



**ASSESSMENT OF PSYCHOLOGICAL DISTRESS, TOLERANCE
AND WELLBEING OF FEMALE SPOUSES OF ALCOHOL AND
OPIOID DEPENDENTS**

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ASSESSMENT OF PSYCHOLOGICAL DISTRESS, TOLERANCE
AND WELLBEING OF FEMALE SPOUSES OF ALCOHOL AND
OPIOID DEPENDENTS

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(A Central University Established by the Act of Parliament No. 35 of 1989)

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CERTIFICATE

This is to certify that the thesis entitled, “**Assessment of Psychological Distress, Tolerance and Wellbeing of Female Spouses of Alcohol and Opioid Dependents**” being submitted to Nagaland University by Miss **Meena Hijam**, Ph.D. Regd. No: PhD/PSY/00867, for the award of Ph.D. Degree in Psychology is a bonafide work carried out by her under my supervision. Her observations and facts reported were checked and verified. The results embodied in this thesis have not been submitted to any other university or institute for the award of any degree or diploma.

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I, Meena Hijam, hereby declare that the subject matter of this Thesis entitled “Assessment of Psychological Distress, Tolerance and Wellbeing of Female Spouses of Alcohol and Opioid Dependents” is the record of work done by me, that the contents of this Thesis did not form basis of the award of any previous degree to me or to the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

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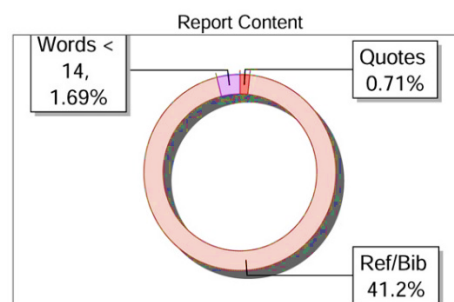
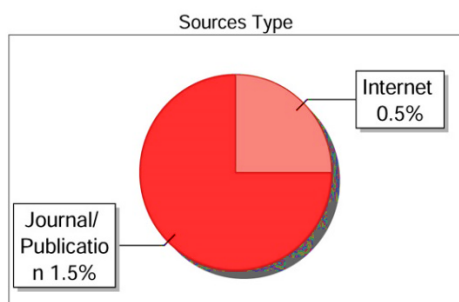
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Abstract

Drug and alcohol abuse is a major public health issue. Use of drugs and alcohol not only affects the individuals themselves, it also entails significant harm to family members, especially wives. Husbands' drug and alcohol abuse was found to be a significant predictor of why women in India are more vulnerable to common mental health disorders such as depression, anxiety and stress. Additionally, such women also experience psychosocial issues, such as facing humiliation, stigma and abuse. In Manipur, drug and alcohol dependence has remained exceptionally high over the decades. The report of the National Mental Health Survey also showed that the most prevalent form of mental health disorder in the state is substance use disorders. Moreover, the mental health burden of Manipuri women was also reported to be significantly higher among women when compared to men.

The present study was aimed to explore and compare the experience of symptoms of psychological distress, depression, anxiety, and stress among female spouses of alcohol and opioid dependents and an age-appropriate control group. Further, the study examined and compared the levels of distress tolerance and psychosocial well-being between the case and control groups. The relationship between distress tolerance, psychopathology, and wellbeing was also investigated. The present study is a cross-sectional study design. Through purposive sampling technique, 400 women took part in the study, consisting of 100 female spouses of Opioid dependents, 100 female spouses of Alcohol dependents and another 200 female spouses as the control group. Tools such as Kessler Psychological Distress Scale, DASS-21, Flourishing Scale and Distress Tolerance Scale were utilised. Data were collected from the Department of Psychiatry and Department of Clinical Psychology, RIMS-Imphal and from various drug de-addiction centres under the Social Welfare Department, Govt. of Manipur. Male patients who were pre-diagnosed and seeking treatment for alcohol and opioid dependence were screened, and female spouses of patients who fulfilled the exclusion and inclusion criteria were recruited for the study. For the control group, women fulfilling the study criteria were identified with the help of local clubs and women's organisations from six communities in Imphal East and Imphal West districts. The communities were selected purposively and conveniently. For the case group, data collection was conducted from the hospitals/ concerned

addiction centres or from respective households based on participants' convenience. For women in the control group, data collection was conducted through home visits.

Descriptive statistics such as percentage analysis, t-test, chi-square, linear regression and logistic regression analysis were carried out. Data were analysed in SPSS version 26, and a p-value less than 0.05 was considered significant. The study found that wives of alcohol- and opioid-dependent men experienced significantly higher levels of psychological distress, depression, anxiety, and stress than wives with non-dependent husbands. Logistic regression revealed particularly high risks for depression (OR=11.23) and stress (OR=7.08) among women in the case group. Distress tolerance was also markedly lower (OR=0.375) and strongly linked to higher depression, anxiety, stress, and lower psychosocial wellbeing. Also, findings from the linear regression analysis revealed that distress tolerance had a significant negative correlation with depression ($R = -0.48$), anxiety ($R = -0.53$), and stress ($R = -0.53$). The regression model further indicated that distress tolerance significantly and negatively predicted depression, anxiety, and stress among women ($p < 0.001$). Specifically, distress tolerance accounted for 23.5% of the variance in depression, 40.8% of the variance in anxiety, and 39.1% of the variance in stress. These findings suggest that lower levels of distress tolerance are strongly associated with higher levels of psychopathology. Further, the study observed that depression is the most common psychological symptom experienced by women; 81% of women in the case group were symptomatic for depression. This is quite alarming as depression, if untreated, can lead to suicide and suicide attempts; hence, spousal intervention becomes a necessity. Further, women in the case group experienced additional burden when compared to the control group; financial strain, social withdrawal, and abuse were reported, with most expressing a need for counselling. Abuse was present in both groups; however, it was more common among women in the case group, underscoring the need to incorporate trauma-informed therapy for such women. Further, socio-demographic factors such as younger age, shorter marriages, childlessness, and abuse history predicted poorer mental health outcomes and reduced wellbeing among women.

Future research should incorporate qualitative methods, such as in-depth interviews and focus group discussions, to capture broader concerns of women with substance-dependent husbands. Since most spouses expressed a need for support and

continued to report high distress, it is crucial to strengthen mental health services in hospitals and de-addiction centres and integrate spouse-focused programs into existing treatment modules. Overall, the findings highlight the heavy psychological burden on female spouses of alcohol and opioid dependents and call for targeted interventions to reduce distress and strengthen psychosocial support.

Keywords: Husbands' substance abuse, women's mental health, wellbeing, distress tolerance

CHAPTER – I

INTRODUCTION

1.1 Alcohol and Opioid Abuse

The World Drug Report (2018) suggest that around 275 million people in the world, which accounts for about 5.6 per cent of the global population aged 15–64 years, used drugs at least once during 2016. Around 31 million individuals who use drugs experience drug use disorders, indicating that their consumption is harmful enough to potentially require treatment. Of all the drugs, opioid use disorder resulted in the maximum number of deaths. Use of drugs has been pointed out as a serious threat not only to health and well-being, but also to security, safety and sustainable development of a nation.

The reports of Magnitude of Substance use in India (2019) have shown that alcohol is the most common substance used by Indians, followed by opioids. The survey indicated that the prevalence of alcohol dependence and opioid dependence in Manipur is 3.8 % and 1.8%, against the national average of 2.83% and 0.26% respectively. Among the states of India, most of the northeastern states, including Manipur, have the highest prevalence of opioid use in the general population. In the recently concluded National Mental Health Survey of India, substance use disorders have been identified as the most common mental health disorders (Pradeep et al., 2018 & Gautham et al., 2020), and a prevalence rate of 4.7% for alcohol use disorder was reported for Manipur, which is quite high (National Mental Health Survey, 2016).

In the eleventh revision of the International Classification of Diseases (ICD-11), both opioid and alcohol dependence form a key part in the section on Disorders due to Substance use. According to the guidelines of ICD- 11, alcohol dependence is a condition resulting from repeated or continuous alcohol use, marked by a strong internal urge to consume alcohol. It is characterized by reduced control over drinking, prioritizing alcohol use over other responsibilities or activities, and continuing consumption despite harmful or negative consequences.

Other physiological features, such as tolerance and withdrawal symptoms, may be present. Features of the symptoms for diagnosis are 12 months; however, the diagnosis can be established if alcohol consumption occurs continuously (on a daily or near-daily basis) for a minimum duration of one month. The same criteria have been implicated for Opioid dependence as well.

1.2 Spouses' Mental Health and Husbands' Substance Abuse

Research has established that use of alcohol, opioid, and other substances cause considerable harm to both the users and close family members. This is particularly more important and relevant for Indian society, as joint family is more common and family has a pivotal role in providing care and assistance. Subjective burden was also reported to be higher among female caretakers of substance dependents when compared to that of men (Sharma et al., 2019). In a review study, Eashwar et al. (2020) reported that alcohol consumption affects the psychological well-being of family members and emotional abuse among spouses was found to be 2.5 times more common among alcohol consumers.

Furthermore, women in the family are frequently the ones most affected by substance use, especially when they are spouses or mothers. This is especially true in Indian society, where women still struggle to have the same opportunities as men (Benegal et al., 2000). In a scoping review conducted on both qualitative and quantitative studies, it was found that affected family members of substances users, women in particular, reported high stress and burden, increased mental health issues, reduced quality of life and social adjustment. The review was done on studies conducted worldwide, including India and factors such as user's severity and low economic status were reported to be significant determinants of increased mental health issues (Di Sarno et al., 2021). Research on women of partners with substance use problems have increased after the year 2010, showing an increased interest in the area. Further, in a scoping review study, it was observed that women's poor quality of life is linked to partner's substance use problems (Birkeland et al, 2018).

1.3 Psychological distress (PD)

Psychological distress refers to "the non-specific symptoms of anxiety and depression" (Cuijpers et al., 2009). It has been referred to as "a state of emotional suffering which is typically characterised by symptoms of depression and anxiety" (Drapeau et al., 2012 & Doran, 2011). Ridener, (2000) has defined psychological distress as "the unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person". Psychological distress is characterised by a mixed symptomology of anxiety and depression that does not fully fit the criteria for either condition, but it significantly disrupts a person's social, emotional, and professional

life. Earlier studies conducted in the area also purposed that psychological distress have strongly correlated symptoms of depression and anxiety and each of these symptoms has both psychological and somatic components (Mirowsky & Ross, 1989; Watson & Kendall, 1989) Hence, psychological distress has psychophysiological symptoms signifying the presence of both physiological as well as emotional problems of individuals (Wells., Golding, & Buram, 1998).

Elevated levels of psychological distress indicate impaired mental health and may eventually lead to common mental disorders, like depressive and anxiety disorders (Cuijpers et al., 2009). Psychological distress needs focus as in severe cases, may be linked to the presence of suicidal ideas and attempts, which can further lead to increased risk of morbidity and mortality in the community (Mossey and Shapiro, 1982; Kalpan et al., 1987).

1.3.1 Theories of Psychological Distress

Ridner's Concept Analysis of Psychological Distress

Ridner purposes five defining characteristics of patients living with psychological distress; perceived inability to cope, changes in emotional status, discomfort, communication of discomfort and harm. Psychological distress is accompanied by an individual's perceived inability to deal with stress (Ridner, 2004). When individuals feel that there is absolutely no solution to stress and hence, affective coping or problem-solving is not achieved, then psychological distress may bound to occur (Jones & Johnston, 1997). Inability to cope may be manifested through signs and symptoms such as an inability to verbalise ways to address problems, dependence on others for decision-making, and avoidance of issues. Change in emotional status includes feelings such as depressed mood, being anxious, irritability and tearfulness. Discomfort may be manifested by sadness, ache, pain, anger, hostility, etc. The discomfort associated with psychological distress is communicated through verbal and non- verbal expressions such as silence, complaining of pain, insomnia, scowling, frowning, avoiding eye contact and being restless. Harm includes pain, suicidal gesture, change in vital signs, etc.

A change in emotional status is reflected in a transition from a stable baseline mood to one marked by anxiety, depression, lack of motivation, irritability, aggression, and self-deprecation. (Masse, 2000). People with psychological distress experienced a significantly high level of mood disturbance (Cimprinch, 1999), nervousness and

tension (Zung, 1983). Discomfort resulting from psychological distress is anything which disturbs the comfort of an individual and it portrays the change in comfort that occurs with PD (Random House Webster's Unabridged Dictionary, 1998). Mental discomfort such as anguish, suffering and misery are often characterized as emotions linked to psychological distress (Spraycar, 1995; Merriam-Webster's Collegiate Dictionary, 2000). It has been proposed that individuals express the physical and psychological changes related to psychological distress in diverse ways. For instance, facial expressions of people may reflect the emotional change related to psychological distress (Izard et al., 1984). However, distress may also be communicated in unusual ways, such as expressing the need to talk about a seemingly benign topic, such as body odour, when one is suicidal (Last, 2000). The last defining characteristic of psychological distress is harm. Psychological distress is reported to be harmful as during distressed state, wear and tear, either permanent or temporary happens, which may further lead to physical and psychological harm such as decreased self-esteem and dependency among individuals (Rhodes & Watson, 1987).

The Three Dimension of Psychological Distress

Arvidsdotter et al., (2015), described three themes/ dimensions of psychological distress while conducting a phenomenological study on people experiencing psychological distress; struggling to cope with everyday life, feeling inferior to others and losing one's grip in life. In struggling to deal with everyday life, individuals feel fatigue and fearfulness about being unable to fulfil the demands of daily life. Hence, feelings such as restlessness, tension, extreme fatigue, sleeplessness, headaches, stomach-aches, chest pain, etc., are common among these individuals. Furthermore, it is also accompanied by fluctuating emotional feelings, which oscillate between feelings of happiness and sadness, anger, crying, and hopelessness.

In the dimension of feeling inferior to others, individuals experience reduced self-esteem, accompanied by a fear of not being good enough in various areas of life and, hence, tend to avoid responsibilities for the fear of not succeeding (Arvidsdotter et al., 2015; Ekstedt & Fagerberg, 2005; Jingrot & Rosberg, 2008). As a result, such individuals consider themselves a burden to others and withdraw from social life and isolate themselves. This phenomenon is explained as undergoing some existential crisis in one's life, where there is an imbalance between the real self and the ideal self; explaining psychological distress from a humanistic perspective (Gustafsson et al.,

2008). The third dimension discusses losing one's grip on life, which refers to feelings of emptiness, meaninglessness, and depleted energy and resources. Such individuals have a pessimistic outlook about the future and hence, lose interest as well as the enthusiasm to continue living (Arvidsdotter et al., 2015; Masse, 2000).

1.3.2 Determinants of psychological distress among women

Multiple authors have established that psychological distress is a common mental health problem in the community (WHO, 2001; Marchand et al., 2012; Doherty et al., 2008 & Drapeau et al., 2012), and risk factors include stress-related and sociodemographic factors and inadequate external and internal resources (Drapeau et al., 2012). According to previous studies taken up in the area, women are more susceptible to psychological distress, depression and anxiety than men (Markkula et al., 2015, Suvisaari et al., 2009 & Bromet et al., 2011). In a recent nationally representative survey conducted by Viertio et al., (2021), women (11%) had considerably elevated levels of psychological distress than men (8.8%).

The significant gender disparity in the experience of psychological distress can be attributed to biological, psychological and societal risk factors. Social factors such as different societal roles and expectations for men and women have been implicated as important factors. The roles at work and in the family as well as the challenges in fulfilling them, may be one factor contributing to gender differences (Beauregard et al., 2011, Marchad et al., 2016). Among working population, loneliness, job dissatisfaction and conflict within the family were linked to higher risk of having psychological distress among women. Protective factors include having children, active community participation, successful work and family roles, and social support (Viertio et al., 2021).

Studies have reported some factors that are more unique to women. First, conflict between work and family is regarded as an important factor in predicting women's psychological distress; women tend to perform most of the domestic work in the family (Cunha et al., 2016) and having children to care and attending to work may all aggravate work- family conflict (Remery & Schippers, 2019). Second, a lack of social support from friends and family increases the chance of having psychological distress (Stansfeld et al., 1998), and among women, inadequate emotional support is an important determinant of psychological distress (Kendler et al., 2005). Third, women experience loneliness more commonly than men, and findings suggest that

loneliness co-occurs with psychological distress among women (Beutel et al., 2017; Hyland et al., 2019). Fourth, status of marriage was also found to be an important factor; living alone and being divorced and widowed was linked with a greater chance of having mental health issues, including psychological distress (Ben-Zur, 2012; Scott et al., 2010; Pulkki-Råback et al., 2012). Fifth, informal caregiving has also been associated psychological distress; women who provide care for both ill and elderly individuals are more likely to experience psychological distress compared to men. (Hajek, & König, 2018). Sixth, financial constraints, which mainly refer to the inadequacy in taking care of daily household needs, is also a central factor of experiencing psychological distress (Ahnquist & Wamala, 2011; Nagasu, et al., 2019).

1.4 Depression, Anxiety and Stress

Depression, anxiety and stress-related disorders are referred to as common mental disorders or CMDs. It has been documented that symptoms of depression, anxiety and unspecified psychological distress are 2-3 times more prevalent among women than in men, and gender was identified to be a critical determinant of mental health (WHO, 2002). Studies conducted in India indicated that CMDs show a strong association with female gender and factors such as excessive drinking by partner, sexual and physical violence by spouses and inadequate support from one's family are important predictors of why women have more risk of having CMDs in India. Additionally, other relevant factors include the lifetime stressors that women, in particular, face, such as maternal roles and caring for ill family members (Shidhaye & Patel, 2010; Patel et al., 2006; Nayak et al., 2010).

1.5 Depression

The term depression appeared for the first time around the nineteenth century, and among other symptoms, mood was considered the core disturbance associated with the disorder (Paykel, 2008). Depression, as we understand it today, is based on the two official classifications provided by the ICD and DSM. Both of these classification systems define depression by the presence of certain clinical features and imply a cluster of signs and symptoms; however, they do not emphasise any specific etiological factors. The common core symptoms of depression, as per the two classification systems, are depressed mood and loss of interest or pleasure, primarily viewing depression as a disorder of mood or affect. Additionally, in ICD-10,

decreased energy or fatigability has been included as an eligible symptom for depressive disorder. Further, the additional symptoms which meet the criteria of depressive disorder are weight loss or gain, hypersomnia or insomnia, retardation or agitation, loss of energy, loss of self-esteem or confidence, feelings of worthlessness or guilt, indecisiveness or reduced concentration, and in severe cases, thoughts of suicide or suicide attempt (American Psychiatric Association, 2013; World Health Organization, 2019).

