

Socio-economic and Gender Disparities in Psychological Distress and Marital Adjustment Among Spouses of Hepatitis C Patients: A Quantitative Assessment

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Abstract

The present study examines differences in psychological distress and marital adjustment between spouses of Hepatitis C patients based on socioeconomic and gender status, specifically addressing dissimilarities in emotional and couple functioning due to economic and gender disparities. Hepatitis C is a chronic and progressive disease, and there is a substantial caregiver burden required, which should increase stress and negatively impact marital quality. With the data collected from 200 spouses of Ayub Medical Complex and Combined Military Hospital Abbottabad Pakistan, this research investigates the moderating effects of economic resources and gender roles on psychological distress and other factors pertinent to marital satisfaction, such as affection expressing marital adjustment and dyadic cohesion. Results identified by the study show that compared to spouses with higher SES, participants with lower SES have significantly elevated levels of psychological distress and reduced marital adjustment, indicating the role of economic stress in caregiver stress. The female spouses continue to display higher levels of distress and lower marital satisfaction and cohesiveness than male spouses, replicating the usual female gender role expectations of the traditional caregiver. Also, gender and economic level cross-tabulations show differences in coping and support seeking and, hence, mental health and relationship quality. These results indicate the further imperative of targeting specific psychological and social support for economically disadvantaged and female carers to alleviate their specific known burdens, providing a foundation for developing policies dealing with marital stress in chronic illness situations, among other proposals.

Keywords: Gender Disparities, Psychological Distress, Marital Adjustment, Hepatitis.

Introduction

Chronic illnesses such as Hepatitis C (HCV) not only affect patients but also place a significant psychological burden on their caregivers. Studies show that Hepatitis C, a chronic and progressive liver disease, impacts approximately 71 million people worldwide, with many of these patients requiring long-term care (World Health Organization, 2020). The caregiving burden is primarily borne by spouses, who experience physical, emotional, and relational strain as they take on caregiving roles. This research aims to explore how socioeconomic status (SES) and gender roles contribute to variations in psychological distress and marital adjustment among spouses of HCV

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patients, with a particular focus on how these disparities affect emotional well-being and couple functioning.

Numerous studies have established that caregivers from lower SES backgrounds face higher levels of psychological distress, primarily due to financial pressures and lack of adequate support services (Caron & Liu, 2011). For spouses of HCV patients, the financial burden is amplified by the long-term medical costs and the time demands associated with caregiving (Hashmi et al., 2007). Lower SES caregivers are at a higher risk of experiencing anxiety and depression, which further exacerbates marital dissatisfaction and reduces the overall quality of the relationship (Lazarus & Folkman, 1984). Research has shown that caregivers in lower SES groups report elevated levels of psychological distress, with women being particularly vulnerable to emotional strain and burnout due to traditional caregiving roles (Misra et al., 2000).

Investigate has established that Chronic illness caregivers who fit in the lower SES groups report high degrees of depression, anxiety, and general distress. For instance, through their study conducted amongst women caregivers, Misra et al. (2000) noted that economic pressure complicates the emotional stress situation among caregivers, with the added stress factor creating more and improved accounts of anxiety and hopelessness. Some of these strains can erode marital satisfaction because both partners, particularly the caregiving one, do not receive the needed emotional support to meet their own needs. This is by Alavian et al. (2006), who noted that caregiver burden in the form of economic stress impacted the marriages of HCV caregivers in Iran by reducing marital satisfaction. Cohesion also pointed to the fact that social-economic factors are critical determinates of the psychological and marital status of caregivers in chronic illness situations.

Sex is a very significant predictor of caregiving and may either determine the degree of psychological distress of the caregivers and marital adjustment. Women are often first-line caregivers in homes and are more likely to provide intensive care in home- and traditional- or low-income-settings (Ridner, 2004). The literature shows that women who are supervisees Have a higher psychological strain level as compared to men in HCV patients and are more prone to sufferer burnout, increased load of physical work, and increased sense of responsibility for household chores and for care of the patient (Cleary & Mechanic, 1983). According to Misra et al. (2000), women are more anxious and depressed than men, and economic stress reduces marital satisfaction when a woman is anxious and depressed.

