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MENTAL HEALTH ISSUES AMONG SPOUSES OF PATIENTS WITH PSYCHIATRIC DISORDERS

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ABSTRACT

Objectives: *The present study aims to examine the mental health status with specific focus on the dimensions of psychological distress and psychological well-being in spouses of patients with psychiatric disorders and compare with the normal control group by using Mental Health Inventory.*
Methods and Materials: *Two hypotheses were formulated: 1) The Level of psychological distress would be higher in spouses of patients with psychiatric disorder than spouses of normal adults, 2) The level of psychological well-being would be lower in spouses of patients with psychiatric disorder than the spouses of normal adults. The Mental Health Inventory (MHI-38; Veit & Ware, 1983) was administered to measure the level of psychological distress and psychological well-being in two above mentioned two groups.*
Findings: *The t-test was computed by using Statistical package of social sciences (SPSS version: 19). The results indicated, high level of psychological distress [t(178)=10.536, p<.001] and low psychological well-being [t(178)=-13.989, p< .001] in spouses of patients with psychiatric disorders as compared to spouses of normal adults.*
Implications: *Findings of the current study have implications for the clinical interventions and help professionals to provide counseling for the caregivers in order to enhance their coping which will in return help to have good prognosis of the patients with psychiatric disorder.*

Keywords: *Mental Health, Spouses, Patient with Psychiatric Disorders*

INTRODUCTION

Keeping in view the complexity of mental health issues, it is evident that psychiatric disorders commonly increase psychological distress and diminish the quality of life of the caregiver, because of the caregiver burden and strain caregivers face (Sales, 2003). Baronet (1999) and Loukissa (1995) reported that spouses of psychiatric patients (depressive illness) suffered psychological distress in terms of providing social, emotional and economical support to their ill partner for longer period of time. This mental health state includes nervousness, apprehensions and irritability and it gradually change into lack of interest, difficulty in sleeping, feeling disappointed or feeling desperate, emotionally disturbed and having ideas of suicide (Winefield, Gill, Taylor & Pilkington, 2012).

Family and primary caregivers may have different emotional impacts and that can vary from general frustration, fear, guilt to grief, depression and anxiety. A study conducted by the National Family Caregivers Association (1997), showed that people caring for their mentally ill parents suffer from more stress, which may eventually lead to serious emotional consequences where depression is one of the emotion experienced by caregivers.

Moreover, spouses feel burden because of the family roles and partnership role in contrast to illness specific burden (Jungbauer, Wittrnund, Dietrich, & Angermeyer, 2004). This long-lasting burden of everyday living can overwhelmingly decrease the spouse satisfaction with the ill partner along with his/her quality of life. Results indicate that when there is reduction in the patient's symptomology, it will lead to low burden on the caregiver and enhanced Quality of life (Jungbauer, Wittrnund, Dietrich, & Angermeyer, 2004). Spouses of mentally ill people experienced their quality of life as lower specifically in the domains of social relationship and psychological well-being. A strong bond between functional level of patients and spouses quality of life in domains of social relationships and environment was existed, this means that more impaired the functional level of the patients, the more poor the spouse's quality of life (Angermeyer, Kilian, Wilms & Wittmund, 2006)

Furthermore, the study of psychological well-being and psychological distress represent complementary approaches to mental health (Masse, Poulin, Dassa, Lambert, Belair, & Battaglinin, 1998). According to Veit and Ware (1983) psychological distress is define as the negative mental health, having feeling of disappointment, lack of interest and hopelessness. Furthermore, well-being is defined as positive approach towards life and psychological well-being comprises of satisfaction in life, positive and negative emotions and attained aims of life. These two components are in positive correlation with each other. According to Montgomery and McCrone (2010), psychological distress is common among spouses of patients suffering from mental illness, which in return influences the psychological well-being of the spouses. Potter (2007) describes that psychological distress among spouses of patients suffering from psychiatric illness refers to the multiple unpleasant emotional experiences such a cognitive, emotional and behavioral ones.