Depression is a common mental disorder, with an estimated 3.8% of the affected population, which accounts for 280 million people in the world. Depression can lead to serious health conditions, especially when it's recurrent and of moderate and severe intensity. When undergoing a depressive episode, an individual typically experiences a persistently low mood, such as sadness, irritability, or emptiness—or a marked loss of interest or pleasure in activities, lasting most of the day, nearly every day, for a minimum of two weeks. Additional symptoms may accompany this, including difficulty concentrating, excessive guilt or low self-esteem, hopelessness, suicidal thoughts, disturbed sleep, changes in body weight or appetite, and pronounced fatigue or low energy. (WHO, 2021).

1.5.1 Theories of depression

The Learned Helplessness Theory

Martin Seligman (1972) developed the theory of learned helplessness based on his behavioural experiment with dogs; dogs that were repeatedly subjected to trauma would cease to attempt to escape even when escape or avoidance was made possible. It was observed that uncontrollable trauma has three effects: first, they become passive in the face of trauma. They are slower to respond and may not respond at all, which can exacerbate the traumatic experience. Second, they are retarded in learning that responding will help control the trauma, i.e., even if a response is made which alleviates the trauma, they may still have problems catching on to the response relief contingency. Third, they start showing more stress upon learning that trauma is uncontrollable. This theory has been applied to explain the phenomenon of depression in humans; repeated exposure to uncontrollable and aversive events can lead individuals to develop a belief that such conditions are inescapable, and a sense of helplessness ensues. This feeling of helplessness, in turn, results in depression (Seligman & Maier, 1967). However, this theory had limitations as it did not give any

explanation to why some individuals did not experience depression when confronted with uncontrollable environmental stimuli (Abramson et al., 1978).

The Cognitive Theory of Depression

In 1967, Aron Beck developed the cognitive theory of depression, which has three main components: cognitive bias, dysfunctional schemas and cognitive triad. Cognitive bias refers to the systematic error in thinking, where people tend to focus on the negative aspects of situations, affecting the way information is processed and leading to distorted perceptions of reality. Beck discovered that depressed people tend to have cognitive biases. Further, schemas are cognitive framework which stores information and ideas and helps us to organise and interpret information around us. Beck observed that depressed people have dysfunctional schemas and negatively interpret information about themselves. Beck further claimed that cognitive bias and dysfunctional schemas maintain the cognitive triad: a negative and irrational view of oneself (believing that one is inadequate, defective, therefore feeling worthless), the world (a negative view of current experience) and the future (expects future of continued hardships, suffering and failure) (Beck, 1967, 1976, 1983).

The Theory of Social Origin of Depression

Brown and Harris (1978) also developed a theory of depression which focuses on three factors: a) provoking factors (recent traumatic life events), b) vulnerability factors (early loss of mother, lack of an adequate confidant, etc) and c) symptom formation factors (symptoms experienced by depressed people is associated with the type of events or loss). The authors argued that loss events lead to a feeling of hopelessness, and the vulnerability factors impair one's self-esteem. Reduced self-esteem results in an increased intensity of the response to loss, through the generalisation of the hopelessness triggered by it. The pain associated with this response further leads to denial. And this mechanism of denial is the factor why a normal response to a loss event is converted into depression (Brown & Harris, 1978).

1.5.2 Determinants of Depression

Studies suggest that the etiological factors of depression are multifactorial, indicating the role of both genetic and environmental causes of depression. First-degree relatives of people with depressive disorders are as thrice as more likely to have

depression; however, people can still develop depression without any underlying family history as well (Pham & Gardier, 2019; Namkung et al., 2018). For instance, psycho-social risk factors like traumatic life events and other hassles of life can serve as a trigger for developing depression. Further, loss of loved ones, informal caregiver burden, financial constraints, lack of social support and interpersonal conflicts are a few factors that can lead to depression among individuals. Gender and age have been reported to be important determinants of depression. It was observed that the chance of having depression is three times higher among people of young age in comparison to individuals above 60 years of age. Also, females had 1.5 to 3 times higher chance of experiencing depression when compared to their male counterparts. Environmental and seasonal factors can also be responsible, as people also experience seasonal affective disorder, which is a form of major depression that arises during winter and fall seasons and resolves as spring and summer approach (Chand & Arif, 2023).

Evidence suggest that women are more vulnerable to depression than men, and this gender disparity is attributed to the changes associated with the endocrine and reproductive system, which is unique to women. Changes that occur during the menstrual cycle, menopause, pregnancy, and the postpartum period are often accompanied by significant mood changes in women (Noble, 2005). Systematic review studies on depression suggest that about 15% of women have depression during the time of pregnancy (Okagbue et al., 2019), and 14% of women who gave birth met the criteria for postpartum depression (Liu et al., 2022). However, the higher prevalence of depression among women cannot be explained by endocrine or reproductive systems alone; focus has also been given to the psycho-social issues that women in particular face, such as gender specific roles, victimization, sex- specific socialization, etc. These factors are equally responsible for women having a higher risk of having depression (Noble, 2005).

1.6 Anxiety

Anxiety is the total response of a human being to threat or danger. Each experience of anxiety involves a perception of danger, thoughts about harm, and a process of physiological alarm and activation. The accompanying behaviours display an emergency effort toward "fight or flight". An anxiety disorder goes beyond normal, transient fears and anxiety and disrupts the normal course of life (Moss, 2002). It is an emotion characterized by feelings of tension, worried thoughts and physical changes

like increased blood pressure. People with anxiety disorders usually have recurring intrusive thoughts or concerns. They may avoid certain situations out of worry. They may also experience physical symptoms, such as sweating, trembling, dizziness, or a rapid heartbeat (APA, 2022).

Further, anxiety is also accompanied by impaired concentration, disorganized thinking, disrupted verbal expression, and unpredictable behaviour. Although it functions as an adaptive response to perceived threats—serving a protective and preparatory role—chronic or severe manifestations can lead to significant psychological distress. Such manifestations are frequently accompanied by intrusive thoughts, compulsive behaviours, interpersonal difficulties, and pervasive restlessness. Moreover, anxiety commonly co-occurs with depression, with the two conditions mutually reinforcing and exacerbating one another (Cole, 2014).

In ICD-11, disorders whose primary features are excessive fear, anxiety, or related behavioural disturbances are grouped under “Anxiety or fear-related disorders.” In the classification, fear is differentiated as a reaction to perceived imminent threat in the present, while anxiety refers to a more future-oriented anticipation of threat. Disorders such as generalised anxiety disorders, selective mutism, social anxiety disorder, separation anxiety disorder, etc., are included in the group.

1.6.1 Theories of Anxiety

Cognitive Theories of Anxiety

Contemporary cognitive theories of anxiety have been established drawing on the research contributions of authors like Albert Ellis (1972) and Beck et al., (2005). The authors propose that fear and anxiety experienced by individuals with anxiety disorders in particular contexts result from threat appraisals rooted in dysfunctional, threat-related cognitive schemas. Moreover, they identify several behavioural and cognitive processes that contribute to the maintenance of these maladaptive beliefs, assumptions, and appraisals. Over time, this foundational cognitive model of anxiety disorders has undergone refinement and further theoretical development (Clark & Beck, 2011). Cognitive theories posit that anxiety disorders arise from distorted threat appraisals, which stem from maladaptive cognitive schemas composed of core beliefs and assumptions. When activated, these schemas have bias cognitive processing toward schema-congruent information, thereby limiting the integration of

disconfirming evidence and preventing schema modification. Furthermore, such maladaptive schemas are maintained and reinforced through the use of dysfunctional coping mechanisms, both behavioural—such as safety-seeking behaviours—and cognitive—such as thought suppression and repetitive negative thinking. Further, these maladaptive coping strategies can also directly exaggerate the symptoms of anxiety (Ehring, 2014).

Lang's Bio informational theory

Lang's Bio informational Theory of Anxiety suggests that emotional responses—particularly fear and anxiety—are organized in memory as associative networks composed of stimulus, response, and meaning elements. When an individual encounters a fear-related stimulus, the activation of this network triggers physiological, cognitive, and behavioural fear responses. Crucially, the theory emphasizes that fear is not merely a reaction to external threats, but the result of internal, encoded representations of threatening events. This memory structures become more readily activated with repeated exposure, potentially reinforcing anxiety responses over time. Lang's model has been influential in guiding imagery-based treatments for anxiety, such as exposure therapy, by targeting and modifying the content of these fear networks (Lang, 1979).

The Emotional Processing Theory

The Emotional Processing Theory (EPT), developed by Foa and Kozak (1986), posits that anxiety disorders are maintained by maladaptive fear structures in memory, which include information about feared stimuli, physiological and behavioural responses, and associated meanings. According to EPT, these fear structures are often rigid and exaggerated, leading to persistent anxiety responses even in the absence of actual threat. According to the theory, successful emotional processing involves both the activation of the fear memory and the integration of new, non-threatening information, leading to a reduction in fear over time. This theory has provided a foundational framework for the development and refinement of cognitive-behavioural interventions for anxiety disorders.

Gray's Neuropsychological Theory of Anxiety

Gray's Neuropsychological Theory of Anxiety, originally proposed by Jeffrey Gray, centres on the function of the Behavioural Inhibition System (BIS) in the regulation of anxiety. According to this theory, the BIS is a neurobiological system that is activated in situations involving conflict (e.g., approach-avoidance), novelty, or punishment signals. Once activated, the BIS inhibits ongoing behaviour, increases arousal and attention, and heightens sensitivity to potential threats—manifesting as anxiety. Gray suggested that the BIS is primarily governed by specific neural structures, and individuals with an overactive BIS are believed to be more prone to developing anxiety disorders. This theory provides a neurobiological framework that complements cognitive-behavioural models, linking brain systems with behavioural and emotional responses (Gray & McNaughton, 2000).

1.6.2 Determinants of Anxiety

Gender was reported to be the most significant factor, with females exhibiting higher rates of anxiety than males across a range of age groups and cultural settings (Remes et al., 2016). This trend is supported by research conducted in both high- and low-income contexts, including a study in South India, where female adolescents reported higher levels of anxiety than their male peers (Muthusamy et al., 2022). Similarly, in Shivamogga, India, urban female adolescents had a higher chance of experiencing anxiety than rural males, suggesting an interplay between gender and location (Mallya Koppad & Kumar, 2024). Additionally, individuals with lower educational attainment or income are more vulnerable, likely due to chronic stress, reduced access to healthcare, and fewer psychosocial resources (Remes et al., 2016; Ahmed et al., 2022). Marital status is another influential factor; being unmarried, separated, or divorced was linked to greater anxiety, perhaps due to reduced social support (Clark & Beck, 2011). Moreover, age is also a central factor—adolescents and young adults typically report higher symptoms of anxiety than older adults, possibly due to transitional life challenges and identity development pressures (Vittersø, 2016). In a national survey, individuals under 40 years, particularly females with lower levels of education, were found to be at significantly greater risk of having anxiety (Baker & Thomas, 2022).

1.7 Stress

Stress has been described by the World Health Organization as the "Health Epidemic of the 21st Century" (Fink, 2017). The term 'stress' was defined by Hans Selye (1936) as "the non-specific response of the body to any demand for change". According to Lazarus (2006), "stress is a dynamic process that occurs when an individual appraises situational demands as exceeding available resources." The latter definition of stress highlights a cognitive component, highlighting the relationship between the person and the surrounding environment. Additionally, authors like Chrousos (2009) have refined the concept of stress by elaborating the variance between 'stressor' and 'stress response'. A stressor is defined as a stimulus that threatens the very equilibrium or the homeostasis (optimum level of physiological variables) of an organism, and the response aimed at gaining homeostasis has been referred to as stress response. Nevertheless, this definition received criticism on the grounds that almost all activities of organisms work to defend homeostasis directly or indirectly. (Romero et al., 2009).

Furthermore, some authors argued that the term "stress" should only be applied in situations where environmental demands exceed the natural regulatory capacity of an organism, particularly in situations that involve unpredictability and uncontrollability. Unpredictability is marked by the lack of an anticipatory response, while loss of control is indicated by a delayed recovery and a characteristic neuroendocrine profile. Physiologically, stress appears to involve either a lack of anticipatory response in unpredictable situations or a diminished recovery of the neuroendocrine system in uncontrollable ones (Koolhaas et al., 2011).

While stress in moderate and manageable forms can contribute positively to biopsychosocial well-being—enhancing performance, motivation, adaptability, and environmental responsiveness—chronic or excessive stress poses significant risks. Prolonged exposure to high levels of stress has been linked to a range of adverse biological, psychological, and social outcomes, potentially resulting in severe health consequences (Tucker et al., 2008). The impact of stress on both emotional and physical health can be profound. Acute stress responses often manifest in emotional symptoms such as anxiety, depression, irritability, and fatigue; behavioural changes including social withdrawal, aggression, tearfulness, and lack of motivation; cognitive impairments such as reduced concentration and problem-solving ability; as well as physical symptoms like palpitations, nausea, and headaches. When stress becomes

persistent, it may contribute to dysregulation across multiple physiological systems—including the neuroendocrine, cardiovascular, autonomic, and immune systems—ultimately increasing vulnerability to a range of mental and physical health conditions, such as anxiety disorders, depression, and cardiovascular disease (Michie, 2002).

1.7.1 Theories of Stress

The Cognitive Appraisal Theory

The cognitive appraisal of stress is based on a thorough evaluation and interpretation of a situation, whether it is perceived as stressful. Events are perceived as stressful depending upon their appraisal as threatening, which happens through perceptions, memory, or expectations. Appraisal takes place in two phases: a) primary appraisal, which is the initial evaluation of whether the event is relevant or threatening, and b) secondary appraisal, which is an individual's perception of whether enough resources and abilities are there to overcome the threat. (Lazarus, 2013; Lazarus & Folkman, 1984). Hence, individuals respond only after an appraisal has been made, and the responses may manifest in the of emotional, cognitive, behavioural, and physiological changes (Tomaka et al., 1997).

The General Adaptation Syndrome (GAS)

One of the earliest theories of stress is the general adaptation syndrome developed by Hans Selye (1956). Selye defined stressors as “demands to which there are no readily available or automatic adaptive responses”. The theory of GAS involves three stages: a) the alarm stage, where body is mobilized to respond to stress, triggering the fight or flight response, b) the resistance stage, in which the body makes an effort to take actions to combat the stress or learns to adapt to it, and c) the exhaustion stage, in which the body's resources are depleted in trying to overcome or adjust to the stressful event. According to GAS, all the three stages of stress result in considerable health problems.

The Cognitive Activation theory of stress

The Cognitive Activation theory of stress (Ursin & Eriksen, 2004) is a relatively newer attempt at understanding and refining the stress process. The theory is slightly different from other approaches, as it emphasizes the positive health consequences of the alarm response. The alarm response triggers non-specific changes

that prepare the body to face any type of challenge or threat. This response leads to coping behaviours, and when these are expected to yield positive outcomes, the alarm is reduced or deactivated. The theory focuses on the nature of the responses and the expectations associated with them. In healthy individuals, these expectations are generally positive, and therefore, there is no risk to health. Negative health effects arise only when coping is absent. CATS clearly defines two types of negative expectations that occur in the absence of coping: helplessness and hopelessness. Both can contribute to physical illness by maintaining chronic arousal and by reducing motivation to pursue healthy behaviours.

1.7.2 Determinants of Stress

Stress is determined by certain psychosocial factors such as financial constraints, lack of social support, feelings of loneliness, and gender, especially being female. (Bak et al., 2012). Further, personality factors were also considered a hidden factor for stress. Personality traits like extraversion and neuroticism were reported to directly influence how people experience and react to stress. Specifically, neuroticism was demonstrated to significantly impact individuals' stress perceptions, coping mechanisms, satisfaction with social support, psychological well-being, and the experience of somatic symptoms (Costa & McCrae, 1990). Further, informal caregiving was reported to be a significant factor for developing stress. The prevalence of stress was significantly high (95.2%) among individuals providing care to the sick and ill persons in the family (Fasiku et al., 2022), and studies confirmed that females constitute more than two-thirds of the caregivers (Fasiku et al., 2022; Özmen & Yurttaş, 2018; Navaie-Waliser et al., 2002) as caregiving is usually considered the responsibility of women in the family (Akpan-Idiok & Anarado, 2014). Additionally, job dissatisfaction and other work-related factors like interpersonal relationships and organizational culture are believed to be strong indicators of stress within occupational settings (Steyn & Vawda, 2014).

1.8 Psychosocial wellbeing

Wellbeing is a multifaceted and evolving concept that includes subjective experiences, social relationships, psychological aspects, and health-related behaviours. It involves more than just the absence of negative emotions or conditions—it's also about how individuals adapt and adjust to a challenging environment. According to

Diener (1984), well-being is understood as a person's subjective assessment of their life, measured through life satisfaction and emotional states. Well-being can be viewed through two lenses: subjective and objective. The subjective aspect refers to personal life experiences, while the objective dimension involves comparing one's life circumstances against societal standards and cultural values (Sfeatcu et al., 2016). Psychosocial well-being is a broader category that encompasses emotional and psychological well-being, along with social and collective well-being (Martikainen et al., 2002).

Human development takes place within intricate environments where numerous factors influence psychosocial well-being. This form of well-being focuses on key elements of social and psychological functioning, as experienced from an individual's perspective. It includes aspects such as having supportive and fulfilling relationships, contributing to others' happiness, feeling respected, leading a life with meaning and purpose, and being actively engaged and interested in daily activities (Diener et al., 2010).

1.8.1 Theories of Wellbeing

The Cognitive Theory of Wellbeing

The cognitive outlook on well-being emphasises how individuals attend to and construe life experiences, shaping their overall psychological well-being. Construal style—one's habitual way of evaluating situations—has been shown to predict well-being (Margolis & Lyubomirsky, 2018). Lyubomirsky and Tucker (1998) found that while happy and unhappy individuals reported similar levels of negative life events, their cognitive responses differed: happier individuals interpreted events more positively and imagined hypothetical scenarios more favourably. Attention also contributes to well-being, as individual differences in attentional focus influence emotional processing. There is a reciprocal link between attention and well-being, and attentional control can causally influence emotional well-being. For instance, individuals with depression show reduced orientation toward positive stimuli and attend to them for shorter durations compared to negative stimuli (Livingstone & Isaacowitz, 2017).

The Eudaimonic Approach to Wellbeing

There are certain theories based on the eudaimonic approach to well-being. Ryff (1989) developed one such theory, which has six dimensions of well-being. The main feature of each dimension are: 1) self-acceptance, which involves recognizing and embracing one's strengths as well as weaknesses; 2) positive relationships with others, which involve forming meaningful and deep bonds with significant others; 3) autonomy which means living according to one's own beliefs and values; 4) environmental mastery which refers to effectively handling and adapting to life situations; 5) purpose in life which reflects the sense that one's life is meaningful and has purposefully directed; and 6) personal growth which occurs when individuals actively develop and make use of their abilities and potential (Ryff, 1989, 2014; Ryff & Singer, 2006).