Spousal quality is adversely affected by the stress that comes with being a female caregiver because caregiving interrupts the normal functioning of marriage. Studies show that women are likely to face more challenges in preserving marital satisfaction and cohesiveness when caregiving demands increase (Sinha & Mukherjee, 1990). In Fang, Manne, and Pape's (2001) study, women who were formal caregivers to chronically ill partners indicated feelings of loneliness and marital discontentment arising from the caregiving role, which impacts dyadic satisfaction and charge marital stress. Such a gender difference provides evidence that female caregivers experience different forms of Challenges in achieving both their psychological health and marital relationships when subjected to prolonged caregiving stress.

HCV's evolution from the acute to the chronic phase exacerbates caregiving roles since the intensity brings about the wife's increased psychological distress and marital quality decline. Chronic HCV is characterized by progressive spillover of caregiving demands, which are time-intensive over the long term, leading to increased stress on caregivers. Caregivers of patients in this stage suffer increased demands, which affect marital integration and satisfaction, as well as increase psychological morbidity (Machado et al., 2014). Mueller (1994) has found that caregivers

experiencing end-stage liver disease suffer from increased depression and anxiety as well as problems in marital satisfaction as the physical condition of the spouse worsens. Perhaps services should be targeted to various stages of caregiving because distress may increase as well as marital strain subsequently during the disease progression.

Spousal satisfaction, affectional expression, and dyadic cohesions provide the framework and essential means of coping with chronic caregiver stress. This study established that high levels of dyadic support and spousal communication worked as another form of moderation in caregiving contexts, which are aspects of caregiver well-being (Pereira et al., 2011). According to Spanier, 1976, the working model underpinning dyadic consensus and cohesion ensured that caregiving turns were rotated more effectively to reduce some psychological impacts on the primary caregiver. Nonetheless, Alavian et al. (2006) pointed out that where economic stressors and caregiving demands coexist, dyadic support usually declines, especially for female caregivers. It is as such that socioeconomic status and gender are paramount in determining the quality of dyadic support as subjects belonging to substandard SES or those taking the traditional roles in caregiving, therefore, are most likely to initiate lower marital adjustment.

Other research has also shown that marital adjustment is related to the caregiver's psychological health and the quality of the marital relationship. For instance, Hashmi et al. (2007) also deemed dyadic adjustment appropriate in predicting marital satisfaction and being a caregiver. More specifically, Pereira et al. (2011) and other authors stress the need to consider marital adjustment as a critical object of interventions to improve informal caregivers' functioning because supportive communication within the marital relationship helps reduce stress, improve marital satisfaction, and increase caregiver resilience.

Methodology

The cross-sectional quantitative research design was used in this study to establish how SES and gender affect psychological distress as well as marital adjustment among the Hepatitis C patients' spouses. A total of 200 male and female spouses from Ayub Medical Complex and Combined Military Hospital Abbottabad Pakistan were selected randomly for this study. Using purposive sampling, participants were selected while satisfying the following inclusion criteria: they are primary caregivers of diagnosed HCV patients. Data was collected through self-reported surveys, including demographic questions and two validated scales: The Kessler Psychological Distress Scale (K10) was used to identify the level of distress, and the Dyadic Adjustment Scale (DAS) was used to check on the status of marriage.

The K10 is a 10-item questionnaire of self-rated psychological distress on a Standard and Expanded 5-point Likert scale. The participant receives a total Difficulty score with a higher value reflecting increased distress. The DAS, consisting of 32 items, measures marital adjustment across four subscales: conformity, contentment, integration, and affective orientation. The internal consistency of K10 and DAS was established, achieving 0.876 and 0.878, respectively, for the Cronbach Alpha coefficient. All data was collected in private hospitals to maintain participants' anonymity, and all participants voluntarily consented to participate in the study. Descriptive statistics, by grouping the participant's mean score and comparing and correlating using the Pearson coefficient and independent t-test, were used to determine relational socioeconomic status, gender, psychological distress, and marital adjustment.

All the health boards of the participating hospitals sought permission and consented to permit the study to be conducted and executed. Participants' identification was kept anonymous at all times.

This work plan offered a systematic review of economic and gender aspects in determinants of caregiving in chronic illness settings.