Moreover, partner with psychiatric illness strongly influences the spouse mental health in various contexts. It creates variety of life stressors for spouses living with the mentally ill partner (Koujalgi & Patil, 2013). This gradually resulted into psychological distress and emotional disturbance. If emotional distress remains unresolved, eventually it impacted negatively a person's coping skills and frustration tolerance due to which persons psychological well-being get on stake (Kahneman & Krueger, 2006). Psychiatric disorders have a huge impact on the emotional level of the family and primary caregivers. Sometime to the extent that caregivers share their partner's symptomatology later in life due to consistent burden of care and exhaustion at emotional level by limiting their own needs (Ostman, Hansson, & Andersson, 2000; Kahneman & Krueger, 2006). Persistent care of partner with psychiatric problem cause chronic stressors for spouses and gradually it changes into feelings of burden and it diminishes the quality of life of spouses as reported by Sales in 2003 which further endorsed in 2010 by Idstad, Ask and Tambs who found high level of anxiety and depression, whereas, low psychological well-being in spouses of psychiatric patients as compared to the other population living with no mental illness (Idstad, Ask & Tambs, 2010).

Although a lot of researches has been done on the general caregiving burden on the caregivers of people who are suffering from psychiatric disorders (Loukissa, 1995; Ohaeri, 2003; Jungbauer, Wittrnund, Dietrich, & Angermeyer, 2004) only a scarce researches has been done on the spouses of the patients, their burden and spouses psychological well-being and life satisfaction of patients

suffering from mental disorders, which shows quality of life of spouses of mentally ill patient is lower and they are at high risk of developing psychiatric disorders (Wittmund, Wilms, Mory, & Angermeyer, 2002; Angermeyer, Kilian, Wilms, & Wittmund, 2006; Steele, Maruyama, & Galynker, 2010).

Keeping in view this fact, there is a dire need to address probability of mental health issues in spouses that could be resulted due to excessive caring burden. So that a better care and strong support could be provided to enhance the prognosis of psychiatric patients. Thus present study aimed to assess level of psychological distress and psychological well-being of spouses of psychiatric patients.

METHODS

Participants

Sample of the present study was recruited from different psychiatric departments of various hospitals, rehabilitation centres and institution/Organization of Karachi, Pakistan. The sample of present study was comprised of 180 respondents (90 spouses of diagnosed patients with psychiatric disorders and 90 spouses of Normal adults).

The sample of psychological patients was diagnosed by their respective psychiatrist and clinical psychologist according to the criteria of DSM-5 (APA, 2013). Which included: spouses of patients with Major Depressive Disorder (N=30), spouses of patients of Schizophrenia (N=30) and spouses of patients of substance use (N=30). Age range of the sample was 25-50 years with mean age of 34 years (patients with psychiatric disorder= 34.6 years and Normal counterparts= 33 years).

Research Procedure

A brief interview was conducted and then the Mental Health Inventory was administered on the participants. All the questionnaires were administered in the individual setting. Diagnosed Psychiatric patients were selected from psychiatric departments of hospitals, Private clinics and rehabilitation centres by evaluating the records of inpatient/outpatient according to diagnosis. To assure validity of diagnosis, patients were further cross checked by the examiner in one to one session on the given criteria of DSM- 5 (APA, 2013) and by using detailed semi structured interview form developed by Institute of Clinical Psychology.

Measures

In present study, Demographic Information Form, semi structured interview form and the Mental Health Inventory (MHI-38; Veit & Ware, 1983) were used.

Demographic information

A demographic information form was mainly comprised of two sections: Items related to personal information of spouse and Items related to partner's illness and other relevant information. Personal information were obtained through items focusing the participant's age, gender, date of birth, education, residential area, duration of marriage, number of children, family structure, family income, and employment status of both the spouses and the patients. Illness related information includes, duration of illness of the patient, duration of treatment and medical history. Moreover, questions related to any physical or mental health problems were also included.

Semi-Structured Interview Form

This interview form is developed by the Institute of clinical psychology, University of Karachi, Pakistan which is based on the statistical manual of mental disorders as well as other detail necessary for the screening of the diagnosis. It consisted of demographic information (age, sex, education, marital status, occupation, number of siblings, family structure, birth order, parent's education and occupation, earning members, language etc.), presenting problems, history of problem, psychopathology in the family, childhood history, family and social life, sexual history ,questions related to the mental status examination and symptoms of psychological disorder/personality disorder. It is qualitative measure which usually requires 20-30 minutes for administration.