The Self-Determination Theory

Self-determination theory also embraces a eudaimonic conceptualisation of well-being. The theory views self-realisation, or eudaimonia, as the central aspect of well-being and emphasises understanding the processes that lead to self-actualisation (Ryan & Deci, 2001). Through their research, Ryan and Deci (2000) identified three fundamental psychological needs—autonomy, relatedness, and competence—that are crucial for healthy personal growth, integration, and positive social functioning. When these needs are fulfilled, they contribute to the enhancement of well-being.

Activity Theory of Wellbeing

Slightly different from the above perspectives, the activity theories assume that humans must act to live and to live well. Activity theories of wellbeing posit that engaging in particular activities, undertaken in specific manners and for certain reasons, possesses intrinsic value. According to this perspective, individuals can engage in actions that either promote or diminish their well-being, depending on the nature and motivation of those actions (Vittersø, 2018). The functional well-being approach is a relatively recent activity-based theory that posits that specific mechanisms link engagement in certain activities to the experience of well-being. This approach conceptualises well-being as an inherent component of human psychological functioning, particularly in the context of behavioural regulation and adaptation. It distinguishes between two fundamental adaptive processes in living organisms—

maintaining stability and facilitating change—which correspond to two distinct forms of wellbeing: hedonic wellbeing, associated with stability, and eudaimonic wellbeing, related to adaptive growth and transformation (Vittersø, 2016).

1.8.2 Determinants of Wellbeing

Well-being is shaped by a wide range of interconnected social, cultural, and economic factors rather than a single factor. Socioeconomic status, poverty, and employment strongly influence life satisfaction and health outcomes, but the benefits of income reach a plateau beyond a certain point. Discrimination and structural inequalities consistently emerge as major threats to well-being, contributing to chronic stress and limiting access to opportunities. Education and meaningful work generally support well-being, though their impact varies depending on context and stress levels. Social relationships and community trust are among the strongest predictors of positive well-being, while unsafe neighbourhoods, crime, and poor health reduce quality of life (Livingston et al., 2022). Religion has also been identified as a contributing factor to well-being. However, this relationship is largely mediated by various intervening variables, including meaning in life, coping mechanisms, social support, and emotion regulation (Krok, 2015; Dolcos et al., 2021).

1.9 Distress Tolerance

Simons and Gaher (2009) define distress tolerance as “the capacity to experience and withstand negative psychological states.” The authors propose that distress may be the outcome of cognitive or physical processes, which are mostly manifested through emotional expression and is shown by an individual’s effort to ease the negative emotional experience. Some authors proposed distress tolerance as “the individual’s perceived and actual ability to tolerate aversive physical and emotional states” (Chapman, Gratz & Brown, 2006), adding the dimension of physiological aspect to the concept.

According to a review study, there are two main ways to define distress tolerance: (a) the perceived capacity to withstand unpleasant emotional and/or physical states, and (b) the behavioural ability to endure distressing internal experiences brought on by a stressor (Leyro, Zvolensky, & Bernstein, 2010). Distress tolerance, then, includes the ability to tolerate distressing physical and cognitive tasks, in addition to the ability to tolerate emotional discomfort. The majority of behavioural evaluations

concentrate on how long a person can endure exposure to a particular upsetting task or stimulus, from which their tolerance of the ensuing experiential distress is deduced (Zvolensky et al., 2010).

1.9.1 Theories of distress tolerance

Simon and Gaher's Concept of Distress Tolerance

Distress tolerance is considered a meta-emotion construct as it usually involves an individual's evaluations and expectations of experiencing negative emotional states. It has four core facets; (1) tolerability and aversiveness, which is an individual's perceived ability to withstand emotional distress, (2) appraisal and acceptability, which refers to the subjective appraisal of distress regarding whether the distress is seen as acceptable or shameful, (3) tendency to absorb attention and disrupt functioning, which refers to the level of attention absorbed by distressing emotions, and (4) regulation of emotions, specifically, the consequent strength of action tendencies to either avoid or immediately attenuate the experience, efforts taken to alleviate distress. First, individuals with reduced distress tolerance are expected to report distress as being unbearable and that they cannot handle being distressed or upset. Second, individual appraisal of being distressed is expected to reflect a lack of acceptance of distress, being ashamed of being distressed, and perceiving one's coping abilities as inferior to others. Third, emotional regulation of individuals who have low distress tolerance is expected to be characterised by great efforts to avoid negative emotions and utilising rapid means of alleviating the negative emotions they do experience. Fourth, when unable to regulate or reduce negative emotions, individuals with low distress tolerance are expected to report being relatively consumed by the experience, indicating that their attention becomes fixated on the experience and that their functioning is significantly disrupted by the experience of negative emotions (Simons & Gaher, 2005).

The preliminary hierarchical structure model

The preliminary hierarchical structure model suggests that distress tolerance is best understood as a broad global construct, termed the 'experiential distress tolerance construct', which encompasses several distinct lower-order dimensions. These dimensions include tolerance of uncertainty, ambiguity, frustration, negative emotion, and physical discomfort (Bernstein et al., 2009). Tolerance of uncertainty refers to

individual differences in the emotional, cognitive, and behavioural responses to unpredictable situations, and it is strongly associated with persistent worries regarding life's uncertainties, particularly in the context of generalised anxiety disorder (Buhr & Dugas, 2002). In contrast, tolerance of ambiguity reflects the extent to which individuals can manage vague, unfamiliar, or unclear stimuli and circumstances. Low tolerance of ambiguity is often linked to heightened emotional distress in response to ambiguous life situations (Furnham & Ribchester, 1995). Tolerance of frustration pertains to one's perceived ability to endure dissatisfaction or irritation arising from unfulfilled goals or unmet expectations. Low frustration tolerance has been associated with maladaptive outcomes such as procrastination, self-harm, and elevated symptoms of anxiety and depression (Leyro et al., 2010). Similarly, tolerance of negative emotions reflects the degree to which individuals perceive themselves as capable of withstanding internal affective distress (Simons & Gaher, 2005). Individuals with lower tolerance for negative emotional states are more vulnerable to developing substance use disorders, as well as symptoms of bulimia and post-traumatic stress disorder (Vujanovic, Bernstein, & Litz, 2011). The fifth dimension, tolerance of physical sensations, refers to individual differences in the perceived capacity to endure uncomfortable bodily experiences (Schmidt, Richey, & Fitzpatrick, 2006). Those with low tolerance for such sensations often attempt to avoid or escape situations likely to trigger them, a pattern that has been consistently associated with heightened anxiety symptoms (Leyro et al., 2010).

Neuro- biological model of distress tolerance

Trafton and Gifford (2011) proposed a slightly different perspective: a neuro-biological model of distress tolerance. Distress tolerance has been described as “the tendency to refrain from emitting behaviours that would provide immediate relief from experiencing an unpleasant sensation”. From a behavioural perspective, distress tolerance measures an individual's ability to continue experiencing discomfort when an escape is available and involves refraining from responding to negative reinforcement opportunities. Further, the authors propose that the construct of distress tolerance is not determined by a single neurobiological process and rather involves a number of anatomically and functionally distinct neurobiological processes (Trafton & Gifford, 2008). This perspective further highlights that distress tolerance is expected to be context specific, modified by previous experiences, belief systems and learning,

and is also influenced by genetic factors. Thus, the approach suggest that distress tolerance is not a static trait and is believed to be modifiable with appropriate intervention approaches (Trafton & Gifford, 2011).

Additionally, from an intervention point of view, it becomes imperative to understand how individuals experience and shape their environment and how they consciously try to control their behaviour. Further, two strategies to improve or alter distress tolerance were discussed: a) conscious practice of distress tolerance, which can be achieved by working to inhibit habitual escape responses, and b) altering distress tolerance, which can be achieved by increasing reward availability and perceived reward value (Trafton & Gifford, 2011).

1.9.2 Distress Tolerance and Psychopathology

People with reduced distress tolerance are more prone to maladaptively respond to distress and distress-eliciting contexts. Such individuals frequently engage in strategies aimed at escaping or minimising negative emotions and other aversive internal experiences. Theoretical perspectives propose that difficulty in enduring intense emotional experiences reduces one's capacity to withstand distress, thereby increasing reliance on maladaptive coping strategies. Conversely, those with higher distress tolerance are generally better equipped to manage and adapt to challenging emotional contexts in more constructive ways. Although emerging evidence highlights its importance, research exploring the relationship between distress tolerance and psychopathology remains limited. A key area for future investigation is whether distress tolerance is uniquely associated with particular psychological disorders or broadly linked across multiple forms of psychopathology. (Zvolensky et al., 2010; Leyro et al., 2010).

CHAPTER-II

REVIEW OF LITERATURE

2.1 Husband's Substance Use and Spouses' Mental Health

Adnan, Arshat, and Ahmad Shahril (2025) studied 132 wives of low-income drug-addicted men in Malaysia, exploring how economic strain, marital conflict, and social support relate to their mental well-being. Family impact was assessed using the Economic Strain Scale (ESS) and the Braiker-Kelly Marital Conflict Scale (BKMCS). Coping strategies and mental wellbeing were evaluated through the Coping and Adaptation Processing Scale – Short Form (CAPS-SF) and the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), respectively. Path analysis showed that lower income, inadequate social support and higher conflict in marriage were all significantly associated with higher depression, anxiety, and stress among the wives. Social support emerged as a protective role: wives with stronger perceived support had relatively better psychological well-being.

Singh et al., (2025) assessed 120 spouses of men meeting the ICD-11 alcohol dependence criteria to examine prevalence and types of psychiatric disorders and socio-demographic correlates in a hospital-based study. They found an extremely high rate of psychiatric morbidity: 94.2% of wives had some psychiatric disorder. Major depressive disorder was the most common diagnosis made (64.2%), followed by generalized anxiety disorder (35%), and suicidal behaviour disorder (24.2%). Other factors such as nuclear vs. joint family structure, longer duration of husband's alcohol dependence, and dependence severity were associated with higher morbidity in wives.

El Kazdouli et al., (2024) assessed the psychiatric morbidity of 97 wives of opioid-addicted men in Egypt. Using structured clinical interviews (SCID), they found that nearly 50% of the women had at least one diagnosable mental health disorder, including dysthymia, anxiety disorders, and hypochondriasis. Husbands' opioid dependence severity was measured through standardized scales. Husbands' severity level was significantly related with the intensity of the wives' psychological distress. The authors concluded that substance abuse by the husband not only have biological and behavioural effects on the individual but also inflicts substantial emotional and

mental tolls on the spouse. The study also touched on inadequate coping mechanisms as well as mental health resources for women in such relationships, suggesting the importance of early identification and family-inclusive treatment approaches.

Castaldelli-Maia et al. (2022) examined the relationship between a family history of alcohol problems and the manifestation of different clusters of depressive symptoms. The study is a cross-sectional, population-based study using data from the São Paulo Megacity Mental Health Survey. The study included 5,037 adult participants from the general population in São Paulo, Brazil. Participants were assessed with the World Health Organisation Composite International Diagnostic Interview (CIDI 3.0). The findings revealed that a family history of alcohol problems was significantly linked to severe depressive symptoms, particularly in the cognitive-affective cluster, including feelings of worthlessness, guilt, and suicidal ideation.

Rao et al., (2022) conducted a cross-sectional, multisite study in Delhi among 433 wives of people who inject drugs (PWID). The study found a very high burden of health; on physical as well as mental health issues: more than 90% of the wives reported having symptoms of anxiety and depression. On the physical health side, more than 50% had menstrual problems (dysmenorrhea), adverse pregnancy outcomes (abortions, miscarriages, stillbirths) were reported among 55.9% of women, around one-fourth reported symptoms of sexually transmitted infections, and many had history of major illnesses or tuberculosis. This study emphasises how substance use in husbands affects wives' health in multiple domains, not confining to mental health alone but reproductive/physical health too, and underscores the need for integrated health services to improve the mental and physical health of such women.

Gaga, Sahu, Sidana, & Bhandari, (2022) conducted a cross-sectional study among 50 wives of men with alcohol dependence syndrome in India. Study tools used were the Domestic Violence Questionnaire, the Kessler Psychological Distress Scale, and the brief Cope. The study explored domestic violence, psychological distress, and coping mechanisms among wives. The report suggested that nearly half (48%) of wives experienced severe psychological distress. Domestic violence (psychological, physical, and sexual) was also increased. These findings highlight that the burden on

spouses (exposure to abuse and psychological symptomatology) of those with substance dependence can increase sharply, particularly in a situation like COVID.

A cross-sectional study was conducted among 104 women whose male spouses had been receiving treatment for alcohol dependence (as per the criteria of ICD- 10). The study attempted to understand the prevalence of depressive and anxiety disorders and factors related with the same. Women whose age were above 18 years and have been living with the husband for more than a year were considered and self-report questionnaires such as Beck depression inventory and Beck anxiety inventory were used to explore the presence of symptoms. In this study, women's use of alcohol and prevalence of Intimate Partner Violence (IPV) were also explored. Chi-square test and logistic regression analysis were used to analyse the data. Results showed that 34.6% were affected with moderate/severe depression, and another 25.2% had symptoms of moderate/severe anxiety. Nearly half of the women reported experiencing IPV in the last one year. Factors such as physical illness among women, number of partner's treatment for alcohol dependence and exposure to physical and/or sexual violence were found to be significant determinants (Dostanic et al., 2022).

Bischof et al. (2022) conducted a nationwide cross-sectional study examining the prevalence, self-rated health, and depression among family members (including wives) affected by addictive disorders in Germany. The study observed that people living with someone experiencing addiction—whether related to alcohol or drugs—reported significantly ($P < 0.001$) higher odds for having depression compared to the general population. Using a representative sample size of 24824 adults, the researchers identified elevated rates of depressive symptoms and decreased self-perceived health in those with close relatives suffering from addiction.

Anxiety, depression, quality of life and suicidal behaviour was studied and compared among 50 wives of alcohol dependent Indian men and 50 age-matched control group. The study was based in a tertiary care hospital setting and tools like the perceived quality of life scale, the hospital anxiety and depression scale and suicidal behaviour questionnaire were utilized to gather the data. Wives of alcohol dependent men had significantly poorer quality of life, higher suicidal behaviour and higher symptoms of depression in comparison to the control group. However, the study did

not observed significant difference in the scores of anxiety between the case and the control group (Patkar et al., 2021).

Joshi et al. (2021) investigated resilience levels and marital quality among wives of individuals with alcohol use disorder in India. The study included 120 women and employed standardised measures to assess resilience, marital satisfaction, and experiences of abuse. Results showed that more than 50% the women reported poor or severely affected marital quality, and those with low resilience had significantly worse outcomes. Furthermore, physical, emotional, and sexual abuse were reported by a substantial proportion of the sample, and these experiences were linked with both lower psychological resilience and greater marital dissatisfaction. The authors emphasised the importance of strengthening coping mechanisms and resilience among women in such marriages as a protective factor against psychological distress. This study contributes to the literature by framing the discussion not only around pathology but also around psychological strengths and vulnerabilities.

A smaller, cross-sectional study in India compared 26 working women with alcohol dependent husbands and 30 whose husbands were not dependent on alcohol or other drugs. The history of alcohol dependence was inquired using the Family CAGE-AID questionnaire. Using the Hospital Anxiety and Depression Scale (HADS), the study found that women with alcohol-dependent spouses experienced higher anxiety ($P < 0.05$) and depression ($P < 0.05$) than wives of non-dependent husbands. Among women whose spouses were diagnosed with alcohol dependence, 84.6% demonstrated symptoms indicative of psychological distress, with 69.2% presenting with anxiety and 15.3% exhibiting depressive symptoms. This points to a measurable mental health impact on spouses, even among working women who might have more resources or social exposure (Kodali, Parvathaneni, Bellapukonda, & Benerji, 2020).

Sujan et al., (2019) carried out a study to assess perceived stress among spouses of individuals with alcoholism. Using the Perceived Stress Scale, they surveyed 100 spouses to determine levels of stress and examine associations with sociodemographic variables. Findings indicated that spouses of alcoholics experience high levels of stress which were statistically related to factors such as duration of spouse's alcohol use, level of education, and socioeconomic status. Emotional responses reported included

self-blame, helplessness, hopelessness, anger, shame, and irritability. The study highlights that the impact of a partner's alcohol dependence extends beyond financial or social domains into deep psychological burdens for spouses.

Juibari et al., (2018) explored the characteristics and correlates of psychiatric issues among 450 women of husbands with substance- related disorders in Iran. Substance-related men were screened based on the criteria of the DSM – 5 and were categorised as Stimulants, Depressants, Hallucinogens and Narcotics. Women were selected purposively and the symptom checklist-90 was employed to assess the presence of psychological symptoms. The global severity index of 62% of the women was higher than 0.7, which were suspected of having psychiatric disorders. Among the disorders, the most prevalent one was depression. The findings also showed that factors including low education, duration of marriage, number of children, type of substance abuse and age were predictors of psychiatric disorders among women. Further, the prevalence of psychiatric disorders was highest among wives of men addicted to Narcotics.

In a cross-sectional study in Iran, Najafi et al., (2018) examined the prevalence as well as psychiatric symptoms correlates among wives of men diagnosed with substance-related disorders. The sample consisted of 137 women whose husbands were in treatment for drug addiction. The findings revealed that 67.1% of the wives exhibited significant psychiatric symptoms, with depression being the most prevalent, followed by obsessive-compulsive symptoms, anxiety, and interpersonal sensitivity. Factors such as lower educational attainment, limited income, longer marital duration, and having more children had a significant association with higher levels of psychiatric distress. The authors highlighted the interconnectedness of socio-demographic stressors and spousal substance use in contributing to psychological morbidity among women. This study adds to the growing body of literature documenting how substance dependence in one partner adversely affects the mental health of the other, particularly in traditionally structured households.

In another study, Dandu et al., (2017) assessed the psychiatric morbidity among 101 spouses of patients with alcohol related disorder at a government hospital in India. ICD – 10 classification was followed to screen wives of men with alcohol dependence,

and tools such as Severity of alcohol dependence and General Health Questionnaire were used. Percentage analysis and chi-square test were applied using R software. Findings of the study showed that duration of alcohol abuse, marital satisfaction, poor family support and low socio- economic status were linked to psychological morbidities in spouses.

Gandhi et al., (2017) conducted a comparative cross-sectional study to examine symptoms of anxiety and depression among wives of men with alcohol use disorder (AUD), compared to wives of men without AUD. Using standardised screening tools—PHQ-9 for depression and GAD-7 for anxiety—the authors found that 38% of women married to men with AUD met criteria for depression, and 59% for anxiety, versus 17% and 38%, respectively, among the comparison group of wives of men who did not have AUD. These differences corresponded to significantly elevated odds ratios: about 3.01 for depression and 2.31 for anxiety for spouses of alcohol-dependent men.