Objectives

1. To analyze how socioeconomic status influences the level of psychological distress among the spouses of individuals with Hepatitis C.
2. To explore how gender affects the degree of psychological distress experienced by caregivers.
3. To examine variations in marital adjustment based on socioeconomic status among the spouses of Hepatitis C patients.
4. To investigate differences in marital satisfaction, cohesion, agreement, and emotional expression across genders.
5. To assess how the stage of illness (whether acute or chronic) impacts psychological distress and marital adjustment for caregivers from varying socioeconomic backgrounds.

Hypotheses

H 1: There is a significant relationship between socioeconomic status and psychological distress, with lower socioeconomic status associated with higher psychological distress among caregivers.

H 2: Female caregivers report higher levels of psychological distress compared to male caregivers.

H 3: Caregivers from lower socioeconomic backgrounds report lower marital adjustment than those from higher socioeconomic backgrounds.

H 4: Female caregivers experience lower levels of marital adjustment, including satisfaction, cohesion, consensus, and affectional expression, compared to male caregivers.

H 5: Psychological distress levels are higher for caregivers of patients in the chronic stage of Hepatitis C than for those in the acute stage, particularly among those from lower socioeconomic backgrounds.

Results

Table 1: Demographic Characteristics and Reliability Analysis of Scales

Variable	Categories/Details	Frequency (N)	Percentage (%)	Reliability (Cronbach's α)
Gender	Male	92	46%	
	Female	108	54%	
Socioeconomic Status	Lower	127	63.5%	
	Higher	73	36.5%	
Disease Stage	Acute	82	41%	
	Chronic	118	59%	
Kessler Psychological Distress Scale (K10)	10 items			0.876
Dyadic Adjustment Scale (DAS)	32 items			0.878

These demographic characteristics and reliability coefficients for the sample demonstrate the suitability of all measures for the present study and its participants. The sample includes 200 caregivers, with a nearly balanced gender distribution: 46 % male participants (n= 92) and 54% female participants (n= 108). It enabled comparability of male and female caregivers'

characteristics which is particularly relevant for the topics of gender differences in psychological distress and marital adjustment in the present study.

According to the SES 63.5% (127) students, fall in the low while 36.5% (73) students fall in high socioeconomic status. Consistent with the study's focus on how economic factors influence caregiver experiences, including psychological and marital functioning, participants were predominantly from a lower SES.

The caregiving demands related to various phases of Hepatitis C are also illustrated, out of 200 caregivers, three different acute Hepatitis C caregiving phase 41 (41%) and 3 four different chronic Hepatitis C caregiving phase 59 (59%). The larger proportion of those providing chronic care thus allows for the exploration of the increased caregiver stress the aggravation of marital conflict due to increased disease stages presuming that as disease progresses caregiving responsibilities also increase.

Thus, in order to ensure the reliability of the obtained results of the two primary dependent variables, namely psychological distress and marital adjustment, two standardized instruments were used in this study. The Kessler Psychological Distress Scale (K10) which is used to measure psychological distress by attaining to ten items was found to have Test-retest reliability – Cronbach's alpha of .876. Likewise, the Dyadic Adjustment Scale (DAS) which measures the marriage adjustment of respondents across 32 items, garnered a high reliability of .878 as per the Cronbach's alpha test. With the reliability scores obtained above, it showed internal consistency hence affirming the scales as practical, and reliable for measuring the psychological and relational features within the sample thus accord genuine merits for this study.

Table 2: Distribution of Psychological Distress by Socioeconomic Status and Gender

Socioeconomic Status	Gender	N	Mean Psychological Distress (K10)	Standard Deviation
Lower	Male	59	26.3	5.4
	Female	68	29.7	6.1
Higher	Male	33	22.5	4.7
	Female	40	25.1	5.2
Total Lower		127	28.1	5.8
Total Higher		73	23.8	5.0
Overall Total		200	26.5	5.6

The results presented in this table reveal that the levels of the psychological distress, as evaluated by the K10 scale, are elevated for most of the caregivers from the lower SES, with women being at the greatest risk of all the studied groups of caregivers.

Table 3: Marital Adjustment by Socioeconomic Status

Socioeconomic Status	N	Mean Marital Adjustment (DAS)	Standard Deviation
Lower	127	86.4	10.2
Higher	73	94.7	8.5
Overall Total	200	89.3	9.8

This table shows that spouses from higher socioeconomic backgrounds report higher levels of marital adjustment (mean DAS score of 94.7) compared to those from lower socioeconomic backgrounds (mean DAS score of 86.4). This suggests that economic stability may positively influence marital satisfaction and cohesion among caregivers.