Mental Health Inventory

The Mental Health Inventory was developed Veit & Ware in 1983.The Mental Health Inventory determines the level of psychological distress and well-

being among people with and without psychiatric disorders. It consisted of total of 38 items with 2 global scales i.e., Psychological Distress and Psychological Well-being scales. Moreover, psychological distress subscale comprised of 24 items and psychological well-being subscale consisted of 14 items. Psychological distress shows negative states of mental health (Anxiety, Depression, Loss of Behavioural / Emotional ties) and psychological Well-being indicates positive states (General Positive Affect, Emotional ties, Life satisfaction). The MHI has elicited reliably strong internal consistencies ranging from .83 to .96 (Veit& Ware, 1983).

Scoring and Evaluation

After collection of data the answer sheets were scored according to the set standard procedures of the measurement given in MHI scoring manual**.** A number of forms were discarded due to various reasons e.g. failure to complete the forms, unable to give clear information regarding diagnosis and having any comorbid disorders or physical illness. To calculate the global scale of psychological distress, items related to Anxiety, Depression and Loss of Behavioural/ emotional control were added to get total score. Similarly to calculate the psychological well-being, items related to General positive affect, emotional ties and life satisfaction were added together. Furthermore, higher scores on psychological distress (24-142) is indicative of high level of psychological distress, whereas high scores on psychological well-being (14-84) is reflective of high psychological well-being. Some items have reverse scoring, depending on the nature of underlying construct being measured.

Statistical Analysis

Descriptive statistics was calculated for better statistical view of characteristics of sample. Main assumptions of the study have been tested by t-test, to explore the mean differences in the scores of psychological distress and psychological wellbeing of spouses of patients with psychiatric disorders and normal adults.

Operational Definition of the terms

Psychological well-being

Psychological well-being has been expressed as a broad construct with numerous cognitive and affective components such as satisfaction with life, positive and negative emotions, pleasure, contentment, and congruence between anticipated and attained life aims (Awan & Sitwat, 2014). In present study psychological well-being is the combination of three aspects i.e., general positive affect, emotional ties and life satisfaction and high scores on scale of psychological well-being shows the positive state of mind and vice versa (Veit & Ware, 1983).

Psychological distress

Psychological distress is negative state of mental health that causes nervousness, worries and irritability. Commonly it is conceptualized as a lack of interest, difficulty in sleeping, feeling disappointed or feeling desperate, emotionally disturbed and having ideas of suicide (Winefield, Gill, Taylor, & Pilkington, 2012). Psychological distress in present study is the combination of three aspects i.e., depression, anxiety and loss of behavioural/emotional control. High scores on Scale of psychological distress indicate negative state of mind and high psychological distress and vice versa (Veit& Ware, 1983).

RESULTS

Descriptive characteristics of the data were illustrated, as several of them have significant impact on the results. Frequencies and percentages were calculated for the demographic characteristics of the sample (i.e., spouses of clinical group and normal control group) for the variables of gender, family structure, education and socioeconomic status, whereas descriptive statistics of mean for the age, duration of illness and duration of marriage described in [Table 1and 2].

Table 1
Mean of Age, Duration of Illness and Duration of Marriage

Variables	*Spouses of Clinical Group*			*Spouses of*
	Schizophrenia	*Depression*	*Substance Use*	*Control gp*
Age*	37	36	31	33
Duration of illness*	16	4	11	NA

Duration of marriage*	9	12	10	9.25

*Note: * reported in years*

Table 2
Summary of Demographic Characteristics of the Sample

	Spouses of Clinical Group						***Spouses of Control gp***	
Variables	***Schizophrenia***		***Depression***		***Substance Use***			
Gender	***F***	***%***	***F***	***%***	***F***	***%***	***f***	***%***
Male	15	50	15	50	0	0	45	50
Female	15	50	15	50	30	100	45	50
Education								
Metric	13	43.3	13	43.3	21	70	8	8.9
FA	12	40	6	20	7	23.3	13	14.4
BA	4	13.3	8	26.7	2	6.7	33	36.7
MA	1	3	3	10	0	0	36	40
Family Structure								
Joint	13	43.3	17	56.7	18	60	59	65.6
Nuclear	17	56.7	13	43.3	12	40	31	34.4
SES								
Low	12	40	10	33.3	17	56.7	12	13.3
Middle	12	40	13	43.3	11	36.7	52	57.8
High	6	20	7	23.3	2	6.7	26	28.9