Soni et al., (2017) carried out a study in North India to examine psychiatric morbidity, quality of life, and marital satisfaction among 100 spouses of men diagnosed with opioid dependence syndrome. The husbands' severity of dependence was assessed using the Severity of Opioid Dependence Questionnaire (SODQ), while spouses' marital satisfaction and quality of life were assessed via the SF-36 Health Survey and the Marital Satisfaction Scale (MSS), respectively. The study found that 33% of the spouses met the criteria for a psychiatric disorder, with 22% experiencing mood disorders and 9% anxiety disorders. Compared with control spouses (i.e., spouses of non-opioid-dependent men), spouses in the study group reported significantly poorer quality of life across multiple SF-36 domains and substantially lower marital satisfaction ($p = 0.0001$).

Sharma et al., (2016) examined the emotional and mental-health problems reported by 30 wives of alcoholic husbands seeking treatment in drug de-addiction centres. The authors developed a structured questionnaire after conducting an intensive review on issues faced by the wives of alcohol abusers. Results highlighted that wives face problems in multiple domains: physical, psychological, and social. The majority of the wives often felt anxious (70%) because of their husbands' drinking habits, felt mentally disturbed, and frustrated. Ignoring one's own physical health, sleep

disturbances, and physical violence are commonly reported. Many also reported emotional distress, though the sample size was relatively small and descriptive. Wives also resorted to maladaptive coping skills such as tolerance and withdrawal. The findings suggest pervasive emotional problems among wives in such marriages.

Ariyasinghe et al. (2015) conducted a community-based cross-sectional study that investigated the psychological impact of husbands' alcohol abuse on 250 spouses in rural Sri Lanka. The study population included married women aged 18–60 years, and descriptive statistics and logistic regression analysis were carried out for analysis. The study found that nearly one-third of these women met the diagnostic criteria for MDD, a rate significantly higher than the general population. The researchers highlighted that frequent alcohol consumption and associated behavioural problems, such as verbal and physical abuse, contribute to the emotional distress experienced by these spouses.

A cross-sectional study was performed on 237 Iranian women, with three comparison groups (wives with non-dependent husbands; wives whose husbands are drug-dependent; wives who are themselves drug-dependent as well). The research employed the Hamilton Anxiety and Depression Rating Scale to measure anxiety and depression, and examined the socio-demographic predictors as well. Higher anxiety levels among participants were significantly predicted by the husband's drug dependence ($p = 0.010$) and lower family income ($p = 0.007$). In contrast, elevated levels of depression were significantly linked to factors such as older age ($p = 0.031$), shorter duration of marriage ($p = 0.016$), lower educational attainment ($p = 0.045$), spousal drug dependence ($p = 0.023$), and reduced household income ($p = 0.014$). This demonstrates that mental health risk among wives is not uniform but varies with these sociodemographic variables (Noori et al., 2015).

A cross-sectional study was conducted by Gupta et al., (2014) at the Drug De-addiction and Treatment Centre, PGIMER, India, among wives of alcohol and opioid dependent men. Psychiatric morbidity, social support and coping strategies were assessed using the General Health Questionnaire, Coping Strategy Check List, and the Social Support Questionnaire. Husband's severity of alcohol use was also studied using Severity of alcohol dependence questionnaire. 100 wives of men who fulfilled the DSM- IV criteria were purposively selected as participants. It was observed that

more than 70 % of women had scores above the cut-off point for having a psychiatric diagnosis, which is quite high when compared to studies discussed above. Further, presence of psychiatric diagnosis was present in 20% of the women with opioid dependent men when compared to 15% of women with alcohol dependent husbands. This shows that spouses with opioid dependent men were more vulnerable to having psychiatric problems.

Grover et al., (2013) explored the relationship between psychiatric morbidity and marital satisfaction in a sample of 50 wives of men diagnosed with alcohol dependence in India. The study found that 65% of the female spouses had a diagnosable psychiatric disorder, with major depression (43%) being the most common. Marital dissatisfaction was high across the sample and was strongly associated with the severity level of husband's alcohol use, as well as the extent of interpersonal conflict and abuse. The researchers also observed significant relationship between lower marital satisfaction scores and higher depression, anxiety, and somatic symptoms in the wives. This study illustrates how substance use within the family system deteriorates the emotional climate of the relationship and increases psychological strain on the non-using partner. The findings support the integration of spousal mental health screening into addiction treatment programs.

In a hospital-based study, Kishor et al. (2013) assessed 60 spouses of men with Alcohol Dependence Syndrome. The General Health Questionnaire, Structured Clinical Interview for DSM-IV, and Marital Satisfaction Scale were utilised to collect the data. Drinker Inventory of Consequences was also used to assess the consequences of drinking in five domains, i.e., physical, intrapersonal, interpersonal, impulse control, and social responsibility. Results indicated that about 65% of the wives had a psychiatric disorder. Major depression was present in about 43%. The authors also observed that marital satisfaction had a significant negative relationship with the severity of the husband's alcohol dependence, and with the adverse interpersonal, intrapersonal, and physical consequences of drinking. The more severe the husband's alcohol-related problems, particularly those that affected the spouse physically or in relationship domains, the higher the wives' psychiatric morbidity and the lower their marital satisfaction.

One particular study by Rognmo et al., (2013) did find some contrasting results, where high consumption of alcohol by partners were related to lower levels of spousal mental distress. The population-based study was conducted among 11,584 couples who participated in a survey. Alcohol consumption was measured by numerical indicators of amount and frequency of use of alcohol, problems related to alcohol were assessed by the CAGE alcohol screening questionnaire and spousal mental distress was studied using the Hospital depression and Anxiety Rating Scale. The results, however, highlighted that alcohol related problems were a significant determinant for spousal mental distress.

Studies using qualitative approaches, such as phenomenological and thematic analysis also suggested that wives of substance use dependents experience mental illness and other psychosocial issues. For instance, Schultz (2018) conducted a qualitative exploration of the lived experiences, challenges, and coping strategies of concerned significant others (CSOs) living with partners who have substance use disorders (SUDs). Using a phenomenological and case study approach, Schultz interviewed 12 CSOs in South Africa. The study revealed that CSOs often face emotional distress, including feelings of anger, guilt, shame, and hopelessness. Many reported taking on additional roles and responsibilities—such as parenting and financial management—due to the dysfunction caused by their partners' substance abuse. The CSOs also faced relational and social consequences such as stigma, emotional withdrawal, and isolation. Importantly, the study proposed practical social work intervention guidelines, including psychoeducation, boundary-setting training, and emotional support programs for CSOs.

Maghsoudi et al., (2019) explored the psychosocial problems of women with spouses of substance abusers among 15 women in Iran. The study employed in- depth interviews to understand the issues experienced by women, and the data was analysed using content analysis. In- depth information was collected from both Government and private drug treatment centres. Results indicated that the majority of female spouses reported experiencing anxiety, depression and stress. Further, at social level, people have a negative viewpoint towards such women and experience humiliation and at the same time tried to preserve the image of the family by concealing the husband's

addiction. Apart from reports of increased psychological distress, this study has helped understand the unique psycho- social challenges of such women.

Ólafsdóttir et al., (2020) conducted a qualitative study in Iceland to explore the impact of substance abuse on close relatives, including spouses, parents, and siblings. Findings showed that most relatives, especially spouses, experienced significant psychosocial distress, including anxiety, depression, and physical health problems. Many also faced social isolation, financial strain, and emotional or physical abuse. In terms of implications, the authors argue that the study highlights the need for social work and public health to more fully recognise the devastating effects of SUD on families, especially spouses.

In another qualitative study, Fereidouni et al., (2014) explored the effect of husband's addiction on women using in-depth interviews. Through the purposive sampling technique, 24 women were selected for the research, and most of the husbands who were attending the De- addiction clinic were addicted to opioids. Results have shown that financial issues, progressive deterioration and suffering, coping with problems to husband's addiction and disruption of family relationships were identified as themes. Such problems have resulted in disruption to normal life and strain on spouses.

Further, in a scoping review conducted on both qualitative and quantitative studies, it was found that affected family members of substance users, women in particular, reported high stress and burden, increased mental health issues, reduced quality of life and social adjustment. The review was done on studies conducted worldwide, including India and factors such as users' severity and low economic status were reported to be significant determinants of increased mental health issues (Di Sarno et al., 2021).

2.2 Husbands' Dependence and Spouses' Psychosocial wellbeing

Apart from experiencing common psychological issues such as depression, anxiety, and stress, a study by Caswell, You, and Huckle (2011) reported that individuals exposed to alcohol abusers (including partners) in their lives also experience significantly low personal well-being and poorer physical health

conditions. The study was conducted among 3068 participants aged between 12-80 years. Data were collected using European Quality of Life-5 and Personal wellbeing index through computer-assisted telephone interviewing. Individuals living with alcohol abusers were twice as likely to have a reduced health status than those without alcohol abusers in their lives. Domains such as daily activities were also reported to be affected, along with feelings of pain and discomfort. The research highlights the physical health issues as well as the psycho-social problems of individuals, including female spouses living with alcohol abusers.

In terms of psychological well-being, studies in India showed that women living with alcohol dependent husbands have significantly lower level of psychological well-being when compared to women with non-dependent husbands. For instance, Balaganeshan & Ragupathy (2019) conducted a case-control study among 30 female spouses of alcohol abusers and 30 spouses of non-alcoholic husbands. The study was carried out in a tertiary care centre located in the urban region of Tamil Nadu. Standardised tools such as the Marital Quality Scale, Psychological General Well-being, and the Brief Cope Scale were used. Results suggest that wives of alcohol abusers have significantly poorer marital quality and psychological wellbeing. Additionally, spouses of alcohol abusers were also found to engage in maladaptive coping skills, highlighting the necessity for psychoeducation and mental health support for such spouses.

Kumari & Prakash (2017) conducted a study among 150 female spouses, comprising of 100 spouses of men with alcohol dependence syndrome and 50 spouses of non-alcoholic men. The age range of women participants was 25-45 years of age. Husbands were screened with the ICD-10 criteria from the Outpatient and the Inpatient Department. It was observed that the psychological wellbeing of spouses of alcohol dependents was significantly lower in comparison to the spouses of men who were not dependent on alcohol (Kumari & Prakash, 2017). Additionally, an Indian hospital-based study was conducted on 50 alcohol dependents and their wives in India. The cross-sectional study was aimed at exploring the wellbeing, domestic violence, and marital satisfaction among partners of patients with alcohol dependence. Data were collected using the marital satisfaction scale, coping questionnaire, and the WHO well-being index scale. Regression analysis revealed that severity of husbands' dependence

was negatively related with wellbeing among women ($r = 0.24$). 36.98% of women were reported to experience domestic violence. Additionally, experience of domestic violence had a significant negative association with marital satisfaction and wellbeing as well (Bunga et al., 2022).

A review study was carried out by Kashyap, Kashyap, and Lalhmingmawii (2024) to examine the effects of alcohol use disorder (AUD) on spouses' quality of life, with an emphasis on women in intimate relationships. Through manual and electronic literature searches (PubMed, Google Scholar), the authors looked at previous research that used common tools to measure quality of life. Results showed that spouses of individuals with AUD consistently report a lower quality of life than the general population. Psychological health, social relationships, occupational functioning, and physical wellness are among the key categories that are impacted. Further, these are frequently made worse by factors such as emotional distress, marital conflict, and intimate partner abuse.

Caregiving burden is also a major psychosocial issue faced by wives of husbands with alcohol and substance dependence. In a case-control study adopted in a tertiary care hospital among wives of men with alcohol dependence, it was observed that women in the case group experienced significantly higher burden (Singh et al., 2024). The sample consisted of 100 spouses belonging to the case group and another 100 age-matched spouses as the control group. To screen for psychiatric illness, the Mini-International Neuropsychiatric Interview was used among spouses. Further, Burden Interview Schedule, EUROHIS-QOL scale, and Brief COPE Scale were also employed in the study. Results showed that the mean burden of care was significantly higher among spouses in the case group (35.11) when compared to the control group (16.56) (Singh et al., 2024).

Caregiver burden of wives with alcohol and opioid dependent husbands was assessed at a tertiary care centre in Northern India. Burden was assessed using the burden assessment schedule. It was observed that wives of both types of dependence experienced moderate to high burden, however, wives of heroin-dependent husbands perceived more burden, especially in marital relationship strain, relations with others, and felt less appreciated for caregiving. Significantly affected domains include impact on marital relationship, appreciation of caregiving and impact on relation with others.

Factors such as education and age of wives had a significant relationship with burden (Sekhawat et al., 2017).

In another study, Vaishnavi et al., (2017) explored the caregiver burden among 200 caregivers, predominantly spouses of men dependent on alcohol in Southern India. The family burden interview schedule was employed, and data were analysed using Pearson's correlation method. Results indicated a significant burden among caregivers and factors such as severity of alcohol dependence, financial burden, adverse mental health, disruption of family dynamics, and activities correlated with a high level of significance.

Additionally, a study was conducted by Haghparast, Riazi, Shams, and Montazeri (2023) to compare burnout among 121 women with substance-dependent husband and 143 women as a control group. The couple burnout measure was used to collect data, and t-test and ANOVA were used to conduct group comparisons. It was observed that the mean score of couple burnout was considerably higher among women with husband's dependent on substance (3.8) when compared to the women in the control group (2.6). Through logistic regression, it was also observed that women with substance-dependent husbands had 4.5 times higher chance of experiencing couple burnout when compared to the control group ($p < 0.001$). However, there were no major differences in couple burnout based on the substance used by husbands. The authors believed that factors such as poor communication, financial constraints, physical and emotional detachment and discord could have a role in higher burnout among women.

Increased caregiving burden among women living with alcohol and substance-dependent men was also reported in other studies conducted in India (Sekhawat et al., 2017; Vaishnavi et al., 2017). Additionally, a recent cross-sectional study explored the burden of care among 70 wives of men with monosubstance dependence and another 70 wives of men with polysubstance dependence. The Burden Assessment Schedule was employed to explore the burden of care, and the Brief COPE Inventory was utilised to explore coping styles of the women. It was observed that the wives of men with polysubstance dependence experienced a significantly high burden in comparison to wives of monosubstance dependent husbands. Also, wellbeing and relationship

domains were significantly affected among wives of men with polysubstance dependence. (Khadanga, Nadadgalli, and Pawar, 2024).

Domestic violence/ intimate partner abuse is also highly prevalent among female spouses of alcohol and other drug dependents. Bunga et al, (2021) observed that husbands' dependence was positively correlated with experiencing violence. Such spouses were reported to have a history of both mental and physical abuse and also experience victimisation and injury (Ólafsdóttir et al., 2020; Dostanic et al., 2022; Gandhi et al., 2017). Social connectedness and family interactions were severely affected among wives of dependents, and experience of domestic violence was also reported (McCann & Lubman, 2018).

Patel, Dalsaniya, Patel, and Patel (2025) studied the prevalence of domestic violence, psychiatric morbidity and marital satisfaction among 105 female spouses of men diagnosed with alcohol use disorder. The cross-sectional study utilised tools such as the Domestic Violence Questionnaire, Mini-International Neuropsychiatric Interview, Hamilton Anxiety Rating Scale and Hamilton Depression Rating Scale. Results showed that around 28.6% of women experienced severe domestic violence, and half of the women (50.5%) reported having low marital satisfaction. Considering psychiatric morbidity, a massive 82.86% of women showed evidence of having psychiatric disorders, primarily in the form of anxiety, followed by depression. Additionally, it was observed that the husbands' dependence severity was significantly related to increased psychiatric morbidity and domestic violence and lower marital satisfaction.

Subodh et al. (2014) conducted a cross-sectional study to examine the prevalence and factors of interpersonal violence against wives of substance-dependent men in India. The study included 267 wives of men having treatment for alcohol and other opioid use disorders. Findings revealed that 55% of the women reported having experienced intimate partner violence (IPV), with significantly higher rates among wives of alcohol-dependent men (63.19%) compared to those whose husbands were opioid-dependent (42.33%). The study identified several socio-demographic risk factors related with IPV, including the husband's older age, lower educational attainment of either spouse, unemployment, lower family income, and living in a

nuclear family system. These findings established that alcohol use may be strongly linked to violent behaviour than opioid use, possibly due to alcohol's disinhibiting effects. The authors emphasise the need for integrating IPV screening and interventions into substance use treatment programs, highlighting the critical role of family dynamics and socioeconomic stressors in both substance dependence and domestic violence.

Spouses of drug and alcohol dependent husbands also face problems at the societal level, such as marital discord, strained social relations, poor family support and financial constraints (George & Devi, 2022; Dandu et al., 2017). Fereidouni et al., (2014) explored the impact of husband's addiction on women using in-depth interviews. Results showed that financial issues, progressive deterioration and suffering, coping with problems to the husband's addiction, and disruption of family relationships were identified as themes. Such problems have resulted in disruption to normal life and strain on spouses. Further, such women were also subjected to stigma as society generally has a negative viewpoint towards such women and hence, experiences humiliation as well. As a result, such women avoid social participation and try to hide their husband's dependence problems to avoid being shamed (Maghsoudi et al., 2019). Through a phenomenological study conducted among 31 individuals with adult alcohol use, similar observations were made; stigmatisation of family members, particularly wives of dependents, was very commonly experienced. The judging attitude toward such individuals further led to isolation and reduced contact with others (McCann & Lubman, 2018), thereby severely affecting the psychosocial domain of such women.

Bisoi, Kalooya, Dhawan, and Sarkar (2024) conducted a comparative study to explore marital adjustment among couples whose husbands were diagnosed with Alcohol and Opioid dependence syndrome. Factors such as personality traits and perceived social support were also examined. 50 married couples participated in the study, which were equally grouped in the two categories. Marital Adjustment Questionnaire, Eysenck Personality Questionnaire, and Maudsley Addiction Profile were used for collecting data from drug de-addiction centres in Northern India. It was observed that marital satisfaction and social support were affected in wives of opioid and alcohol dependents equally, and the type of drug used did not play a significant

role. Further, among couples with opioid dependent husbands, duration of substance dependence was significantly related with marital adjustment. The study shows that regardless of the drug type used, dependency can impair social support and marital adjustment.

2.3 Distress Tolerance and Psychopathology

Literatures suggest that distress tolerance (DT) is associated with a diverse array of psychological disorders, including depression, anxiety and stress. Research conducted over the years has established some consistent findings, which have been discussed subsequently.

Tanguy, Kaur, and Asnaani (2024) conducted a study with 137 college students (mean age ~20.5 years) to explore how various internalising symptoms (depression, general anxiety, PTSD, panic disorder, OCD, etc) relate to distress tolerance (both as a trait and state measure), and whether emotion regulation (ER) moderates these relationships. To assess trait distress tolerance, the Distress Tolerance Scale (DTS) was administered. State distress was measured using subjective reports obtained during a trauma film paradigm, and emotion regulation (ER) was evaluated via a self-report scale measuring difficulties in regulating emotions. Regression analysis found that initially, depression were strongly related with more difficulty tolerating distress (i.e., higher trait DTS-reverse scores) ($\beta \approx 0.58$), explaining about 34% of variance in trait DT. When PTSD symptoms were added, they also contributed significantly ($\beta \approx 0.30$), and in a further step, social anxiety symptoms were additionally associated. In that final model, with depression, PTSD, and social anxiety included, the model explained about 46% of the variance. The authors conclude that, from a transdiagnostic standpoint, symptoms of PTSD and social anxiety may have a particularly strong relationship with lower perceived distress tolerance.

