial issues and self blame as well blame for the husband's addiction by others. Also reported effects of these stresses include worry, anger, guilt, and shame; financial and emotional strain; marital dissatisfaction and discord; diminution in the quality of life and hopefulness of spouse caregivers, negative impacts on the normal growth and development of children in the family and physical effects of the stress of living with a substance abuser. Suicide is one common factor found in both the spouse caregivers of male patients with single and poly substance use disorder. Hence, there is inadequate attention and affection toward the spouse and inability to satisfy the emotional needs of partner.

In our study, the spouse caregivers experienced significant burden in various domains due to patient's substance abuse. It is probably because the spouses were dependent on the patients for various reasons like finance and child-rearing.

Moreover, the societal views of being separated from the husbands suffering from alcoholism or substance use disorder will cause them more mental trauma and hence most of them prefer to live with the patients despite the fact that they faced significant

burden. In most of the families, patients were the sole earning member of the family and majority of the caregivers were unemployed. Also money was deviated for procuring the substance and treatment expenditures.

Frequent arguments, verbal abuse, and physical abuse of family members under the influence of alcohol or drugs caused significant disruption in the communication between family members, disruption in their leisure activity, and significant adverse impact on caregiver physical and mental health.

Therefore, while treating alcoholics or patients with substance use disorder it is important to alleviate the burden of the caregivers which in turn will lead to better treatment effectiveness.

## CHAPTER VI

### SUMMARY, CONCLUSION AND SUGGESTIONS FOR FURTHER RESEARCH

One of the worst psychosocial hazards being faced by any society today is addiction to alcohol and psychotropic drugs. The use and abuse of various licit and illicit substances and its negative consequences is increasingly becoming a major public health concern. One worrisome factor is the progressive decline in the age of initiation. Living with spouse with severe mental illness is stressful. Burden of care is a universal concern affecting family caregivers in both developed and developing countries. The aim of this study is to study the relationship between care burden, perceived social support and depression of the spouse-caregivers of individuals with single and poly-substance abusers of Assam. This study will also aim to compare the care burden, perceived social support and depression in spouse-caregivers of patients with single and poly- substance use disorder and study the common between wife caregivers of patients with single and poly-substance use disorder of Assam.

In marriages where one partner struggles with substance abuse disorder, the non-addicted spouse carries the responsibility for two people, including care of the children, finances and is often the primary breadwinner for the family. The call for support and to get suitable treatment for the addicted loved one becomes overpowering. The decline of patient's condition can boost care burden and be a basis of a vicious cycle, and if appropriate intervention is not made, it may direct to a gradual exhaustion of the caregivers. Also, social support is becoming recognized as a positive influence on health

and health maintenance. Therefore, timely identification of these pressures in caregivers plays a decisive role in promoting their physical and mental health. Little attention has been paid to the relationship between caregiver burdens and perceived social support in spouse-caregivers of patients with substance use disorder. Thus, conducting a study on the care burden and perceived social support of the spouse-caregivers of patients with single and poly-substance use disorder seems necessary. The present study will examine the care burden, social support received by the spouses and its effects on depressive symptoms in spouse-caregivers experienced by caring for their male spouses with single and poly- substance use disorder.

### **Objectives of the study**

1. To find out burden, social support, depression and their relationship among spouse-caregivers of male patients with single and poly-substance use disorders.
2. To determine the effect and level of significance of burden, social support and depression among spouse-caregivers of male patients with single and poly-substance use disorders.
3. To evaluate the main effect of the selected demographic variables on depression among spouse-caregivers.

### **Hypotheses of the study**

1. A significant correlation would exist between burden, perceived social support and depression among spouse-caregivers of male patients with single and poly- substance use disorder.