Note: N=180

Analysis of the first hypothesis begins with the exploration of difference in the level of psychological distress between the spouses of patients with psychiatric disorders and the spouses of normal adults. Results illustrated the significant difference among spouses of clinical group and normal adults on the variable of psychological distress. Indicating high psychological distress in the spouse of patients with psychiatric disorders [$t\ (178)$ =10.536, p<.001; Table 3] as compared to their normal counterparts.

Table 3

Independent sample t-test showing mean differences on the variable of psychological distress between spouses of patients with psychiatric disorder and normal control

Spouses	*N*	*M*	*SD*	*t*	*P*
Patients with Psychiatric Disorders	90	86.422	19.814	10.536	.000*
Normal Control	90	56.577	18.152		

*Note: N= 180, df=178, *= Significant at .001 level*

Analysis of the second hypothesis begins with the exploration of difference in the level of psychological well-being among the spouses of patients with psychiatric disorder and the spouses of normal control group. Results of t-test indicates significant difference among two groups on the variables of psychological well-being, indicating high psychological well-being of spouses of normal adults in comparison with spouses of patients with psychiatric disorder[$t(178) = -13.989$, $p < .001$; Table 4].

Table 4
Independent sample t-test showing mean differences on the variable of psychological well-being between spouses of patients with psychiatric disorders and normal control

Spouses	*N*	*M*	*SD*	*t*	*p*
Patients with Psychiatric Disorders	90	34.76	11.824		

				-13.989	.000*
Normal control	90	58.28	10.706		

*Note: N=180,df=178, * = significant at .001 level*

DISCUSSION

Present study investigated mental health status of spouses of patient with psychiatric disorders by considering the particular role of psychological distress and psychological well-being in mental health issues in spouses.

First hypothesis of the present study focuses on the psychological distress among spouses of patients suffering from psychiatric disorder and comparing it with the normal control group. Findings showed significant differences on the variable of psychological distress between spouses of patients with psychiatric disorder and normal control *[t (178) =10.536, p< .001; Table 3]*. These findings are consistent with the previous findings (Angermeyer, Kilian, Wilms, & Witmund, 2006; Manguno-Mire, Sautter, Lyons, Myers, Perry, Sherman, & Sullivan, 2007).

Spouses of psychiatric partners perceived high degree of psychological distress (Manguno-Mire et al., 2007). This level of distress can be due to variety of reasons. The most important factor could be the generalized concept of "Stigmatization" associated with different psychiatric illness under its influence. Spouses generally perceive their partner's illness as "stigma" and overwhelmed due to expected challenges from the society. Partners feel an extreme difficulty to share such problems with friends and even sometimes with family members due to fear of disapproval and sense of rejection. As reported by Corrigan (2004), in his work that stigma diminishes the self-esteem and socialization of patient and family. Sometimes to avoid the harm they are getting because of stigmatization of illness they stop the treatment of the ill partner. Mental illness is stigmatized more as compared to other physical illness (Corrigan et al., 2000, as cited in Corrigan, 2004).Due to this stigma patient and family receive particular discrimination in the society at every level, whether it is any social situation, hospital setting or job setting. It also impacted their overall socialization which in return creates psychological distress among the family and especially spouse of mentally ill patients (Lai, Hong, & Chee, 2001; Corrigan & Watson, 2002; Corrigan, 2004). Prevailing negative views or negative beliefs as mentally disturbed individual are mostly irresponsible, indecisive , dangerous and widespread (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005) due

to these negative beliefs spouses have to cope up with discriminatory behaviors of the society towards themselves as a consequence of illness of their partner, which ultimately leads to psychological distress.