In a recent meta-analysis conducted by Li et al., (2024), it was observed that distress tolerance was negatively and significantly correlated with symptoms of depression ($r=-0.36$). The study analysed 56 research papers conducted on 39, 492 participants. The review consisted of studies that utilised both self-report and behavioural measures of distress tolerance. In line with the findings reported by Bernstein et al., (2011), the present study also observed that self-report measures of

distress tolerance had stronger relationship with depressive symptoms when compared to the behavioural measures of DT. Further, self-report measures of depression had stronger association with DT when compared to the responses provided by caregivers.

Zhong et al., (2023) examined the mediating role of distress tolerance on the relationship between stressful life events and suicidal risk among 125 patients diagnosed with Major Depressive Disorder. Measures used were the Distress Tolerance Scale, the Hamilton Depression Rating Scale, the Life Event Scale, and the MINI. It was reported that there was a significant positive correlation between stressful life events and risk for suicide. Further, it was also observed that stressful life events and suicide risk were negatively correlated with an individual's distress tolerance ($p < .01$). The study concludes that high distress tolerance is a protective factor not only for depression and stress, it also serves as a vital factor for improving and reducing suicidal risk among individuals with Major Depressive Disorder. Therefore, distress tolerance training must be integrated into the existing behavioural modules for the treatment of common mental health disorders.

Li et al. (2023) examined the role of distress tolerance as a mediating mechanism between mindfulness and depression and anxiety using both cross-sectional and daily diary methods. In Study 1, a large sample of 905 participants completed self-report questionnaires to assess trait mindfulness, distress tolerance, depression, and anxiety. The findings demonstrated that distress tolerance significantly mediated the association between mindfulness and depressive and anxiety symptoms at the between-person level. Study 2 involved 110 participants who completed daily measures for 14 consecutive days, capturing fluctuations in state mindfulness, distress tolerance, and mood symptoms. Multilevel mediation analyses indicated that daily distress tolerance consistently mediated the effects of daily mindfulness on depression and anxiety, both within individuals over time and between individuals. These results highlight that mindfulness may reduce psychological distress, by enhancing an individual's ability to tolerate emotional discomfort. The study highlights the potential value of mindfulness-based interventions for improving distress tolerance and, consequently, alleviating depressive and anxious symptoms.

Abbas, Latif, Muneer, Khan, and Baig (2023) examined the association of distress tolerance and depression in a cross-sectional study. The study also explored the mediating role of stress and anxiety symptoms on the association between distress tolerance and depression. The sample consisted of 500 individuals whose age ranged from 20-40 years. Self-report measures such as the Distress Tolerance Scale and the Depression Anxiety Stress Scale (DASS-21) were used to collect the data. Descriptive analysis, t-test, and mediation analysis was employed. Results showed that stress and anxiety significantly mediated the relationship between distress tolerance and symptoms of depression. Additionally, the results indicated that individuals with lower levels of distress tolerance were more likely to experience higher symptoms of stress and anxiety, which eventually contributed to elevated symptoms of depression.

Akbari et al., (2022) carried out a systematic review and meta-analysis study on the relationship between distress tolerance and post-traumatic stress. The authors yielded 2,212 initial studies, of which 56 studies fulfilling the study criteria were retained for analysis. The total number of participants in the study was reported to be 12,672, with a mean age reporting to be 29.96 years. The sample was almost equally distributed between genders (women constituting about 44.94%). Results indicated a negative relationship between distress tolerance and symptoms of post-traumatic stress disorders, indicating that a lower level of distress tolerance was associated with higher severity of PTSD symptoms ($r=-0.335$).

A study examined the association between distress tolerance and perceived stress among 331 youths aged between 10-14 years. The longitudinal study also explored the relation between distress tolerance and internalising symptoms among youths. For this study, a behavioural task was used to measure distress tolerance instead of a self-report questionnaire. The authors examined whether distress tolerance predicted perceived stress among participants. Findings from the study suggest that distress tolerance in the baseline significantly predicted an increase in perceived stress, which eventually increases the internalising symptoms among participants. The research findings point to the important role of distress tolerance in the experience of stress and internalising symptoms among individuals (Felton et al., 2017).

Laposa et al., (2015) investigated the relationship between distress tolerance and anxiety symptomology among individuals diagnosed with various types of anxiety disorders. Participants for the study consisted of 308 individuals who were currently seeking treatment for anxiety disorders, including social anxiety disorder (SAD), generalised anxiety disorder (GAD), and obsessive-compulsive disorder (OCD). The distress tolerance scale and the structured clinical interview were employed in the study. The sample involved 58% women and 42% men. For analysis, Pearson correlation, regression analysis, and t-test were applied. Findings showed that DT was significantly correlated with symptoms of OCD, SAD, and GAD. Further, no group significance was observed for DT across the different types of anxiety disorders, including OCD. This suggests that, regardless of the type of anxiety disorders, distress tolerance predicted the symptom severity across a diverse range of disorders (Laposa et al., 2015). However, a study reported that intolerance of uncertainty and anxiety sensitivity are better predictors of anxiety than distress tolerance (Michael et al., 2016).

A multi-method study by Bernstein et al., (2011) highlighted that low scores on DT were linked with higher symptoms of anxiety and depression, further leading to higher risks of comorbidity. This study added a new dimension to the existing literature of distress tolerance and psychopathology by exploring the nature and the degree of association between different measures of distress tolerance. Further, the study also explored the association between the different DT measures and psychopathological syndromes and quality of life as well. The study recruited 149 adults, with 23 years as mean age. Self-report measures for DT included the Distress Tolerance Scale and Discomfort Intolerance Scale. Further, for behavioural measures of DT, tests such as mirror tracing, breadth holding, etc., were conducted. Findings from the study showed that scores of DT had a significant transdiagnostic association with psychopathology and quality of life as well. Reduced distress tolerance were significantly linked to anxiety and mood disorder diagnostic status and a higher chance of comorbidity. Results also suggest that low distress tolerance was significantly linked to reduced quality of life. Interestingly, behavioural measures of DT showed no association with any of the psychopathological syndromes.

2.4 Distress Tolerance and Wellbeing

Literatures have reported that individuals with high distress tolerance can adapt to stressful environment, whereas people with low distress tolerance have difficulty adapting, thereby resulting in negative emotional states, reduced quality of life and overall well-being (Bernstein et al., 2011; Saputra et al., 2024). Additionally, a study conducted by Azizmohammadi et al., (2019) among married women also reported that distress tolerance is positively correlated with well-being ($r=0.545$).

In a study by Tavakoli Azad, Akbari, Moghtader & Shakerinia (2025) the relation between distress tolerance and psychological wellbeing was explored, with brain-behavioural systems as mediator. The study was conducted on 264 men diagnosed with substance use disorders, recruited through purposive sampling method. The distress tolerance scale, Well-Being Scale were used as study tools along with the BIS/BAS Scale to assess brain behaviour systems. Structural equation modelling was used, and the model demonstrated a good fit. More specifically, there was a significant positive effect of distress tolerance on psychological wellbeing. The results also indicated that the behavioural inhibition system had a significant negative effect, while the behavioural activation system showed a significant positive effect on psychological well-being ($p < 0.05$). Also, the brain-behaviour system significantly mediated the relationship between distress tolerance and psychological wellbeing.

Abd Ellatif Elsayed and Aleriani (2024) explored the association between one's perceived distress tolerance and satisfaction of life in a cross-sectional study. The study was conducted on 348 individuals, of whom 77 were males and 271 were females. The age range of the participants was between 20-30 years. Validated tools such as the Distress Tolerance Scale and Satisfaction with Life Scale were employed to collect data through online mode. For statistical analysis, linear regression and descriptive statistics were used. Results showed that distress tolerance was significantly correlated with one's satisfaction with life. However, no significant association was observed between males and females over distress tolerance and satisfaction with life. Additionally, linear regression analysis suggests that distress tolerance significantly and positively predicts life satisfaction among individuals.

A study in India explored the inter-relationship between perceived distress tolerance and various psycho-social domains. Study participants consisted of 200 caregivers aged between 25 and 60 years. The psycho-social domains in the study included psychological wellbeing, quality of life, and caregiver burden. Results showed a significant negative correlation between distress tolerance and caregiver burden, signifying that caregivers with higher distress tolerance experience reduced burden. Whereas, distress tolerance was observed to correlate positively with both psychological wellbeing and quality of life, indicating that individuals with a higher ability to tolerate distress experienced better overall functioning and satisfaction in life when compared to individuals with low distress tolerance. Additionally, domains of psychological wellbeing, such as self-acceptance, tolerance levels and psychosocial health in particular, were strongly influenced by distress tolerance. Hence, the study findings highlight the protective role of distress tolerance in enhancing wellbeing and overall quality of life. (Sreelekha & Rajalakshmi, 2024)

Yılmaz & Satıcı (2023) examined whether distress tolerance predicted mental well-being among 299 consenting adults. Self-report measures such as the Distress Tolerance Scale and Warwick-Edinburgh Mental Wellbeing Scale were used to collect information from the participants. Statistical tests such as correlation and regression analysis were conducted to test the association. Results indicated that there is a strong positive correlation between one's capacity to tolerate distress and one's wellbeing. Linear regression analysis also showed that distress tolerance accounted for about 28% variance in the outcome of wellbeing, after controlling for variables such as gender and age. The study also reported that socio-demographic factors such as educational background and socio-economic status also played a significant role in enhancing wellbeing among individuals.

A study was conducted in Iran by Dehlani and Sori (2022) to determine whether distress tolerance and psychological flexibility predicted psychological wellbeing among university students. 200 students participated in the study, who were recruited through a stratified random sampling method. Using multivariate regression analysis, the authors explore the predictive role of distress tolerance and psychological flexibility on psychological wellbeing. Findings suggest that psychological flexibility and distress tolerance accounted for approximately 67% and 46% of the variance in

psychological wellbeing. Further, results showed that both psychological flexibility and distress tolerance, together, account for approximately 67% of the variance in psychological well-being among participants. In the study, both distress tolerance and psychological flexibility were significant predictors of psychological wellbeing.

Azizmohammadi et al., (2019) investigated the predictive role of distress tolerance and self-compassion on the social health of women participants. Study participants included 291 women who were taking responsibilities as household heads in the families. Data were collected with the help of self-report measures such as the Distress Tolerance Scale, the Keys Social Health Questionnaire, and the Self-Compassion Scale- Short Form. Pearson's correlation and multiple linear regression analysis were employed for analysis. Results indicated a significant positive correlation between self-compassion and social wellbeing ($r = 0.627$) and between distress tolerance and social wellbeing as well ($r = 0.545$). Further, it was also observed that both distress tolerance ($r = 0.517$) and self-compassion ($r = 0.603$) significantly and positively predicted the social health of women. Hence, the protective role of distress tolerance also extends to the social domain of individuals, in addition to the psychological and emotional domain.

2.5 Rationale

From the review of literature, use of alcohol, opioid and other substances have been linked to adverse mental health outcomes among female spouses. Additionally, psychosocial issues such as marital discord, financial constraints, reduced social participation and history of abuse were also reported. The study is particularly important for a state like Manipur where alcohol and drug abuse have remained exceptionally high over decades (Magnitude of drug use, 2019). According to the reports of NMHS (2015-16), Manipur had the highest prevalence of lifetime mental morbidity (19.9%), and current mental morbidity (13.9%) and substance use disorder was the most prevalent form of mental health disorders in the state. Also, the mental health burden of Manipuri women was reported to be significantly higher than that of men (Kesharvani & Sarathy, 2020). Despite these findings, studies have not looked at the wide array of mental health and psychosocial challenges of Manipuri women, especially those living and taking care of husbands with substance dependence. Also, treatment strategies or behavioural interventions specific to women have not been developed and tested so far (Albert, 2015). Hence, apart from exploring the negative mental health outcomes, it is also important to explore such women's psychological strengths and the ability to tolerate distressful emotions. Further, there is a need to explore additional psychosocial risk factors such as financial constraints, changes in social participation, support system, help seeking behaviour and history of abuse. Understanding all the above factors is pivotal for developing an effective, women-centric behaviour intervention module for female spouses who are providing care and assistance to substance dependent husbands.

CHAPTER- III

METHODOLOGY

3.1 Aim of the study

To explore and compare psychological distress, depression, anxiety and stress, psychosocial wellbeing and distress tolerance among female spouses of alcohol and opioid dependents and a control group

3.1.1 Objectives

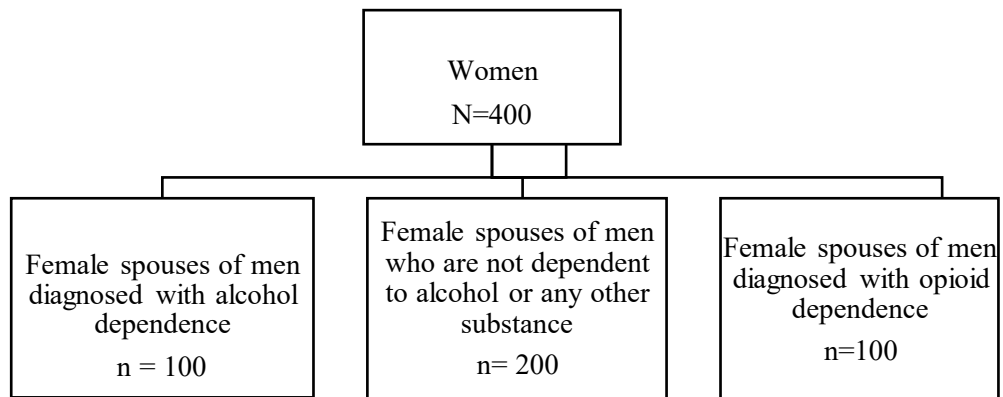
1. To study and compare psychological distress among spouses of alcohol and opioid dependents and a control group
2. To assess and compare depression, anxiety and stress among spouses of alcohol and opioid dependents and a control group
3. To study and compare distress tolerance among spouses of alcohol and opioid dependents and a control group
4. To assess and compare the psychosocial well-being of spouses of alcohol and opioid dependents and a control group
5. To determine the predictive role of distress tolerance on depression, anxiety, and stress among the study sample
6. To study the predictive role of distress tolerance on psychosocial well-being among the study sample.

3.1.2 Hypothesis

1. Psychological distress will be significantly higher among spouses of alcohol and opioid dependents in comparison to spouses in the control group
2. Depression, anxiety, and stress will be significantly higher among spouses of alcohol and opioid dependents in comparison to spouses in the control group
3. There will be a significant difference in distress tolerance among spouses of alcohol and opioid dependents and the control group
4. There will be a significant difference in the well-being of spouses of opioid and alcohol dependents and the control group
5. Distress tolerance will significantly predict depression, anxiety, and stress among the study sample
6. Distress tolerance will significantly predict psychosocial well-being among the study sample

3.2 Research Design

The study is a cross-sectional study design conducted on 400 women participants. The following diagram shows the distribution of the sample.



3.2.1 Sample

Through purposive sampling technique, 400 women took part in the study, consisting of 100 female spouses of Opioid dependents, 100 female spouses of Alcohol dependents and 200 female spouses as the control group. Althubaiti, (2023) and Steyerberg, (2009) reported that for observational studies with two-group comparisons, a sample size of at least 100 in each group is recommended. Further, sample size can also be gleaned from similar studies with similar outcomes (Das et al., 2016). Based on previous studies conducted in India (Sekhawat et al., 2017; Vaishnavi et al., 2017; Dandu et al., 2017), the sample size was determined (sample size in previous studies range from 50 to 200). Further, 200 age-appropriate spouses were selected as the control group, recruited through purposive and convenience sampling.

3.2.2 Inclusion criteria for female spouses of alcohol and opioid dependents

- Spouses of husbands who were pre-diagnosed with alcohol and opioid dependence
- Spouses belonging to 25- 45 years of age
- Spouses with a minimum education of 8th standard and who can understand English

3.2.3 Exclusion criteria for spouses of alcohol and opioid dependents

- Spouses who had chronic psychiatric, neurological, or medical illness
- Spouses who were dependent on alcohol, opioid, and other drugs (except nicotine)

3.2.4 Inclusion criteria for the control group

- Female spouses of men who were not dependent on alcohol, opioid, or any other substance (except nicotine)
- Female spouses belonging to 25-45 years of age
- Female spouses with a minimum education of 8th standard and who can understand English

3.2.5 Exclusion criteria for the control group

- Female spouses who have chronic neurological, psychiatric, or medical illness
- Female spouses of men who have chronic neurological, psychiatric, or medical illness

3.3 Operational Definition

3.3.1 Psychological Distress

According to Ridener, (2000), “psychological distress is the unique discomfoting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person”.

3.3.2 Depression

Depression is defined as “a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life” (American Psychological Association, 2018).

3.3.3 Anxiety

Anxiety is defined as “an emotion characterised by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune” (American Psychological Association, 2018)

3.3.4 Stress

According to Lazarus (2006), “stress is a dynamic process that occurs when an individual appraises situational demands as exceeding available resources.”

3.3.5 Distress Tolerance

Simons and Gaher (2009) define distress tolerance as “the capacity to experience and withstand negative psychological states.”

3.3.6 Wellbeing

According to Diener (1984), well-being is defined as “a person's subjective assessment of their life, measured through life satisfaction and emotional states.”

3.4 Description of tools

3.4.1 Semi-structured Questionnaire

A semi-structured questionnaire was developed to study the socio-demographic characteristics of participants, such as age, educational level, occupation, no of children, working status, duration of marriage, monthly income, religion, use of smokeless tobacco, and history and type of abuse. For women in the case group, additional information such as duration of husbands' opioid/alcohol dependence, history of relapse, financial difficulties, changes in social participation, mental health care needs, etc., was also explored. Two separate questionnaires were developed for women in the case and control groups.

3.4.2 Kessler Psychological Distress Scale or K10 (Kessler et al., 2002)

The K10 comprises 10 questions to be answered on a five-point scale (where 5 = all of the time, and 1 = none of the time). Total scores are then summed, and the maximum score of 50 indicates severe distress, and the minimum score of 10 indicates no distress. Internal consistency reliability of the scale is 0.93. The scale was used in previous studies among the Indian population (Lukose et al., 2014), and particularly in Manipur as well (Bala et al., 2021).