2. Burden and social support would contribute significantly in predicting depression among spouse-caregivers of male patients with single and poly- substance use disorder conjointly as well as independently.
3. Spouse-caregivers of male patients with poly- substance use disorder would score high on burden compared to spouse-caregivers of male patients with single substance use disorder.
4. Spouse-caregivers of male patients with single and poly- substance use disorder with low social support would experience more burden compared to spouse-caregivers of male patients with single and poly- substance use disorder with high social support.
5. Spouse-caregivers of male patients with multiple substance abusers would score high on depression compared to spouse-caregivers of male patients with single substance abusers.
6. There would be significant effect of selected socio-demographic variables on depression among spouse-caregivers of male patients with single and multiple substance abusers.

## **METHOD**

A total number of 60 spouse-caregivers (30 spouse-caregivers of male in-patients with single and 30 spouse-caregivers of poly-substance use disorders) of age range of 18 years to 40 years were selected for the study from different psychiatric hospitals and rehabilitation centers of Assam. Both quantitative and qualitative research method (mixed method) was employed for collection of data. Five spouse-caregivers of male in-patients

with single substance use disorder and 5 spouse-caregivers of male in-patients with poly-substance use disorder were interviewed individually by using in-depth interview technique for in-depth understanding of their problems. Methods for data collection include self-report inventories and scales by the technique of purposive random sampling. The present sample consists of 60 participants, 30 spouses of patients with single-substance use disorder and 30 spouses of patients with poly-substance use disorder. The spouses include were in the age range of 18-40 years. The mean age of the participant is 31.96 and SD is 5.96.

### **Tools used**

*Socio-demographic Datasheet (Self, 2019):* Socio-demographic data sheet consists of the personal record of the spouse-caregivers like age, sex, name, education, religion, residential address, ethnicity, socio-economic status like employment, income of the spouses, etc. It helps in acquiring the characteristics of the caregivers and the patients and to check the difference with any previous studies or theories.

*The Burden Assessment Schedule (Sell et al., 1998):* The Burden Assessment Schedule (BAS) has been developed by Sell, Thara, Padmapati and Kumar (1998) with the support of the WHO. BAS is a 20-item instrument rated on a 3-point scale, marked 1-3, covering five domains: Impact on well being, Impact on marital relationships, Appreciation for caring, Impact on relations with others, Perceived severity of the disease.

*The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) -* The Multidimensional Scale of Perceived Social Support (MSPSS), developed by Zimet, Dahlem, Zimet and Farley (1988) is a short instrument designed to measure an

individual's perception of support from 3 sources: family, friends and a significant other. Each section consists of 4 items. This instrument contains 12 questions items, rated on 12-point Likert type scale ranging from very strongly disagree to strongly agree.

*Beck Depression Inventory II (Beck et al., 1996)*: The Beck Depression Inventory (BDI II) is a 21-item self-reporting questionnaire for evaluating the severity of depression in normal and psychiatric populations. The BDI-II was designed to act as an indicator of depressive symptoms based on diagnostic criteria in the DSM IV. The BDI-II contains 21 items on a 4-point scale from 0 (symptom absent) to 3 (severe symptoms).

Qualitative data was collected from 5 spouse-caregivers of in-patients with single substance use disorder and 5 spouse-caregivers of in-patient poly-substance use disorder. They were interviewed individually by using in-depth interview technique for in-depth understanding of their problems. The following probable questions were asked at the time of interview:

- How is your relationship/life with your husband on financial and emotional aspects?
- How do you take care of yourself? Can you please explain what kind of support you get from your relatives or significant others and what kind of support do you expect?
- Can you please tell us about your experience when you feel low?

### **Statistical Techniques**

The collected data were analyzed by using the various statistical techniques using SPSS. The scores of the psycho-social determinants of depression among spouse-caregivers of male patients: a comparative study of single and poly-substance use disorder were calculated by means of descriptive statistics such as percentage, mean, frequency and

standard deviation. Collected data was tabulated and t-test and regression was used to find out the significant difference between spouse- caregivers of male patients with single and poly-substance use disorder. The comparisons between the two groups were calculated. The correlation was used to measure the relationship between the t variable. The comparisons between the different groups were made on the basis of 0.05 and 0.01 levels of confidence considered significant.

