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A comparative study of quality of life and marital satisfaction in patients with depression and their spouses

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ABSTRACT

Spouses of patients suffering from depression experience various forms of burden. Present study assesses and compares the marital satisfaction and quality of life (QOL) of the patients and their spouses. Further it assesses these variables in terms of illness severity, duration of untreated illness (DUI) and other demographic parameters especially gender. In this cross sectional study, 50 patients diagnosed with Depressive Disorder along with their spouses were recruited. Both groups were assessed separately for marital satisfaction and QOL along with demographic details followed by appropriate statistical analysis. A high level of marital distress found amongst both patients and their spouses whereas only patients reported poor QOL. Increasing DUI worsens both marital satisfaction and QOL in spouses with no effects on patients. Illness severity worsens QOL in both groups with no effect on marital satisfaction. Gender was not found to have any impact on either of the groups. Small sample size and cross sectional study design were main limitations. Early and faster intervention will be helpful in patient's prognosis, and also the perception and QOL of spouses. A better treatment response may be expected if focus is at improvement in QOL rather than only symptom control.

Further work will be needed with a larger population and in a longitudinal study design. Future research also needs to focus upon establishment of better norms for the DUI for depressive disorder.

1. Introduction

Mental health has been termed as a mirror to the subjective well being or individuals' evaluation of quality of their lives. Amongst the mental health disorders, depression has always attracted the researchers owing to its high prevalence and it being the 4th leading cause of disability worldwide (Üstün et al., 2004) which is expected to rise to 2nd position by year 2020 (Murray, 1996). As per the epidemiological studies, life time prevalence of depression is 12.1% globally and 26.3% in South Asia (Patel and Shidhaye, 2010). As per a US based study, depressive disorders have enormous economic impact; it alone accounts for 26 billion dollars loss annually as health care cost and also incurs additional indirect cost of 52 billion dollars annually due to loss of productivity (Donohue and Pincus, 2007). Even as compared to other chronic conditions (except heart related morbidities) it leads to significantly more impairment in functioning and personal well being (Wells et al., 1989).

Traditionally morbidity and mortality have been used to assess disease parameters (Mundial, 1993) but in case of chronic illnesses, patients and their relatives seems to be more concerned about the functionality (Wilson and Drury, 1984). Patient's perception of improvement has been found to be a crucial factor determining compliance (Rabkin et al., 2000; McKenna and Whalley, 1998; Skevington, 2002). Orley et al. (1998) also pointed that 'quality of life *responds to patients' concerns not to be treated as cases but as human beings, who have lives with many facets not connected directly to their disease*'. Thus, WHO made an attempt to define quality of life as "individuals' perception of their position in life in context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHOQOL Group, 1995).

As per WHO collaborative study on psychological problems in general health care, depressive illness leads to functional disability despite its treatment (Ormel et al., 1994). Also the improvement in symptoms and QOL occurs at different time frames with the presence of a definite time gap (Diehr et al., 2006; Berlim and Fleck, 2007; Papakostas et al., 2004). Longer duration of illness reduces the chances of complete remission and worsens the dysfunction (Keller et al., 1992). Thus for these illnesses, remission should not just be the clinical improvement in symptoms rather it should be the return of normal functioning (O'Donovan, 2004) or the improvement in QOL (Papakostas et al., 2004). Indeed it is the most important strategy to prevent recurrence and relapse (Lam and Kennedy, 2004).

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The effects of mental health disorders extend beyond the classically defined symptoms to almost every facet of an individual's life including their social interactions, and even beyond the individual, to their close relatives especially the spouse (Benazon and Coyne, 2000; Coyne, 1976).

Marital adjustment is one of the crucial factors to have an impact on the QOL and vice versa. Marital adjustment is "a state in which there is an overall feeling in husband and wife of happiness and satisfaction with their marriage and with each other" (Thomas, 1997). Thus poor QOL of depressed individuals may also have a negative impact on their marital life as well as the QOL of their spouse which in turn may have adverse impact on patient's prognosis, as criticism and hostility of non depressed spouse are associated with greater risk of relapse or lower probability of remission (Butzlaff and Hooley, 1998; Hooley and Licht, 1997; Hooley et al., 1986; Hooley and Teasdale, 1989). In one of the major and earliest studies in the field done on depressed females by Weissman and Paykel (1974), the authors concluded that "the marital relation was a significant barometer of clinical status".

Recent studies have shown differences in the way patient and their spouses perceive their respective marital satisfaction with patients reporting worse satisfaction than the spouses. Though on face it seems that with a depressed partner, even the non depressed spouse's marital satisfaction would deteriorate, but in contrast, a study showed spouses were frequently found to perceive themselves as more satisfied compared to their depressed counterparts (Vibha et al., 2013). Thus, it's important to consider individual perception of both the spouses but not much work has been done on this aspect (Gotlib and Hooley, 1988).