3.4.3 Flourishing scale (Diener et al., 2009)

The Flourishing Scale is an eight-item measure that captures key dimensions of human functioning, including positive relationships, a sense of competence, and the experience of meaning and purpose in life. Each item is rated on a 7-point Likert scale, ranging from *Strongly Disagree* to *Strongly Agree*. Higher scores indicate that individuals perceive themselves positively across these essential domains of wellbeing. Cronbach alpha of the scale is 0.87, and construct validity is 0.62. The scale has been validated and found to be reliable in Indian population (Singh et al., 2016).

3.4.4 DASS (Depression anxiety Stress scale)- 21(Lovibond & Lovibond, 1995)

The DASS-21 is a 21-item self-report scale designed to measure the negative emotional states of depression, anxiety, and stress for people aged 17 years and above. Subjects are asked to use 4-point severity/frequency scales to rate the degree to which they have encountered each condition during the previous week. Scores for Depression, Anxiety, and Stress are calculated by summing the scores for the relevant items. The Cronbach alpha for Depression, anxiety, and stress is 0.88, 0.82, and 0.90, respectively. The scale has been widely used in the Indian population (Iqbal et al., 2015 & Rehman et al., 2021).

3.4.5 Distress tolerance scale (Simons & Gaher, 2005)

The DTS is specifically aimed at measuring the perceived capacity to tolerate distress. 15 items are rated on a 5-point Likert scale (5=*Strongly disagree* to 1=*Strongly agree*), with higher scores corresponding to greater levels of distress tolerance. Internal consistency of the scale is 0.82. The scale has been utilised in research conducted in India (Slabbert et al., 2021 & Ram et al., 2019).

3.5 Procedure

The study was conducted under the Department of Psychology, Nagaland University. First, a semi-structured questionnaire was constructed, and the psychological tools were procured. Prior to data collection, the study was approved by the Departmental Research Committee and Board of Studies. It was further approved in the 37th Academic Council Meeting of Nagaland University. Official permission was taken from the concerned authorities of the Department of Psychiatry at the Regional Institute of Medical Sciences- Imphal and the Director of the Social Welfare Department, Govt. of Manipur, for permission to collect data from drug de-addiction centres located in Imphal.

Male patients who were pre-diagnosed and seeking treatment for alcohol and opioid dependence were screened, and female spouses of patients who fulfilled the exclusion and inclusion criteria were recruited for the study. For the control group, women fulfilling the study criteria were identified with the help of local clubs and women's organisations from six communities in Imphal East and Imphal West districts. The communities were selected based on convenience sampling and women

were recruited through purposive sampling method. For the case group, data collection was conducted from the hospitals/ concerned addiction centres or from respective households based on participants' convenience. For women in the control group, data collection was conducted through home visits.

3.6 Data Analysis

Descriptive statistics such as mean and percentage analysis were used to summarize the characteristics of the data. t-test was applied to study the significant differences in psychological distress, depression, anxiety, stress, distress tolerance, and well-being between the case and control group. Further, binary logistic regression analysis was used to study the odds of the case group having psychopathology and high/low distress tolerance and well-being in comparison to the control group. Women were categorised as having psychological distress, depression, anxiety and stress (Yes or No) based on the cut off scores. For distress tolerance and psychosocial well-being, women were categorised as High or Low based on the mean scores. Further, linear regression analysis was applied to study whether distress tolerance predicts depression, anxiety, stress and well-being. Finally, chi – square test was employed to study the relationship between the socio- demographic variables and the psychological measures. SPSS software version 26 was used to analyse the data. A p-value less than 0.05 was considered significant.

3.7 Ethical considerations

The study was conducted following the guidelines of the 2024 Revision of the Declaration of Helsinki. A participation information sheet was provided to the participants prior to data collection. The aim, procedure, rationale of the study, and benefits and consequences of participation were thoroughly explained

Verbal informed consent was obtained from all respondents and documented in the Informed Consent Form. To maintain anonymity and confidentiality, all identifying information was removed during data processing. Participants were also free to withdraw from the interview at any point. The nature of the study did not involve any further ethical concerns.

CHAPTER- IV

RESULTS

The results are presented in the form of tables, figures, and graphs. The normality of distribution test was conducted for the six psychological constructs using the Shapiro-Wilk test: psychological distress (PD), depression, anxiety, stress, distress tolerance (DT), and wellbeing, and the data was observed to be normally distributed. Hence, parametric tests of statistics were applied for analysis.

Table 4.1: Socio-demographic characteristics of women in the case and the control group (N=400)

Variable	Categories	Case		Control		Total	
		N	%	N	%	N	%
Age	25-30 years	56	28	12	6	68	17
	31-35 years	54	27	43	21.5	97	24.2
	36-40 years	53	26.5	44	22	97	24.2
	41-45 years	37	18.50	101	50.5	138	34.5
Highest education completed	8 th standard	37	18.5	18	9	55	13.8
	Secondary	48	24	20	10	68	17
	Senior secondary	25	12.5	25	12.5	50	12.5
	Graduate	58	29	70	35	128	32
	Postgraduate & above	32	16	67	33.5	99	24.8
Working status	Working	62	31	112	56	174	43.5
	Not working	138	69	88	44	226	56.5
No of children	None	33	16.5	25	12.5	58	14.5
	One	66	33	59	29.5	125	31.2
	Two	68	34	89	44.5	157	39.2
	Three and above	33	16.5	27	13.5	60	15
Duration of marriage	Up to 5 years	63	31.5	42	21	105	26.2
	6-10 years	48	24	48	24	96	24
	11-15 years	59	29.5	48	24	107	26.8
	16 years & above	30	15	62	31	92	23
Religion	Sanamahism	57	28.50	56	28	113	28.2
	Hindu	92	46	115	57	207	51.8
	Muslim	33	16.5	12	6	45	11.2
	Christian	18	9	17	8.5	35	8.8
District	Imphal East	44	22	92	46	136	34
	Imphal West	78	39	108	54	186	46.5

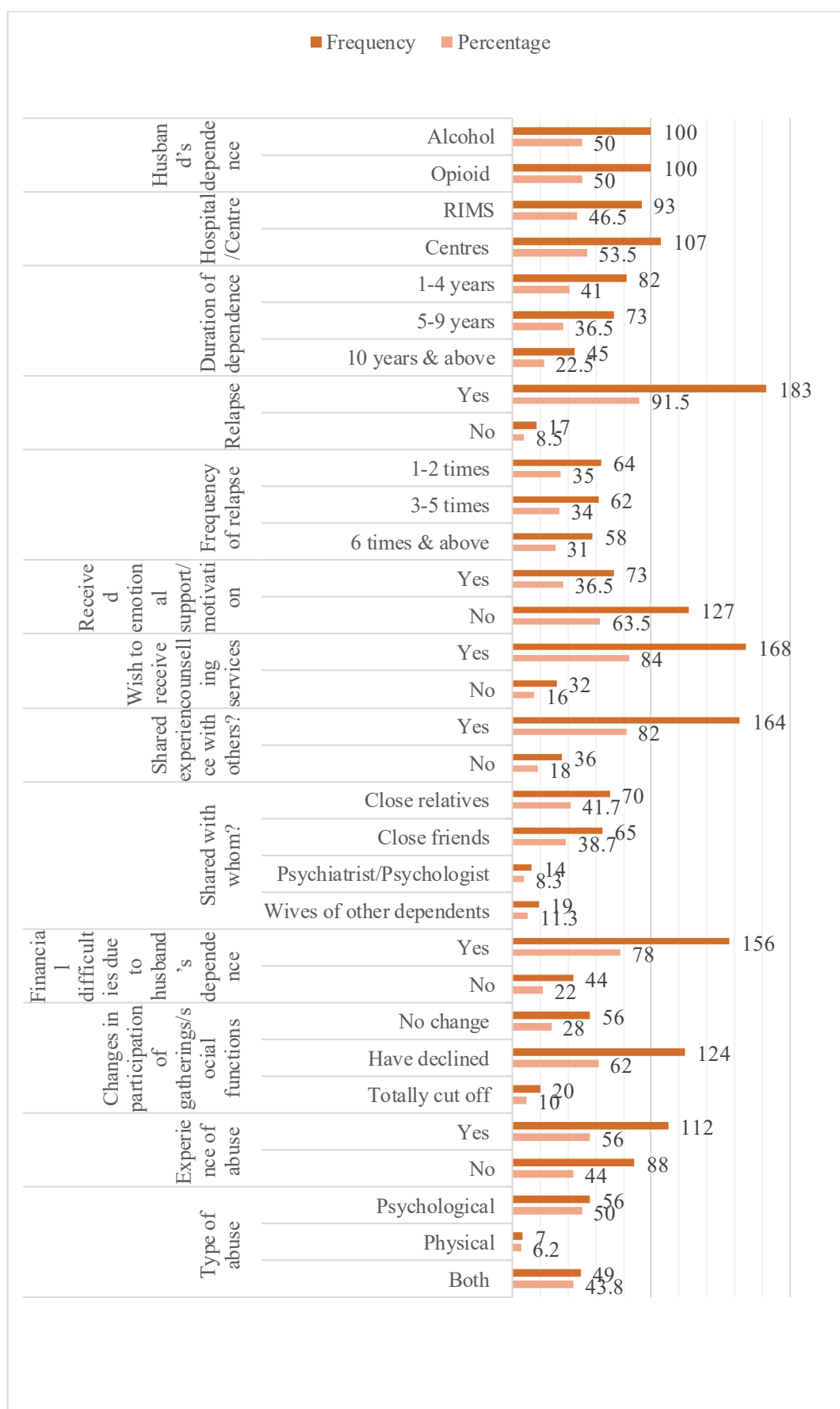
	Others	78	39	0	0	78	19.5
Monthly family income (in rupees)	Up to 20000	86	43	29	14.5	115	28.8
	21000-50000	53	26.5	74	37	127	31.8
	51000-1Lakh	32	16	65	32.50	97	24.2
	Above 1Lakh	29	14.5	32	16	61	15.2
Use of smokeless tobacco (SLT)	No	107	53.5	150	75	257	64.2
	Yes	93	46.5	50	25	143	35.8
History of abuse	No	88	44	173	86.5	261	65.2
	Yes	112	56	27	13.5	139	34.8
Total		200	100	200	100	400	100

4.1 Socio-demographic Characteristics of women

Table 4.1 shows the socio-demographic characteristics of spouses belonging to the case and the control group. In the case group, women predominantly belonged to the younger age groups: 25-30 years (28%), 31-35 years (27%) and 36-40 years (26.5%). Whereas, in control group, half of the women (50.5%) belonged to the oldest age group (41-45 years), followed almost equally by 36-40 years (22%) and 31-35 years (21.5%) of age. Spouses of younger age (25-30 years) constitute about only 6% of spouses belonging to the control group. Considering the highest education achieved, majority of spouses in the case group were educated till graduate level (29%), followed by secondary (24%) and 8th standard (18.5%). For women in the control group, 33.5% and 33% were educated till post-graduate and graduate level respectively, followed by senior secondary (12.5%), secondary (10%) and 8th standard (9%). Majority of the spouses belonging to the case group reported not working (69%), whereas, more than 50% of the spouses in the control group were reported working (56%) at the time of data collection. Regarding the number of children, majority of women in both the case (34%) and control (44.5%) group reported having two children, followed by one child (33% for case and 29.5% for control group). Further, 31.5% of spouses belonging to the case group were married for up to 5 years, followed by 11-15 (29.5%) years of marriage and 6-10 years of marriage (24%). Whereas, majority of spouses in the control group had a marriage duration of 16 years & above (31%). Spouses with marriage duration of 6-10 years and 11-15 years were reported to be 24% each. Regarding religious affiliation, most of the spouses in the case (46%) and control group (57%) belonged to Hindu religion. 28.5% of spouses in the case group and 28% of women in the control group reported following Sanamahism. In the case group, women

predominantly belonged to Imphal West district (39%) and others (39%), followed by Imphal east district (22%). More than half of women (54%) in the control group belong to Imphal west district and the remaining 46% belonged to Imphal east district. Further, 43% of women in the case group belonged to the lowest income group of up to 20,000 rupees, followed by income group of 21,000-50,000 rupees (26.5%). Whereas majority of women in the control group had a family income of 21,000-50,000 rupees (37%) and 51,000- 1 Lakh rupees (32.5%). Nearly half of spouses (46.5%) belonging to the case group use smokeless tobacco, whereas, among control group, 25% of the spouses use smokeless tobacco. More than half of women (56%) in the case group reported having history of abuse, however, in the control group, history of abuse was reported to be only 13.5%.

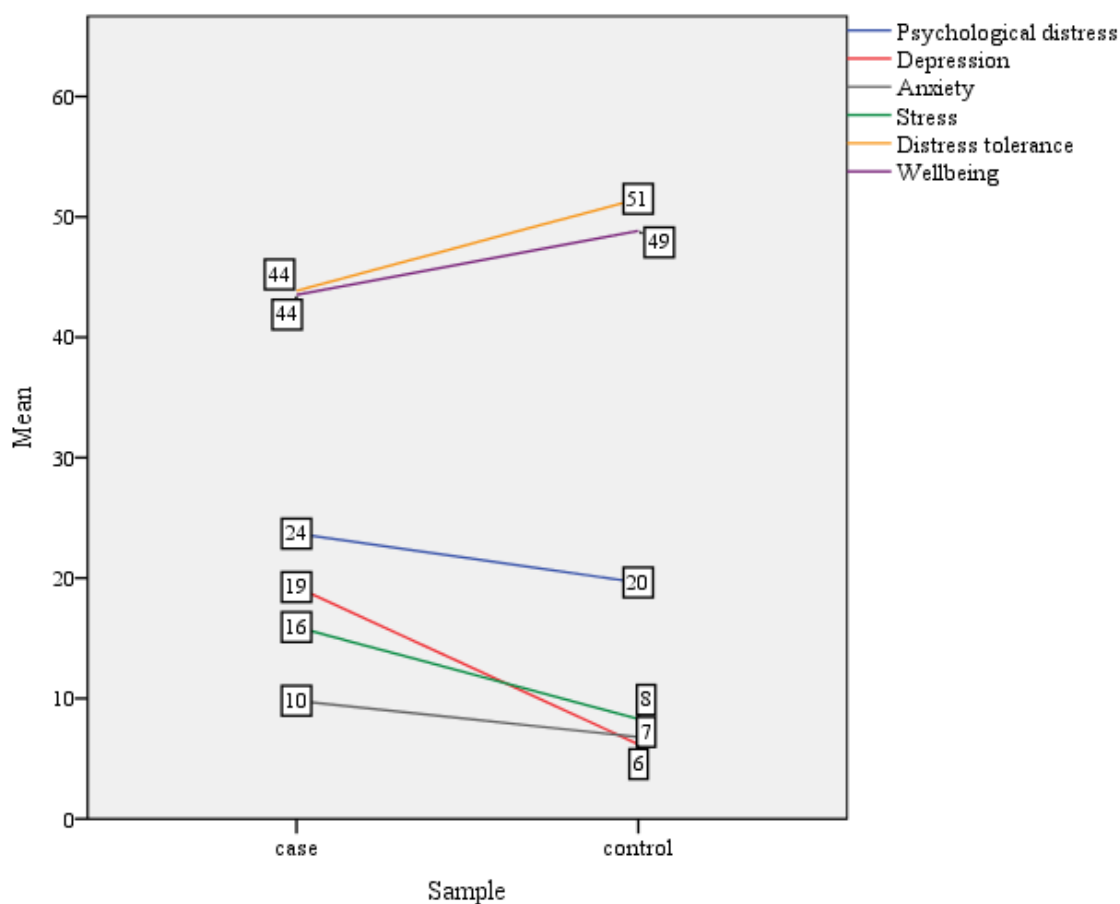
Fig. 4. 1: Additional Psycho-social experiences of women in the case group



4.2 Psychosocial Issues of Women in the Case Group

Fig. 4. 1 shows some additional psychosocial issues of women in the case group. The case group consists of 200 women; 100 spouses of alcohol dependents and another 100 spouses of opioid dependents. Almost half of the women (46.55%) were recruited from RIMS hospital whereas the remaining 53.5% consists of women whose husbands were seeking treatment in various drug de-addiction centres in Imphal. 41% of the husbands were dependent for about 1-4 years, followed by 5-9 years (36.5%) and 10 years & above (22.5%). Majority of the husbands were reported having history of relapse (91.5%) and only 8.5% had no history of relapse. 36.5% of the women reported getting emotional support from hospitals/centres whereas a majority of women (63.5%) did not receive the same. Further, women predominantly wished to receive counselling services (84%) and only 16% reported not wanting such services. The majority of the women (82%) reported sharing the experience with others; the highest being with close relatives (41.7%) and friends (38.7%). Further, it can be observed that 78% of the women experience financial difficulties as a result of husbands' dependence and 62% had reduced social gatherings. Women also experience abuse (56%), with psychological abuse reporting the highest (50%), followed by both physical and psychological abuse (43.8%).

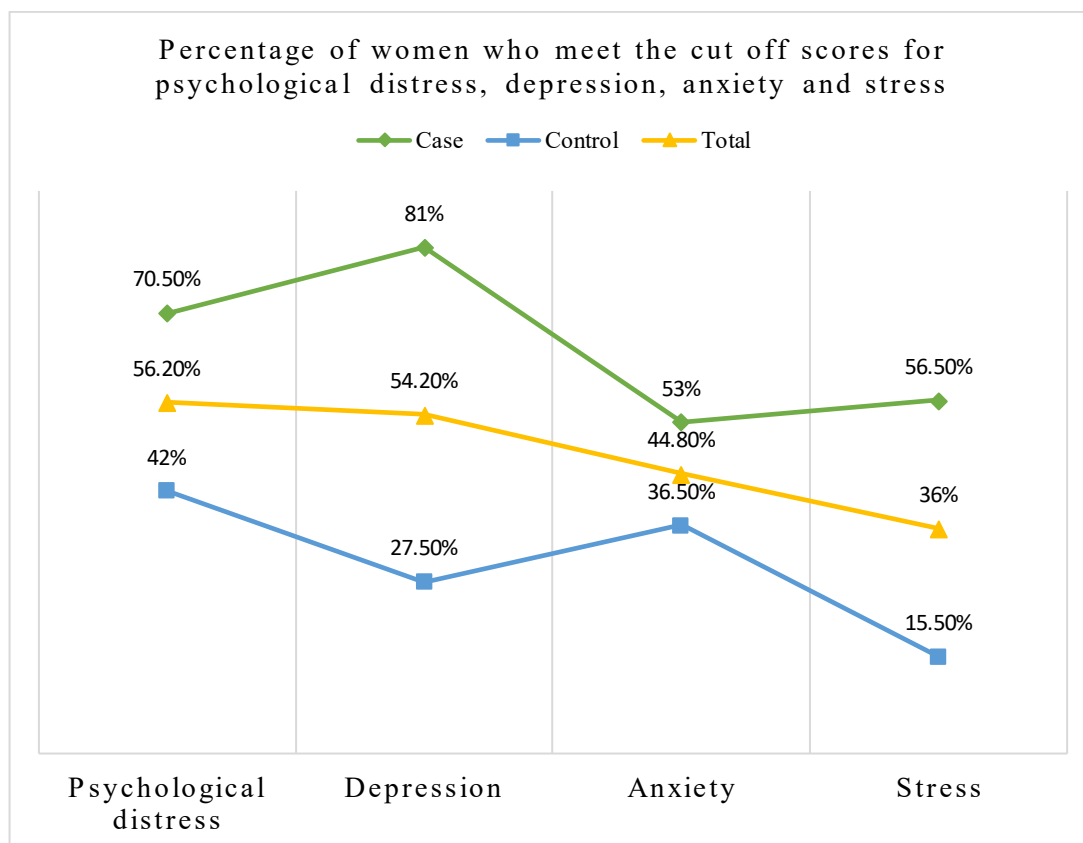
Fig 4.2: Mean scores of Psychological Distress, depression, anxiety, stress, Distress Tolerance and Wellbeing



4.3 Mean Scores of Women on the 6 Psychological Constructs

Fig. 4.2. represents the mean scores obtained by women belonging to the case and control group in all six psychological constructs: psychological distress, depression, anxiety, stress, distress tolerance, and psychosocial wellbeing. It is observed that spouses in the case have higher mean scores on psychological distress (24), depression (19), anxiety (10), and stress (16) in comparison to the control group. Further, spouses in the control group scored higher on distress tolerance (51) and wellbeing (49) when compared to the case group.