### ***Major Findings***

Burden and support has been found to positively related to depression. All the dimensions of burden, impact on well being (F1), impact on marital relationship (F2), appreciation for caring (F3), impact on relation with others (F4) and perceived severity of the illness (F5) have been found to be positively significant. Social support and two of its dimensions, support from significant other and support from friends is significantly related to depression. Also, burden and social support both are found to predict depression individually as well as jointly. Differences are found between spouse caregivers of male patient with single and poly substance use disorder. Spouse-caregivers of male patients with poly substance use disorder are found to high on burden and depression than spouse-caregivers of male patients with single substance use disorder. However, a positive relationship is found between depression and social support which contradicts our assumption that low social support will lead to more depression in spouse- caregivers and vice versa. No sociodemographic data (age, religion, social group, education and income of the spouses) is found to predict depression in spouse-caregivers of male patients with single and poly substance use disorder except family type.



From the narrative analysis it is seen that the spouse caregivers of both single and poly substance users experience high burden and have depressive symptoms. Suicidal attempt and suicidal ideation are common in both the spouse caregivers of single and poly substance users. Feeling of isolation, crying spells, irritation, fatigue are common factors in the spouses.

It was concluded that the greatest burden was economic followed by stigmatization, emotional and relationship difficulties. Drug abuse magnifies violence within marital relationships. One of the major burdens the wives faced was the burden of blame – blame for the drug use in the family member, blame for hiding the issue from others, and blame for not getting timely treatment. Thus, the wife often became the victim of not just the drug abuser but also the society. Most women suffer abuse silently, responding with humiliation, frustration, helplessness, and suicidal thoughts. Shame and embarrassment caused many women to build “a wall of silence” around her, thus increasing isolation and helplessness in the situation.

## **6.1 Conclusion**

The following conclusions can be made from the above findings:

- Spouse-caregivers have little time to care for themselves and to visit their own physicians while caring for a prion disease patient.
- Spouse-caregivers should be encouraged to self-care whenever possible. Exercising, getting adequate sleep, and eating healthfully will benefit the family members and

- enable them to continue caregiving for the patient. The caregiver can furthermore benefit from stress drop through prayer, massage, meditation and therapy.
- Spouse-caregivers may need encouragement to ask for help from professional caregivers or family and friends.

Perceived and received support are not superfluous constructs, 2) the associations between social support and subjective burden depends on whether the social support is considered as perceived or received, 3) the association of perceived social support by means of subjective burden has a larger effect size as compared to received social support, the link between received support and subjective burden being clinically beside the point, 4) perceived social support may be a excellent predictor of subjective burden.

While caring for a loved one can be very rewarding, it also involves many stressors. And in view of the fact that caregiving is time and again a long-term challenge, the emotional impact can magnify over time. One may face years or even decades of caregiving responsibilities. It can be particularly disheartening when there's no hope that your family member will get better or if, despite your best efforts, their condition is gradually deteriorating.

Comprehensive care for patients with substance use disorder and their spouse caregivers is lacking in our health system, leaving millions of individuals struggling under the weight of unmanaged symptoms, stress, and emotional burden.

## **6.2 Limitations of the Study**

- The present study sample group was selected from only 5 institutes of Guwahati, Assam.

- The study consists of only wives of patients with substance use disorder.
- The study consists of only 60 spouse-caregivers of male patients with single and poly substance use disorder.

### **6.3 Implications of the Study**

Very little research exists that prospectively analyzes spouse caregiver experiences of burden and depression when providing care for a family member. Interventions aimed at lessening caregiver depressive symptoms should be directed at caregivers who are employed, middle aged and adult children. Interventions intended at lessening the burden connected with feeling neglected and having schedules interrupted due to providing care should be focused at caregivers who are female spouse patients with substance use disorders.