Moreover, people associate the psychiatric illness with supernatural things, some people say this is due to committing something wrong in life and it is a punishment from supreme authority because of some sins or immoral acts, people also associate the reappraisal of God powers to distress and illness (Phillips & Stein, 2007), which is always painful for the partner and has a strong impact on whole family as people always deal with children and spouse with less respectful manner, which enhances the guilt among the caregivers (spouses) and family. Unfortunately, all these interpretations cause psychological distress with long lasting emotional pain (Lai, Hong, & Chee, 2001; Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005).

Another factor could be the 'feeling of insecurity' resulted from illness of the main authority figure. If security figure/authority figure is not feeling well, resulted in the insecure and stressful environment, in terms of lack of adequate supporting resources providing for the family, this impacted the well-being and self-esteem of the family members.

Moreover, financial burden due to inability to cope up with job requirements or sudden loss of job of the ill partner while going through the expensive treatment procedures causes distress in partners. As supported by the findings of Tsang, Tam, Chan and Chang (2003), that unemployment is one of the outcome of prejudice of other employers towards the mental illness, which resulted in limited employment opportunities and increase the financial burden on the family. If the mentally ill person is the only sole breadwinner for his family, his unemployment is going to impact the functioning of his family and creates psychological distress for the spouse (Noh & Avison, 1988; Tsang, Tam, Chan & Chang, 2003)

Furthermore, the long term treatment procedures and multiple variations of treatment modalities for patients suffering from psychiatric disorders also put burden on the family. Delimma resulted to treatment methods may be another factor causing psychological distress among the spouses of psychiatric patients. People are mostly unaware of the treatment necessary for their ill partner, in most cases usually both mode of treatment i.e., psychotherapy and medicines is necessary for the effective management of the problem. However, initially

families and spouses focus only on psychotropic treatment which halfway covers the patient treatment but associated problems remains there and leads to relapse or recurrence of the problems due to lack of awareness. Mostly, families consider mental illness as some spiritual power and take the patient to spiritual healers (Dein, Alexander, & Napier, 2008; Ae-Ngibise, Cooper, Adiibokah, Akpalu, Lund, Doku, & Consortium, 2010) which resulted in more deterioration rather than improvement as the problem not dealt at its root cause. At initial level family/spouse support the ill partner, however due to unclear guidance they are unable to access quality base treatment timely which further hampers the functioning of patient and in turn affect the spouse and family functioning as well.

With reference to partner suffering from depressive disorders cannot focus on the household responsibilities (Mirza & Jenkins, 2004). Similarly, spouses of patient with psychiatric disorders use to face extra responsibilities and duties. For example, partner with schizophrenic disorder has poor life functioning as well cognitive function. Not only partners has to look after him with extra care but also sometime partner has to face physical or emotional abuse because partners with psychiatric disorders usually become aggressive and they cannot have control over self, due to emotional disturbance and lack of poor insight. Moreover, sometimes if spouse is unable to handle or understand the emotional liabilities associated with the fluctuation of symptomatology of disorder, it mainly impacted the interpersonal relationship and leads to marital conflicts. Similarly, person with substance used disorder also does not pay attention over the rights of children and partner. All these situations affect partner's emotional well-being, with the passage of time it changes into psychological distress, and it decreases quality of life (Gadit & Khalid, 2002).

Another research by Siegel and colleagues (2004), Stein, Nyamathi, Ullman and Blentler (2007), reported that if one partner is having depression, there are high risk that it will develop hopelessness and helplessness in non-depressed partner. Providing extensive care to the psychologically ill patient leads to the avoidance of own basic and emotional needs. Moreover, spouse may feel psychological distress because he/she may miss the friendship and companionship the couple shared before depression.