Table 4: Gender Differences in Marital Adjustment Subscales

DAS Subscale	Gender	N	Mean Score	Standard Deviation
Satisfaction	Male	92	22.1	3.5
	Female	108	19.8	4.0
Cohesion	Male	92	18.7	3.2
	Female	108	16.5	3.8
Consensus	Male	92	24.9	4.1
	Female	108	21.6	4.5
Affectional Expression	Male	92	17.3	3.0
	Female	108	15.2	3.6
Overall Total		200		

It is evident from this table that Male caregivers have higher mean scores on all the four subscales of DAS; satisfaction, cohesion, consensus and affectional expression than the female caregivers. These dissimilarities imply that married women caregivers might face more difficulties in preserve certain characteristics of marital satisfaction, largely because of higher family caregiver burden and its consequent psychological load.

Table 5: Psychological Distress by Disease Stage and Socioeconomic Status

Disease Stage	Socioeconomic Status	N	Mean Psychological Distress (K10)	Standard Deviation
Acute	Lower	52	27.8	5.3
	Higher	30	24.6	4.8
Chronic	Lower	75	30.2	6.0
	Higher	43	26.1	5.4
Total Acute		82	26.7	5.1
Total Chronic		118	28.5	5.7
Overall Total		200	27.6	5.4

As shown in this table, spouses of patients with Hepatitis C who are in the chronic stage have higher psychological distress scores than do spouses of patients in the acute stage, and this difference is particularly pronounced for spouses from less economically advantaged backgrounds. This suggests that economic strain and disease progression are factors contributing to caregiver elevated psychological distress.

Discussion

The purpose of this study was to determine the effects of socioeconomic status, gender and disease progression on psychological distress and marital adjustment of spouses of Hepatitis C patients. These findings tell us much about the psychological and relational problems that caregivers face,

and in particular, the inequities that stem from them — both from economic and gender disparities. The following discussion interprets these findings in light of each objective and hypothesis.

Hypothesis 1 suggested that socioeconomic status contributes to differing levels of psychological distress in caregivers with lower socioeconomic status being more distressed than those with high socioeconomic status. This hypothesis is supported by Table 2, which reveals that caregivers from lower socioeconomic backgrounds had significantly higher psychological distress than those from higher socioeconomic backgrounds. This is consistent with earlier work, which found that economic constraints both served stress perception and restricted access to resources, social support, and mental health services (Caron & Liu, 2011). For caregivers with low incomes, it is much more challenging to meet those demands of caregiving with a financial strain to overcome. By pinpointing reasons for distress for caregivers in lower social classes, these findings stress the recourse of targeting financial and psychological support for these caregivers to safeguard their headaches.

Hypothesis 2 was that female caregivers would report higher levels of psychological distress than male caregivers. This hypothesis was confirmed in Table 2, where distress scores are generally higher in female caregivers than male caregivers, regardless of socioeconomic group. This result is consistent with previous caregiving literature, which finds that women carry a more substantial amount of caregiving work and, therefore, are at greater risk for stress and burnout (Cleary & Mechanic, 1983). The elevated levels of distress found in female caregivers could be due to a traditional gender role, which may entail straightforward social and familial expectations for women that can make them psychologically 'loaded.' Taking together these findings suggests a requirement for gender-based interventions to help reduce female caregivers' distress.

Hypothesis 3 suggested that caregivers from lower socioeconomic backgrounds reported lower marital adjustment than caregivers from higher socioeconomic backgrounds. Table 3, with its findings, further supports the hypothesis that lower socioeconomic status is related to less marital adjustment. In particular, caregivers from low socioeconomic backgrounds showed lower scores on the Dyadic Adjustment Scale (DAS), indicating that poorer economic social status worsens marital relationships by increasing marital conflict and reducing marital cohesion and satisfaction. These results support studies that suggest the quality of a spouse's marriage is negatively impacted by financial stress due to time and monetary resources available for relationship nurturing (Hashmi et al., 2007). This leads to the conclusion that resources designed to promote marital resilience in caregiving homes, especially those with chronic illness, must be directed at financial barriers.