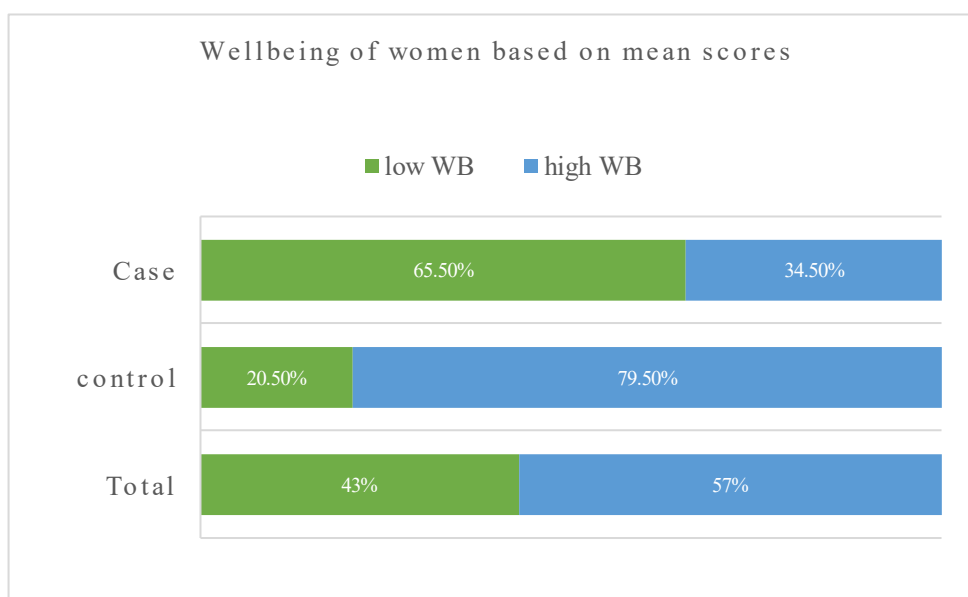
Fig 4.3: Chart showing the percentage of spouses meeting the cut-off scores for Psychological Distress, Depression, Anxiety and Stress



4.4 Percentage of Psychological Distress, Depression, Anxiety and Stress

Fig. 4.3 shows the percentage of women in the case and control group who have met the cut-off score for psychological distress, depression, anxiety and stress. 70.5% and 81% of women in the case group were found symptomatic of psychological distress and depression, respectively. Over half of the spouses in the case group were symptomatic for anxiety (53%) and stress (56.5%) as well. Whereas, 42% and 27.5% of women in the control group have reached the cut-off scores for psychological distress and depression, respectively. Further, 36.5% and 15.5% of women belonging to the control group have been found symptomatic of anxiety and stress, respectively. In total, more than half of women reported experiencing symptoms of psychological distress (56.2%) and depression (54.2%), followed by anxiety (44.8%) and stress (36%).

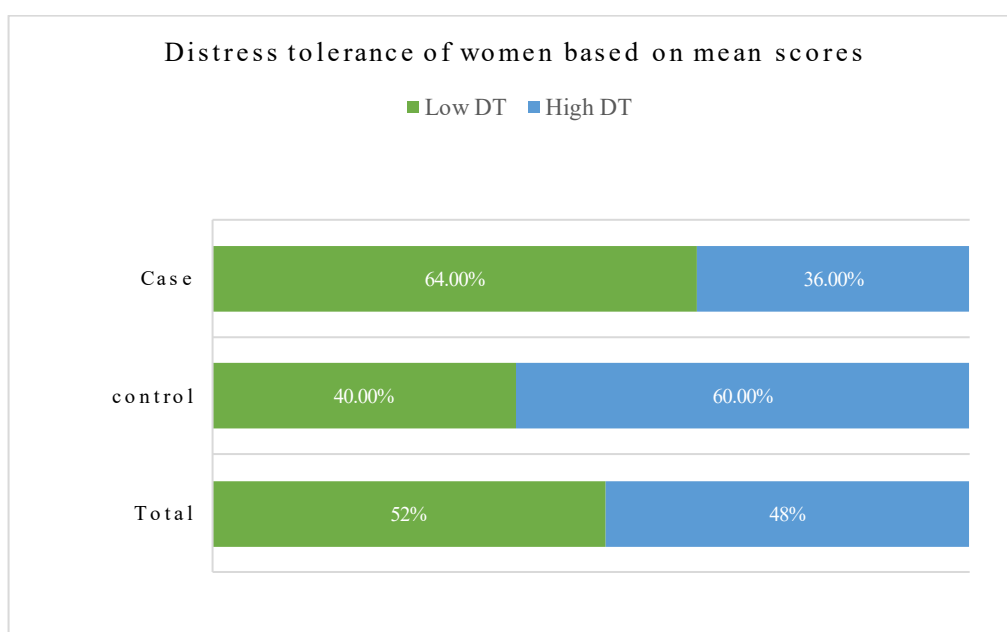
Fig 4.4: Wellbeing of women in the case and control group



4.5 Wellbeing of Women

In Fig. 4.4, wellbeing has been categorised as low and high based on the mean scores obtained by women. 34.5% of women in the case group have high wellbeing, whereas in the control group, more than one-third of women have high wellbeing (79.5%). Further, only 20.5% of women in the control group were observed to have low well-being. In total, more than half of the women have high wellbeing (57%) and the remaining 43% have low wellbeing.

Fig. 4.5: Distress tolerance of women in the case and control group



4.6 Distress Tolerance of Women

Fig. 4.5 represents the level of distress tolerance among women belonging to the case and control group. 64% of women in the case group have low distress tolerance, whereas in the control group, 40% of women have low distress tolerance. It can be observed that women belonging to the control group have higher distress tolerance (60%), in comparison to the case group (40%). In total, more than half of the women in the study have low distress tolerance (52%).

Table 4.2: t-tests for PD, depression, anxiety stress, Distress Tolerance and Wellbeing

Psychological constructs	Sample	N	Mean	t	df	p-value
Psychological distress	Case	200	23.69	5.742	398	0.000*
	Control	200	19.59			
Depression	Case	200	19.25	15.285	398	0.000*
	Control	200	6.17			
Anxiety	Case	200	9.81	3.752	398	0.000*
	Control	200	6.79			
Stress	Case	200	15.93	9.723	398	0.000*
	Control	200	8.26			
Distress tolerance	Case	200	43.86	-4.836	398	0.000*
	Control	200	51.61			
Psycho social wellbeing	Case	200	43.53	-8.169	398	0.000*
	Control	200	48.88			

*p- value less than 0.05

4.7 Depression, Anxiety, Stress, DT and Wellbeing in the two groups

From the table, it is observed that the mean scores of women in the case group is higher for psychological distress (23.69), depression (19.25), anxiety (9.81), and stress (15.93) when compared to women in the control group. It is clear from the table that women in the case group experience significantly higher levels of psychological distress, depression, anxiety, and stress as evident by p-values of 0.000. Further, women in the case group have lower mean scores of distress tolerance (43.86) and psycho social wellbeing (43.53), indicating that spouses of alcohol and opioid dependents have significantly lower distress tolerance and experience a lower level of psychosocial well-being when compared to women in the control group ($p < 0.005$).

Table 4.3: Binary logistic regression analysis for psychological distress among women in the case and control groups

Predictor variable	Psychological distress				
	Odds ratio	p-value	Chi-square	95% confidence interval	
				Lower	Upper
Control	Reference				
Case	3.33	0.000*	33.0	2.182	4.992

*p-value is less than 0.05

4.8 Psychological Distress in the Case and Control Group

Table 4.3 presents the results of the binary logistic regression analysis for women in the case and control groups. It is evident from the table that women in the case group were 3.33 times more likely of having psychological distress when compared to women in the control group and the result is statistically significant ($p=0.000$).

Table 4.4: Binary logistic regression analysis for depression among women in the case and control group

Predictor variable	Depression				
	Odds ratio	p-value	Chi-square	95% CI	
				Lower	Upper
Control	Reference				
Case	11.239	0.000*	115.32	7.023	17.987

*p-value is less than 0.05

4.9 Depression in the Case and Control Group

Table 4.4 shows the result of binary logistic regression analysis for depression among women in the case and control group. It is evident from the table that women in the case group had 11.23 times higher chance of experiencing depression when compared to women in the control group and the result is statistically significant ($p=0.000$).

Table 4.5: Binary logistic regression analysis for anxiety among women in the case and control group

Predictor variable	Anxiety				
	Odds ratio	p-value	Chi-square	95% CI	
Sample				Lower	Upper
Control	Reference				
Case	1.962	0.001*	11.01	1.315	2.927

*p-value is less than 0.05

4.10 Anxiety in the Case and Control Group

The table shows the result of binary logistic regression analysis for anxiety of women in the case and control group. It is evident from the table that women in the case group were 1.96 times more likely to experience anxiety when compared to women in the control group and the result is statistically significant ($p=0.000$).

Table 4.6: Binary logistic regression analysis for stress among women in the case and control group

Predictor variable	Stress				
	Odds ratio	p-value	Chi-square	95% CI	
Sample				Lower	Upper
Control	Reference				
Case	7.081	0.000*	72.96	4.407	11.376

*p-value is less than 0.05

4.11 Stress in the Case and Control Group

Table 4.6 shows the result of binary logistic regression analysis for stress among women in the case and control group. It is evident from the table that women in the case group had 7.08 times higher chance of having stress when compared to women in the control group and the result is statistically significant ($p=0.000$).

Table 4.7: Binary logistic regression analysis for distress tolerance among women in the case and control group

Predictor variable		Distress tolerance			
Sample	Odds ratio	p-value	Chi-square	95% confidence interval	
				Lower	Upper
Control	Reference				
Case	0.375	0.005*	23.07	0.250	0.562

*p-value is less than 0.05

4.12 Distress Tolerance in the Case and Control Group

The table 4.7 shows the result of binary logistic regression analysis for distress tolerance among women in the case and control group. It is evident from the table that women in the case group had 62.5% fewer chance of having high distress tolerance when compared to women in the control group and the result is statistically significant (p=0.000).

Table 4.8: Binary logistic regression analysis for Wellbeing among women in the case and control group

Predictor variable		Wellbeing			
Sample	Odds ratio	p-value	Chi-square	95% confidence interval	
				Lower	Upper
Control	Reference				
Case	0.17	0.000*	82.61	0.11	0.262

*p-value is less than 0.05

4.13 Wellbeing in the Case and Control Group

Table 4.8 represents the results of binary logistic regression analysis of women in the case and control group. It can be observed that women in the case group had 83% fewer chance of having high psycho social wellbeing when compared to women in the control group and the result is statistically significant (p=0.000).

Table 4.9: Linear regression analysis for predicting the role of distress tolerance on depression, anxiety, stress, and Psychosocial wellbeing

Outcome variables	R	R²	F	p-value
Depression	-0.484	0.235	122.081	0.000*
Anxiety	-0.531	0.408	155.487	0.000*
Stress	-0.530	0.391	155.334	0.000*
Psychosocial Wellbeing	0.377	0.142	65.963	0.000*

*p-value is less than 0.05

4.14 Predictive role of DT on Depression, Anxiety, Stress and Wellbeing

Table 4.9 shows the result of linear regression analysis for exploring the predictive role of distress tolerance on symptoms of depression, anxiety, stress, and psychosocial well-being among women. It is evident from the table that distress tolerance negatively predicted depression ($R=-0.484$), anxiety ($R=-0.531$), and stress ($R=-0.530$) among women. Whereas, distress tolerance positively predicted psychosocial well-being ($R=0.377$) and the result is statistically significant ($p=0.000$). The linear regression model indicated that 23.5% of the variance in depression is explained by distress tolerance. Further, 40.8% and 39.1% of the variance in anxiety and stress, respectively, is explained by distress tolerance. Also, 14.2% of variance in wellbeing scores is explained by distress tolerance.

Table 4.10: Psychological distress and socio-demographic characteristics of women in the control group

Independent variables	Psychological distress			
	No		Yes	
	N	%	N	%
Age	$\chi^2 = 9.24^*$			
25-30	7	58.3	5	41.7
31-35	23	53.5	20	46.5
36-40	18	40.9	26	59.1
41-45	68	67.3	33	32.7
Education	$\chi^2 = 2.09$			
8 th standard	9	50	9	50
Secondary	13	65	7	35
Senior secondary	17	68	8	32
Graduate	39	55.7	31	44.3
Postgraduate and above	38	56.7	29	43.3
Working status	$\chi^2 = 0.77$			
Not working	52	59.1	36	40.9
Working	64	57.1	48	42.9
Duration of marriage	$\chi^2 = 1.17$			
Up to 5 years	24	57.1	18	42.9
6-10 years	30	62.5	18	37.5
11-15 years	25	52.1	23	47.9
16 years & above	37	59.7	25	40.3
No of children	$\chi^2 = 2.49$			
None	13	52	12	48
One	31	52.5	28	47.5
Two	57	46	32	36
Above three	15	55.6	12	44.4
Family income	$\chi^2 = 1.16$			
Up to 20,000	16	55.2	13	44.8
21,000-50,0000	40	54.1	34	45.9
51,000- 1 Lakh	40	61.5	25	38.5
Above 1 Lakh	20	62.5	12	37.5
District	$\chi^2 = 0.22$			
Imphal East	55	59.8	37	40.2
Imphal West	61	56.5	47	43.5

Religion	$\chi^2 = 11.17^*$			
Sanamahism	36	64.3	20	35.7
Hindu	71	61.7	44	38.3
Muslim	5	41.7	7	58.3
Christian	4	23.5	13	76.5
SLT use	$\chi^2 = 0.10$			
No	86	57.3	64	42.7
Yes	30	60	20	40
History of Abuse	$\chi^2 = 16.4^*$			
No	110	63.6	63	36.4
Yes	6	22.1	21	77.8

*p-value is less than 0.05

4.15 Psychological Distress and Socio-demographic Factors for Control Group

The table shows the chi-square analysis conducted to investigate the relation between various sociodemographic factors with psychological distress of spouses in the control group. Among the factors assessed, age, religion, and history of abuse had significant associations with psychological distress. Women aged 36–40 years reported the highest level of psychological distress (59.1%), whereas women aged 41–45 years showed the lowest (32.7%) ($\chi^2 = 9.24$, $p < 0.05$). Religious affiliation was also significantly related with distress ($\chi^2 = 11.17$, $p < 0.05$); the highest prevalence observed among Christians (76.5%) and Muslims (58.3%), compared to Hindus (38.3%) and women who follow sanamahism (35.7%). Notably, a history of abuse was significantly linked to psychological distress ($\chi^2 = 16.4$, $p < 0.05$), with 77.8% of those reporting past abuse experiencing distress, in contrast to 36.4% among women without such a history. Other factors such as education level, working status, duration of marriage, number of children, family income, district, and smokeless tobacco use (SLT) had no associations with psychological distress among women in the control group ($p > 0.05$).