Another very important aspect could be the associated dissatisfaction related to neglected needs of intimacy, affiliation and belongingness within partner relationship. As it was observed that in course of illness of following

disorders schizophrenia, depression and substance use, the patient suffer from very low libido to high libido and loss of interest in sex or feeling lethargic at night because of the medicines (Ambler, de C Williams, Hill, Gunary, & Cratchley, 2001) or sometime that need become so high that leads to sexual abuse and violence with the partner, which overburden the spouse with psychological distress. Similarly, in excited state patients with chronic illness like schizophrenia and substance abuse may be sexually overactive without protective measures and more prone to risk of developing sexually transmitted diseases and HIV/AIDS. Psychosis may impaired their judgment and show reckless behavior and they don't use any precautions and are unable to maintain monogamous relationship (Assalian, 2000; Kelly & Conley, 2004) this make partners health on stake as well. So, when need for intimacy and need of affiliation is not fulfilled because of the high expressed emotions and instability of partner, it creates psychological distress among spouses.

Some partner perceives their life is different from those couples whose are normal and spending life more peaceful. This comparison usually hurts spouse's expectation of having ideal life after marriage. Because ideal life after marriage is the common expectation of every couple but when such hopes break, this cause emotional disturbance among partners and increase the feeling of loneliness among spouses. It also develops sense of helplessness among spouses that they wouldn't be able to take appropriate actions that they can subside the problems which in turn cause high level of distress and poor coping with the challenging situation. This badly affects partner's quality of life satisfaction, daily functioning and cognitive functions. Studies have shown that high level of psychopathology continuously increases level of emotional distress and causes more stressful situations (Wintersteen & Rasmussen, 1997).

Findings showed significant differences on the variable of psychological well-being between spouses of patients with psychiatric disorder and normal control *[t (178) =-13.989, p< .001; Table 4]*. These findings are in favor of our study and consistent with the previous findings of various researches showing lower psychological wellbeing among spouses of psychiatric patients (Aneshensel, Pearlin, Mullan, Zarit, & Whitlatch, 1995; Fillingim, 2000; Piccinelli & Wilkinson, 2000; Angermeyer, Kilian, Wilms & Wittmund, 2006; Manguno-Mire, Sautter, Lyons, Myers, Perry, Sherman, & Sullivan, 2007).

Psychological well-being is an important aspect to overcome emotional disturbance. Awan and Sitwat in 2014, explain that psychological well-being is

an important aspect for attaining life satisfaction and goals. Thus it means that, to deal effectively with the challenges of partners having psychiatric illness, positive psychological well-being would be an important factor in the life of spouses of patients with psychiatric illness. Couple with good psychological well-being show positive attitudes toward each other and positive emotional attachment. Healthy relationship between couple always increases personal well-being. Keeping in view the results of the present study, it is found that spouses of normal adults perceived high degree of psychological well-being in comparison to counterparts; because those spouses perceived high degree of life satisfaction and positive emotional attachment with partners which usually comes due to caring and affectionate attitudes. On the other hand, spouses who are living with partners having psychiatric disorder usually face negative behavior from the ill partner (Karp & Tanarugsachock, 2000) which may lower's their life satisfaction and wellbeing.

Psychological distress and psychological well-being work together and are interlinked; if there is psychological distress i.e., depression, anxiety, and loss of control/behavior, it resulted in poor emotional ties, low positive affect and life satisfaction. So, greater level of depression and anxiety and low subjective well-being is associated with impairment in caregivers own behavior and cognitions, affected spousal relationship, duration and time of care provided to the ill partner (Richard Schulz & Sherwood, 2008).

Quality of life is the most important predictor of psychological well-being. If spouse has good quality of life he/she may have good psychological well-being. Researches illustrates that if spouse has better understanding of the partner illness he/she may have good quality of life (Chen, Yang, Liao, Lee, Yeh, & Cheng Chen, 2004) and it will enhance the psychological well-being of the spouse.

When person is suffering from the psychiatric illness, his/her spouse also suffer from the deprivation of need of intimacy and affiliation which leads to high distress level and lowers the psychological well-being of the spouse. Marital conflict also occurs because of the deprivation of these needs and lowers down the psychological well-being of spouse. Studies have shown that marital conflict increase level of emotional distress (Wintersteen & Rasmussen, 1997) which negatively impacted the psychological well-being. Furthermore, it also blocks the spouse from further growth.