In the past, studies have assessed marital satisfaction and QOL individually for patients and their spouses and compared them with community controls. Not much emphasis has been laid on inter spouse perceptual differences on these parameters. Moreover, owing to higher prevalence of depression in females, most studies have focused on female patients only.

The aim of this study has been to find out if there exist any differences in the perception of spouses' opinion about their marital satisfaction and quality of lives. Further, an attempt will be made to assess if there is any variation based on demographic or disease parameters.

2. Methods

2.1. Participants and procedures

A cross sectional study was conducted in psychiatry OPD of a tertiary care hospital of Delhi, India. Fifty patients meeting the diagnostic criteria of depressive episode as per ICD 10 DCR, along with their spouses were enrolled to participate in the study via systematic random sampling. Couples were screened for inclusion and exclusion criteria and also briefed about the study. Couples meeting the selection criteria and willing to give the informed consent were included in the study. If a couple fails to meet the criteria or refuses to consent, next patient satisfying the criteria was included. Simultaneously, patients and their spouses (if needed) were offered appropriate treatment.

2.1.1. Inclusion criteria

For the purpose of study, patients meeting the criteria of depressive episode as per ICD 10 DCR were considered. Only couples with both partners more than 18 years of age and cohabitating for at least 1 year were included. Also the written informed consent from both the partners individually was considered mandatory for inclusion.

2.1.2. Exclusion criteria

Patients or spouse suffering from any chronic physical illness, substance use disorder or any psychiatric illness other than depression in the index patient was excluded.

2.2. Measures/instruments

2.2.1. Semi structured performa

It was used to record socio demographic details including marital details like duration of marriage and cohabitation and also illness details like duration and type of illness & duration of untreated illness (DUI; taken from the onset of first episode to the initiation of treatment for the first time).

2.2.2. Modified kuppuswamy socio economic scale

Kuppuswamy scale is a composite score of education and occupation of the head of the family along with monthly income of the family. This scale classifies the study populations into high, middle, and low SES. For the purpose of study modified criteria for June 2012 were used (Labour Bureau, Ministry of Labour, Government of India).

2.2.3. Hamilton rating scale for depression − 17 (HAM-D 17)

It is a standard tool to assess the severity of depression. It is a 17 item examiner rated questionnaire in which 8 items are on 5 point scale (0–4) and 9 are on 3 point scale (0–3), with 3 point scale for items where quantification is either difficult or impossible. Total scores are then interpreted as follows: 0–7 = Normal, 8–13 = Mild Depression, 14–18 = Moderate Depression, 19–22 = Severe Depression, > 23 = Very Severe Depression (Hamilton, 1960).

2.2.4. Dyadic adjustment scale (DAS) – hindi adaptation

It is a 32 item questionnaire for overall measurement of marital adjustment. It can be easily incorporated as a self administered questionnaire, or can be adopted for use in interview studies. The scale has scoring of 0–5 for most items except for item no. 23–24 (0–4), 29–30 (0–1), and 31 (0–6). Total score ranges from 0 to 151, with higher scores signifying better marital adjustment (Spanier, 1976) For further categorization, scores < 100 are suggestive of marital distress and ≥ 100 as no marital distress (Messer and Reiss, 2000). Hindi adaptation has been done by Kumar et al. (1999).

2.2.5. Brief version of world health organization quality of life instrument (WHOQOLBREF) (Hindi adaptation)

It is an abbreviated version of WHOQOL-100. It is a 26 item self rated questionnaire of which 24 items cover 4 domains of QOL i.e. physical health, psychological health, environment and social relationships and two items (Item no. 1 & 2) reflect general well being. All items are scored 1–5 with total score ranging from 26 to 130, with higher scores suggestive of better QOL. Its psychometric properties have been found to be comparable to the full version of WHOQOL-100. Participants are expected to fill in the responses based on their functioning in last 2 weeks (WHO, 1996). Its Hindi adaptation has been standardized in India by Saxena et al. (1998)

2.3. Statistical analysis

Data was entered and analyzed using computer based software SPSS version 22. Descriptive statistics was used for the socio-demographic variables. Since most of the variables were found to follow a normal distribution, mean scores of different variables were compared using *t*-test.

Correlation between illness severity and DUI with study variables was carried out using Pearson's test. Analysis of variance (ANOVA) was carried out to determine association of study variables with different demographic parameters and post hoc analysis by Least Significant Difference (LSD) test was done wherever appropriate. A p value of less than 0.05 was considered statistically significant at 95% confidence level.