Assuming a hierarchical relation between marital adjustment, we hypothesized (and tested the further hypothesis) that the female caregiver would experience lower marital adjustment (generic measure) than the male one. This hypothesis is supported by table 4, in which female caregivers scored significantly lower on all DAS subscales than male caregivers. Such findings imply that female caregivers face more significant obstacles at the level of marital quality maintenance, most probably due to the emotional toll of caregiving and a greater emphasis on them by traditional caregiving role norms (Ridner, 2004). Female caregivers among women with lower scores in marital satisfaction and affectional expression have lower scores, which may reflect the use of more time and emotional energy devoted to meeting caregiving responsibilities rather than enhancing their intimate relationships with their spouses. In general, findings from this study underscore the need to provide relational and emotional support to female caregivers to mitigate the husband's caregiving pressure on their marriage.

Hypothesis 5 also proposed that caregivers of patients diagnosed with Hepatitis C in the chronic stage would score higher on psychological distress (mainly from lower socioeconomic

backgrounds). This hypothesis is supported by table 5, which illustrates that caregiving elderly patients in the chronic stage had significantly higher levels of psychological distress scores, and caregivers of less socioeconomic backgrounds possessed the highest levels of psychological distress scores. Consistent with previous studies, we found that caregiving demands accrue as the disease progresses and that chronic caregiving is associated with higher levels of anxiety and depression (Machado et al., 2014). Identification of prolonged exposure to stressors in caregivers of chronically ill patients indicates that more significant psychological strain is likely. However, these demands interact with economic constraints, further increasing caretaker distress when combined, implying a further stressed role of disease progression and socioeconomic factors. This indicates that caregivers of chronically ill patients who are financially disadvantaged must be supported with ongoing psychological assistance.

Summary of Findings and Implications

The findings of this study reveal that economic stress and gender roles play a pivotal role in shaping the psychological well-being and marital satisfaction of caregivers. It is concerning that female spouses, particularly those from economically disadvantaged backgrounds, bear the brunt of caregiving stress, which leads to higher levels of distress and lower marital satisfaction. This trend underscores the need for targeted interventions that address these specific vulnerabilities. Programs focusing on emotional support, financial assistance, and caregiving resources are crucial to help alleviate the burden on caregivers, especially those in lower socioeconomic strata and women who typically assume the caregiving role.

Differences by disease stage in observed psychological distress underscore the need for flexible support systems, which vary with disease progression. For patients in the chronic stage, the caregivers need specific interventions that account for their caregiving role's prolonged and intensive nature, significantly when additional financial constraints further hamper these caregivers.

They provide some practical implications. Caregivers of Hepatitis C patients should be addressed comprehensively with support programs that address both caregiver mental health and caregiver relational needs in healthcare provider implementations. Lower-income caregivers could get the financial counselling and access to community resources they need; gender-sensitive approaches like stress management and relationship counselling would be beneficial for female caregivers. Future policies should prioritize policies that provide mentally accessible mental health services for caregivers or economic assistance for those in need.

Limitations and Directions for Future Research

There are several limitations in this study. None of its cross-sectional design prevents the investigators from observing changes in psychological distress and marriage adjustment with time while the disease progresses from acute to chronic states. For future longitudinal studies, a dynamic understanding of how caregiving demands and caregiving experience change over time could be better understood. Second, the sample was only two hospitals in Abbottabad, so generalization of the findings to other geographic or cultural settings may be limited. Adding studies in other regions and cultural backgrounds might give the research more reach. Furthermore, because self-reported measures may suffer from social desirability bias, especially for sensitive topics such as marital satisfaction and psychological distress, there is a possibility for systematic reporting biases associated with data collection mode. However, additional insights could be gained by incorporating qualitative methods or caregiver interviews.

Conclusion

Finally, this study found that socioeconomic and gender disparities have profound effects on psychological distress and marital adjustment of caregivers of Hepatitis C patients. Socioeconomic status and gender were both crucial predictors of more significant distress and less marital quality, highlighting the incremental influence of economically challenging and gendered caregiving roles. These findings emphasize the necessity for multidimensional support interventions that fit the issues of the economically deprived and women caregivers. Caregiver healthcare has the potential to address both the mental health and relational needs of caregivers and improve the quality of life of these caregivers, thereby ultimately improving the health outcomes of patients and caregivers.

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