The severity of symptoms of patient suffering from psychiatric disorder is also an evident factor for more psychiatric symptoms in spouses and lowers the level of psychological well-being (Chen et al., 2004). For example, person suffering from psychosis and is having hallucinations and delusions, person with depressive disorder have severe mood shifts and aggression, and person suffering from substance use also impacted the psychological well-being of the spouse because spouse have to take extra care for them and due to this burden increases. Moreover, efficient treatment will lead to the high psychological well-being of the spouses and patient (Chen et al., 2004) by managing the symptoms at adjusted functional level.

Social support also plays an important role in describing psychological well-being of the spouses suffering from psychiatric problem. As social support is really necessary for the taking care of the mentally ill partner and owns well-being. There is evidence in literature that amount and quality of social support plays vital role in moderating the impact of caregiving. Furthermore, having larger social support leads to greater life satisfaction and less anger and frustration than the caregivers who shows less informal support (Savage & Bailey, 2004). Magliano, Fadden, Madianos et al. (1998) (as cited in Saunders, 2003), that lower social support will enhance the burden on caregivers and lowers the psychological wellbeing on the other hand.

Spouses of partner of patient with psychotic disorders have to face various emotional and behavioral problems. Partner with poor reality contact usually approaches the things according to own perspectives which most of the times deviates reality. Moreover, patients with psychosis might not think rationally and logical, show non-compliant behavior towards the treatment. With reference to this context, even healthy partner cannot convince the ill partner for treatment. Sometimes this argument change into conflicts and emotional and physical abuses starts. High expressed emotions negatively impacted the psychological well-being of the spouse by increasing the burden (Heru, 2000; Chen et al., 2004). This limits the positive ties and affection towards spouses which impacted their quality of life. Continuous relational problems and gradual increase in severity of partner's problem significantly influence other partner psychological well-being (Pickett, Vraniak, Cook, &Cohler, 1993, Chen et al., 2004, Idstad, Ask, & Tambs, 2010). Furthermore, substance use creates disruption in every aspect of life domain, for example stealing, lying and manipulation. Moreover, person with substance use is always a constant threat for spouse and family members in terms of violence and all negative behaviors

due to which spouses doesn't face any positive affect or emotion from their ill partner.

Moreover, spouses of patient with depressive disorders also perceived poor psychological well-being as compared to normal because they use to face various emotional problems (Heru, 2000) such as partner's irritable mood most of the times and lack of interest in daily life activities even in personal care. Sometimes it increases partner's workload in sense of care for his heath, treatment and financial management. However, sometimes it changes into severe emotional pain, which subside the aspect of life satisfaction and lowers the spouse psychological well-being. Furthermore, if partner severity of illness increases, it changes into severe episodes, suicidal attempts and dysfunctional in life activities. Such things often increase emotional disturbance among partner and it badly hits Person's psychological well-being (Singleton, Maung, Cowie, Sparks, Bumpstead, & Meltzer, 2002).

Despite psychotic and depressive disorders, substance used disorders is another problem which significantly influence partner's psychological well-being. Person with good level of psychological well-being usually has positive emotions and works for achievements. Similar perceptions reflects in partner when they expect everything better in life but this becomes very painful when one partner start to abuse drug on regular bases. This situation becomes worse for the partner when patient with substance used disorder is fired from job or becomes failure in business due to his illness. Families have to face numerous negative impacts because of their substance use problem. For example, partner has to manage financial budgets to run family functioning. Such kind of illness also becomes stigma for the spouse and family. Moreover, it sometimes reserve the partner to avoid social involvement which is important for healthy life functioning. This refers to poor emotional and social support and it decreases person's psychological well-being (Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1983).

Conclusion and Recommendation

In conclusion, there is a dire need to help for the people who are providing care to their partner suffering from psychiatric disorders. Because, partners who are already suffering from psychological problems are impacting the caregiver spouse, this in turn is impacting their lives and creating distress in that group. Caregiver spouses of patients with psychiatric disorder should be

assessing first on an immediate bases, because otherwise the results will be worse if both partners will suffer from the psychiatric illness. It will deteriorate the overall family functioning and adjustment level of the partner; negatively impact the children and whole society. Policy makers should consider this problem seriously and should work for the betterment of the caregiver's spouses in order to have healthy family, society and over all environment.

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