The results of the study can be applied to health care practitioners in two different ways. First, study data point to that a particular group of caregivers are at danger for negative consequences, and that recognition of groups at risk call for the practitioner to be aware of sociodemographic distinctiveness of the caregiver. Interventions planned to advance the emotional wellbeing of caregivers of substance use patients should be directed at employed caregivers, unemployed spouse caregivers, and caregivers of persons with other mental illness. Furthermore, study findings emphasized the interrelationship of caregiver and patient variables – those patient variables can affect caregiver outcomes. Therefore, health care practitioners should be alert that interventions meant at lessening symptom severity can have an effect on caregiver burden and depression. Practitioners should treat the patient as a ‘patient-caregiver dyad’, be aware that caregivers are at risk

from negative outcomes from both caregiver and patient characteristics, and be aware that to provide care, concern should be given to the caregiver's wellbeing, in addition to that of the patient.

#### **6.4 Suggestions for Further Research**

Research in any field is never a closed book. There is always a persistent need for finding a solution to the new problems and testing the variety of solutions to other problems. For further research some suggestions are listed below:

- This type of research can also be extended to all the districts of Assam as well as other north-east states of India to gain a clear picture about the spouse-caregivers of patients with substance use disorder.
- This study may also be replicated in other north-eastern states like Sikkim, Manipur, Tripura, etc.
- Depression may be studied in relation to other variables like self-esteem, self-concept, emotional intelligence, personality, peer pressure, aggression, study habits, social stress, family stress, anxiety etc.
- Sample size needs to be increased in order to increase the reliability and generalization of the research.
- A study may be done to assess prevalence of depression in caregivers from different states.
- Psychosocial determinants of mental illness on children, parents or siblings of patients with substance use disorder can be explored.

- An experimental study may also be conducted on a sample of caregivers having severe depression with the use of psychotherapy.
- Some intervention programme can be developed for reduction and control of burden and depression and enhancement of social support in caregivers.

Research on spouse-caregivers of substance use disorder are limited and the few studies that are reviewed lack empirical evidences. The researches done on spouse-caregivers are merely done for expanding knowledge but not applied. The proposal that seeking assistance for mental health issues makes the caregiver look ‘weak’ needs to be deal with from both a general research viewpoint and from the viewpoint of the caregivers themselves. More high-quality epidemiological and intervention studies are needed to inform optimal strategies to identify and respond to caregivers’ needs.

Thus, research studies in this area evince good scope and will contribute to make notable contributions in the future. Research focused in these directions will, ideally, allow investigators to create, test, and recommend interventions to healthcare providers that will affect the path and patterns of care provided in the home by family caregivers for patients with substance use disorder.

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From

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I am hereby willing to participate in the study initiated by by Kuwari Barua on "Psycho-Social Determinants of Depression among Spouse-Caregivers of Male Patients: A Comparative Study of Single and Poly-Substance Use Disorders". Ms Kuwari Barua has explained in details the procedure aspects of the study well in advance. I agree to be a part of the study in my wish and not by force. I have not been paid any amount by the researcher for the purpose of providing information.

Signature

## SOCIODEMOGRAPHIC DATA SHEET

1	Name				
2	Address(present) & Mobile no.				
3	Name of the institute/hospital				
4	Age				
5	Gender	Male	Female		
6	Religion	General	OBC	ST	SC Others
7	Social Group				
8	Family type	Joint family	Nuclear family		
9	Education	None	Primary	Matriculation	10+2 Graduation
10	Occupation				
11	Income (in Rs. Per month)	0-10000	10000-30000	30000 and above	
12	Any other psychiatric illness				



## Burden Assessment Schedule

1. Do you think that your family appreciates the way you care for the patient?  
Not at all.....3  
To some extend.....2  
Very much.....1
2. Does the patient's illness prevent you from having a satisfying relationship with the rest of the family?  
Not at all.....3  
To some extend.....2  
Very much.....1
3. Does your spouse help with family responsibilities?  
Not at all.....3  
To some extend.....2  
Very much.....1
4. Is your spouse still affectionate towards you?  
Not at all.....3  
To some extend.....2  
Very much.....1
5. Is your spouse able to satisfy your needs for intimacy?  
Not at all.....3  
To some extend.....2  
Very much.....1
6. Has the quality of your marital relationship decline since the spouse illness?  
Not at all.....3  
To some extend.....2  
Very much.....1
7. Does caring for the patient makes you feel tired and exhausted?  
Not at all.....3  
To some extend.....2  
Very much.....1

17. Does the patient's illness prevent you from having satisfying relationships with your friends?

Not at all.....3

To some extend.....2

Very much.....1

18. Do you often feel frustrated that the improvement of the patient is slow/ there is no improvement at all?

Not at all.....3

To some extend.....2

Very much.....1

19. Do you have the feeling that the patient understands and appreciates your effort to help him/her?

Not at all.....3

To some extend.....2

Very much.....1

20. Is the patient's illness preventing you from looking for a job?

Not at all.....3

To some extend.....2

Very much.....1

Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

- Circle the "1" if you **Very Strongly Disagree**
- Circle the "2" if you **Strongly Disagree**
- Circle the "3" if you **Mildly Disagree**
- Circle the "4" if you are **Neutral**
- Circle the "5" if you **Mildly Agree**
- Circle the "6" if you **Strongly Agree**
- Circle the "7" if you **Very Strongly Agree**

1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7	SO
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	SO
3.	My family really tries to help me.	1	2	3	4	5	6	7	Fam
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7	Fam
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7	SO
6.	My friends really try to help me.	1	2	3	4	5	6	7	Fri
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7	Fri
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7	Fam
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7	Fri
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7	SO
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7	Fam
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7	Fri

The items tended to divide into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant other (SO).

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

**Instructions:** This questionnaire consists of 21 groups of statements. Please read each group of statements carefully then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

**1. Sadness**

- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

**2. Pessimism**

- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

**3. Past Failure**

- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

**4. Loss of Pleasure**

- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

**5. Guilty Feelings**

- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

**6. Punishment Feelings**

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

**7. Self-Dislike**

- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

**8. Self-Criticalness**

- 0 I don't criticize or blame myself more than I used to.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

**9. Suicidal Thoughts or Wishes**

- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

**10. Crying**

- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.



**11. Agitation**

- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

**12. Loss of Interest**

- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than before.
- 2 I have lost most of my interest in other people or things.
- 3 It's hard to get interested in anything.

**13. Indecisiveness**

- 0 I make decisions about as well as ever.
- 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

**14. Worthlessness**

- 0 I do not feel I am worthless.
- 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless as compared to other people.
- 3 I feel utterly worthless.

**15. Loss of Energy**

- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- 2 I don't have enough energy to do very much.
- 3 I don't have enough energy to do anything.

**16. Changes in Sleeping Pattern**

- 0 I have not experienced any change in my sleeping pattern.
- 1a I sleep somewhat more than usual.
- 1b I sleep somewhat less than usual.
- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.
- 3a I sleep most of the day.
- 3b I wake up 1-2 hours early and can't get back to sleep.

**17. Irritability**

- 0 I am no more irritable than usual.
- 1 I am more irritable than usual.
- 2 I am much more irritable than usual.
- 3 I am irritable all the time.

**18. Changes in Appetite**

- 0 I have not experienced any change in my appetite.
- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.
- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.
- 3a I have no appetite at all.
- 3b I crave food all the time.

**19. Concentration Difficulty**

- 0 I can concentrate as well as ever.
- 1 I can't concentrate as well as usual.
- 2 It's hard to keep my mind on anything for very long.
- 3 I find I can't concentrate on anything.

**20. Tiredness or Fatigue**

- 0 I am no more tired or fatigued than usual.
- 1 I get more tired or fatigued more easily than usual.
- 2 I am too tired or fatigued to do a lot of the things I used to do.
- 3 I am too tired or fatigued to do most of the things I used to do.

**21. Loss of Interest in Sex**

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.