Table 4.11: Chi-square test for Depression, anxiety, stress and socio-demographic characteristics of women in the control group

Independent variables	Depression				Anxiety				Stress			
	No		Yes		No		Yes		No		Yes	
	N	%	N	%	N	%	N	%	N	%	N	%
Age	$\chi^2 = 14.14^*$				$\chi^2 = 3.59$				$\chi^2 = 1.79$			
25-30	6	50	6	50	7	53.3	5	41.7	11	91.7	1	8.3
31-35	35	81.4	8	18.6	28	65.1	15	34.9	38	88.4	5	11.6
36-40	24	54.5	20	45.5	23	52.3	21	47.7	35	79.5	9	20.5
41-45	80	79.2	21	20.8	69	68.3	32	31.7	85	84.2	16	15.8
Education	$\chi^2 = 5.76$				$\chi^2 = 1.46$				$\chi^2 = 2.01$			
8 th standard	10	55.6	8	44.4	9	50	9	50	14	77.8	4	22.2
Secondary	14	70	6	30	13	65	7	35	17	85	3	15
Senior secondary	16	64	9	36	17	68	8	32	22	88	3	12
Graduate	51	72.9	19	27.1	45	64.3	25	35.7	57	81.4	13	18.6
Post graduate and above	54	80.6	13	19.4	43	64.2	24	35.8	59	88.1	8	11.9
Working status	$\chi^2 = 6.19^*$				$\chi^2 = 0.30$				$\chi^2 = 1.74$			
Not working	56	63.6	32	36.4	54	61.4	34	38.6	71	80.7	17	19.3
Working	89	79.5	23	20.5	73	65.2	39	34.8	98	87.5	14	12.5
Duration of marriage	$\chi^2 = 2.30$				$\chi^2 = 2.58$				$\chi^2 = 1.74$			
Up to 5 years	31	73.8	11	26.2	28	66.7	14	33.3	39	92.9	3	7.1
6-10 years	35	72.9	13	27.1	33	68.8	15	31.2	43	89.6	5	10.4
11-15 years	31	64.6	17	35.4	26	54.2	22	45.8	36	75	12	25
16 years & above	48	77.4	14	22.6	40	64.5	22	35.5	51	82.3	11	17.7
No of children	$\chi^2 = 9.60^*$				$\chi^2 = 2.86$				$\chi^2 = 6.02$			
None	20	80	5	20	17	68	8	32	24	96	1	4
One	35	59.3	24	40.7	33	55.9	26	44.1	45	76.3	14	23.7
Two	66	74.2	23	25.8	61	68.5	28	31.5	76	85.4	13	14.6
Above three	24	88.9	3	11.1	16	59.3	11	40.7	24	88.9	3	11.1
Family income	$\chi^2 = 21.63^*$				$\chi^2 = 9.74^*$				$\chi^2 = 11.60^*$			
Up to 20,000	16	55.2	13	44.8	14	43.3	15	51.7	34	82.8	5	17.2
21,000-50,000	45	60.8	29	39.2	44	59.5	30	40.7	55	74.3	19	25.7
51,000- 1 Lakh	53	81.5	12	18.5	42	64.6	23	35.4	59	90.8	6	9.2
Above 1 Lakh	31	69.1	1	3.1	27	84.4	5	15.6	31	96.9	1	3.1
District	$\chi^2 = 0.29$				$\chi^2 = 1.75$				$\chi^2 = 0.01$			
Imphal East	65	70.7	27	29.3	57	62	35	38	78	84.8	14	15.2

Imphal West	80	74.1	28	25.9	70	64.8	38	35.2	91	84.3	17	15.7
Religion	$\chi^2 = 4.34$			$\chi^2 = 7.83 (0.05)$				$6.82 (0.05)$				
Sanamahism	44	78.6	12	21.4	42	75	14	25	49	87.5	7	12.5
Hindu	83	72.2	32	27.8	72	62.6	43	37.4	100	87	15	13
Muslim	9	75	3	25	6	50	6	50	9	75	3	25
Christian	9	52.9	8	47.1	7	41.2	10	58.8	11	64.7	6	35.3
SLT use	$\chi^2 = 0.20$			$\chi^2 = 0.35$				$\chi^2 = 0.62$				
No	110	73.3	40	26.7	97	64.7	53	35.3	125	83.3	25	16.7
Yes	35	70	15	30	30	60	20	40	44	88	6	12
History of abuse	$\chi^2 = 24.01^*$			$\chi^2 = 15.45^*$				$\chi^2 = 25.40^*$				
No	136	70.6	37	21.4	119	68.8	54	31.2	155	89.6	18	10.4
Yes	19	33.3	18	66.7	8	29.6	19	70.4	14	51.9	13	48.1

*p-value is less than 0.05

4.16 Socio-demographic Factors, Depression, Anxiety and Stress for Control Group

Table 4.1.1 represents the chi-square analysis performed to investigate the relationship of various sociodemographic variables with depression, anxiety, and stress among women in the control group. The analysis revealed that age, working status, number of children, family income, and history of violence had significant relationship with depression. Symptoms of depression was higher among participants aged 25-30 years (50%) and 36–40 years (45.5%) when compared to older age groups ($\chi^2 = 14.14$, $p < 0.05$). Further, non-working women also experience higher symptoms of depression (36.4%) when compared to working women (20.5%) ($\chi^2 = 6.19$, $p < 0.05$). Additionally, women with one child (40.7%) and lower family income (e.g., up to 20,000 rupees, 44.8%) showed significantly higher symptoms of depression. Furthermore, individuals with history of violence showed higher symptoms of depression (66.7%) compared to women without such a history (21.4%) ($\chi^2 = 24.01$, $p < 0.05$).

In the case of anxiety, significant associations were observed with family income ($\chi^2 = 9.74$, $p < 0.05$) and history of violence ($\chi^2 = 15.45$, $p < 0.05$). Participants with a monthly income up to rupees 20,000 reported significantly higher anxiety levels (51.7%) compared to women of higher income groups ($\chi^2 = 9.47$, $p < 0.05$). History of violence associated significantly with anxiety, with 70.4% of such individuals

reporting anxiety, in comparison to 31.2% among those without history of violence ($\chi^2 = 15.45$, $p < 0.05$).

Similarly, stress was significantly related with monthly income: women with monthly income of up to 20,000 rupees (17.2%) and 21,000-50,000 (25.7) rupees reported experiencing higher stress ($\chi^2 = 11.60$, $p < 0.05$) when compared to women with higher income. Significant higher levels of stress was observed among women exposed to violence, with stress prevalence reaching (48.1%) compared to 10.4% among those without history of abuse ($\chi^2 = 25.40$, $p < 0.05$). While religion showed near-significant associations with anxiety and stress, other variables such as district, SLT use, duration of marriage, and education did not significantly relate to any of the three common mental health outcomes.

Table 4.12: Chi- square test for distress tolerance and psychosocial wellbeing and socio-demographic characteristics of women in the control group

Independent variables	Distress tolerance				Psychosocial wellbeing			
	Low		High		Low		High	
	N	%	N	%	N	%	N	%
Age	$\chi^2 = 5.85$				$\chi^2 = 5.67$			
25-30	4	33.3	8	66.7	2	16.7	10	83.3
31-35	18	41.9	25	58.1	5	11.6	38	88.4
36-40	24	54.5	20	45.5	14	31.8	30	68.2
41-45	34	33.7	67	66.3	20	19.8	81	80.2
Education	$\chi^2 = 1.648$				$\chi^2 = 3.15$			
8 th standard	8	44.4	10	55.6	4	22.2	14	77.8
Secondary	7	35	13	65	5	25	15	75
Senior secondary	12	48	13	52	8	32	17	68
Graduate	25	35.7	45	64.3	13	18.6	57	81.4
Post graduate and above	28	41.8	39	58.2	11	16.4	56	83.6
Working status	$\chi^2 = 0.05$				$\chi^2 = 1.95$			
Not working	36	40.9	52	59.1	22	25	66	75
Working	44	39.3	68	60.7	19	17	93	83
Duration of marriage	$\chi^2 = 6.51$				$\chi^2 = 4.33$			
Up to 5 years	12	28.6	30	71.4	5	11.9	37	88.1
6-10 years	24	50	24	50	11	22.9	37	77.1
11-15 years	23	47.9	25	52.1	8	16.7	40	83.3
16 years & above	21	33.9	41	66.1	17	27.4	45	72.6
No of children	$\chi^2 = 1.64$				$\chi^2 = 3.15$			
None	6	24	19	76	2	8	23	92
One	32	54.2	27	45.8	13	22	46	78
Two	35	39.3	54	60.7	20	22.5	69	77.5
Above three	7	25.9	20	74.1	6	22.2	21	77.8
Family income	$\chi^2 = 7.94^*$				$\chi^2 = 4.53$			
Up to 20,000	13	44.8	16	55.2	6	20.7	23	79.3
21,000-50,0000	35	47.3	39	52.7	20	27	54	73
51,000- 1 Lakh	26	40	39	60	12	18.5	53	81.5
Above 1 Lakh	6	18.8	26	81.2	3	9.4	29	90.6
District	$\chi^2 = 1.93$				$\chi^2 = 8.18^*$			
Imphal East	32	34.8	60	65.2	27	29.3	65	70.7

Imphal West	48	44.4	60	55.6	14	13	94	87
Religion	$\chi^2 = 6.91$				$\chi^2 = 9.92^*$			
Sanamahism	17	30.4	39	69.6	9	16.1	47	83.9
Hindu	46	40	69	60	20	17.4	95	82.6
Muslim	8	66.7	4	33.3	4	33.3	8	66.7
Christian	9	52.9	8	47.1	8	47.1	9	52.9
SLT use	$\chi^2 = 0.44$				$\chi^2 = 3.69^*$			
No	58	38.7	92	61.3	26	17.3	124	82.7
Yes	22	44	28	56	15	30	35	70
History of violence	$\chi^2 = 11.99^*$				$\chi^2 = 28.77^*$			
No	61	35.3	112	64.7	25	14.5	148	85.5
Yes	19	70.4	8	29.6	16	59.3	11	40.7

*p-value is less than 0.05

4.17 Socio-demographic Factors, DT and Wellbeing in the Control group

Table shows the chi-square analysis conducted to explore the relationship between various socio-demographic factors and distress tolerance and psychosocial wellbeing. The analysis revealed that family income and history of violence had significant relationship with distress tolerance. Participants with lower family income (e.g., up to 20,000 rupees) had lower distress tolerance (44.8%), whereas women with income above 1 lakh rupees reported having higher distress tolerance levels (18.8%) ($\chi^2 = 7.94$, $p < 0.05$). Additionally, individuals with a history of violence showed significantly lower distress tolerance (70.4%) compared to those without such history (35.3%) ($\chi^2 = 11.99$, $p < 0.05$).

Regarding psychosocial wellbeing, significant relationships were observed with district ($\chi^2 = 8.18$, $p < 0.05$), religion ($\chi^2 = 9.92$, $p < 0.05$), SLT use ($\chi^2 = 3.69$, $p < 0.05$), and history of violence ($\chi^2 = 28.77$, $p < 0.05$). Women from Imphal West reported higher psychosocial wellbeing (87%) compared to those from Imphal East (70.7%). Similarly, Christians and Muslims showed lower psychosocial wellbeing (52.9% and 66.7%, respectively) compared to women who follow Sanamahism (83.9%) and Hindu (82.6%). Women who reported using smokeless tobacco (SLT) had a lower percentage of high psychosocial wellbeing (70%) compared to non-users (82.7%). Most notably, a history of abuse had significant association with poorer psychosocial wellbeing, with only 40.7% of such individuals reporting high wellbeing, compared to 85.5% among those without history of abuse.

Other variables such as age, education, working status, duration of marriage, and number of children were not related to either outcome ($p > 0.05$). However, some trends were observed, such as higher distress tolerance and psychosocial wellbeing in younger and higher educated women.

Table 4.13: Psychological distress and socio-demographic characteristics of women in the case group

Independent variables	Psychological distress			
	No		Yes	
	N	%	N	%
Age	$\chi^2 = 1.72$			
25-30	13	23.2	43	76.8
31-35	16	29.6	38	70.4
36-40	18	34.0	35	66
41-45	12	32.4	25	67.6
Education	$\chi^2 = 5.13$			
8 th standard	13	35.1	24	64.9
Secondary	18	37.5	30	62.5
Senior secondary	7	28	18	72
Graduate	16	27.6	42	72.4
Postgraduate and above	5	15.6	27	84.4
Working status	$\chi^2 = 3.245$			
Not working	46	33.3	92	66.7
Working	13	21	49	79
Duration of marriage	6.97*			
Up to 5 years	13	20.6	50	79.4
6-10 years	13	27.1	35	72.9
11-15 years	19	32.2	40	67.8
16 years & above	14	46.7	16	53.3
No of children	$\chi^2 = 15.20^*$			
None	3	9.1	30	90.9
One	27	40.9	39	59.1
Two	15	22.1	53	77.9
Three & above	14	42.4	19	57.6
Family income	$\chi^2 = 2.14$			
Up to 20,000	29	33.7	57	66.3
21,000-50,0000	16	30.2	37	69.8
51,000- 1 Lakh	8	25	24	75
Above 1 Lakh	6	20.7	23	79.3
District	$\chi^2 = 0.17$			

Imphal East	14	31.8	30	68.2
Imphal West	23	29.5	55	70.5
Others	22	28.2	56	71.8
Religion	$\chi^2 = 5.19$			
Sanamahism	19	33.3	38	66.7
Hindu	31	33.7	61	66.3
Muslim	7	21.2	26	78.8
Christian	2	11.1	16	88.9
SLT use	$\chi^2 = 2.014$			
No	27	25.2	80	74.8
Yes	32	34.4	61	65.6
History of abuse	$\chi^2 = 0.406$			
No	28	31.8	60	68.2
Yes	31	27.7	81	72.3

*p-value is less than 0.05

4.18 Socio-demographic Factors and Psychological Distress in the Case Group

In the above table, it is observed that socio-demographic characteristics like age, education, working status, family income, district, religion and tobacco use did not relate significantly with psychological distress. 70.6% of spouses belonging to age range of 25-30 years and 70.4% of women of age 31-35 years have high psychological distress. Considering education, 84.4% of women who were educated till postgraduate and above have high psychological distress, followed by women who were educated till graduate level (72.4%). Symptoms of psychological distress were lower among women with secondary-level education (62.5%). Further, 79% and 66.7% of women who were working and not working, respectively had high psychological distress. Regarding duration of marriage, women with younger duration of marriage had significantly higher level of psychological distress ($\chi^2 = 6.97$); 79.4% of women with marriage duration for less than 5 years and 72.9% of women married for 6-10 years had significantly higher symptoms of psychological distress in comparison to women married for longer duration. Further, 90.1% of women with no children experience significantly higher psychological distress in comparison to women with higher number of children ($\chi^2 = 15.2$). Considering family income, 79.3% of women with family income of rupees 1 lakh and above have higher psychological distress, followed by women with family income of rupees 51,000 to 1 Lakh (75%). Further, 71% of

women belonging to 'Others' district have high psychological distress, and 70.5% of women residing in Imphal west district have high psychological distress. Women belonging to Christian (88.9%) and Muslim (78.8%) religions have higher psychological distress when compared to Sanamahism (66.3%) and Hindu (66.7%). Women who do not use smokeless tobacco have higher psychological distress (74.8%) when compared to smokeless tobacco users (65.6%), however, the result is not statistically significant ($p > 0.05$).

Table 4.14: Chi-square test for Depression, Anxiety, Stress and socio-demographic characteristics of women in the case group

Independent variables	Depression				Anxiety				Stress			
	No		Yes		No		Yes		No		Yes	
	N	%	N	%	N	%	N	%	N	%	N	%
Age	$\chi^2 = 10.00^*$				$\chi^2 = 2.89$				$\chi^2 = 13.08^*$			
25-30	6	10.7	50	89.3	24	42.9	32	57.1	22	39.3	34	60.7
31-35	15	27.8	39	72.2	24	44.4	30	55.6	32	59.3	22	40.7
36-40	6	11.3	47	88.7	24	45.3	29	54.7	14	26.4	39	73.6
41-45	11	29.7	26	70.8	22	59.5	15	40.5	19	51.4	18	48.6
Education	$\chi^2 = 25.59^*$				$\chi^2 = 3.67$				$\chi^2 = 0.85$			
8 th standard	6	11.2	31	83.8	21	56.8	16	43.2	18	48.6	19	51.4
Secondary	6	12.5	42	87.5	25	52.1	23	47.9	19	39.6	29	60.4
Senior secondary	1	4	24	96	11	40	25	60	11	44	14	56
Graduate	9	15.5	49	84.5	26	44.8	32	55.2	26	44.8	32	55.2
Postgraduate & above	16	50	16	50	12	37.5	20	62.5	13	40.6	19	59.4
Working status	$\chi^2 = 7.91^*$				$\chi^2 = 0.76$				$\chi^2 = 0.36$			
Not working	19	30.8	119	86.2	62	44.9	76	25.1	62	44.9	76	55.1
Working	19	30.6	43	69.4	32	51.6	30	48.4	25	40.3	37	59.7
Duration of marriage	$\chi^2 = 9.27^*$				$\chi^2 = 2.60$				$\chi^2 = 3.46$			
Up to 5 years	17	27	46	73	25	39.7	38	60.3	28	44.4	35	55.6
6-10 years	6	12.5	42	87.5	23	47.9	25	52.1	17	35.4	31	64.6
11-15 years	6	10.2	53	89.8	29	49.2	30	50.8	27	42.4	34	57.6
16 years & above	9	30	21	70	17	56.7	13	43.3	17	56.7	13	43.3
No of children	$\chi^2 = 5.51$				$\chi^2 = 5.88$				$\chi^2 = 5.38$			
None	7	21.2	26	78.8	12	36.4	21	63.6	12	36.4	21	63.6
One	17	25.8	49	74.2	37	56.1	29	43.9	29	43.9	37	56.1
Two	7	10.3	61	89.7	27	39.7	41	60.3	26	38.2	42	61.8
Above three	7	21.2	26	78.8	18	54.5	15	45.5	20	60.6	13	39.4
Family income	$\chi^2 = 3.19$				$\chi^2 = 17.84^*$				$\chi^2 = 5.00$			
Up to 20,000	13	15.1	73	84.9	52	60.5	34	39.5	43	50	43	50
21,000- 50,000	11	20.8	42	79.2	21	39.6	32	60.4	24	45.3	29	54.7
51,000- 1 Lakh	5	15.6	27	84.4	16	50	16	50	12	37.5	20	62.5
Above 1 Lakh	9	31	20	69	5	17.2	24	82.8	8	27.6	21	72.4
District	$\chi^2 = 23.50^*$				$\chi^2 = 1.27$				$\chi^2 = 5.01$			
Imphal East	17	38.6	27	61.4	23	52.3	21	47.7	25	56.8	15	43.2
Imphal West	18	23.1	60	76.9	33	42.3	45	57.7	28	35.9	50	64.1
Others	3	3.8	75	96.2	38	48.7	40	51.3	34	43.6	44	56.4
Religion	$\chi^2 = 11.01^*$				$\chi^2 = 24.09^*$				$\chi^2 = 4.89$			

Sanamahism	16	28.1	41	71.9	40	70.2	17	29.8	28	49.1	29	50.9
Hindu	19	20.7	73	79.3	30	32.6	62	67.4	36	39.1	56	60.9
Muslim	0	0	33	100	19	57.6	14	42.4	18	54.5	15	45.5
Christian	3	16.7	15	83.3	5	27.8	13	72.2	5	27.8	13	72.2
SLT use	$\chi^2 = 5.81^*$				$\chi^2 = 0.593$				$\chi^2 = 0.530$			
No	27	25.2	80	74.8	53	49.5	54	50.5	44	41.1	63	58.9
Yes	11	11.8	82	88.2	41	44.1	52	55.9	43	46.2	50	53.8
History of abuse	$\chi^2 = 2.41$				$\chi^2 = 11.03^*$				$\chi^2 = 4.92^*$			
No	21	23.9	67	76.1	53	60.2	35	39.8	46		42	47.7
Yes	17	15.2	95	84.8	41	36.6	71	64.4	41	36.6	71	63.4

*p-value is less than 0.05

4.19 Socio-demographic Factors, Depression, Anxiety and Stress in the Case Group

The above table represents the relationship between the socio-demographic factors and the symptoms of depression, anxiety, and stress among women in the case group.

It is evident from the table that depression is significantly associated with age ($\chi^2 = 10.00$, $p < 0.05$), education level ($\chi^2 = 25.59$, $p < 0.05$), working status ($\chi^2 = 7.91$, $p < 0.05$), duration of marriage ($\chi^2 = 9.27$, $p < 0.05$), district of residence ($\chi^2 = 23.50$, $p < 0.05$), religion ($\chi^2 = 11.01$, $p < 0.05$), and use of smokeless tobacco (SLT) ($\chi^2 = 5.81$, $p < 0.05$). Women belonging to younger age group of 25-30 years experienced higher symptoms of depression (89.3%). Further, spouses with lower level of education had significantly higher symptoms of depression; 96% and 87.5% of women with senior secondary and secondary level of education, respectively, have higher symptoms of depression. Further, 82.6% of non-working women had significantly higher symptoms of depression when compared to working women (69.4%). Further, 87.5% and 89.8% of women married for 6-10 years and 11-15 years respectively reported higher symptoms of depression when compared to women married for 16 years & above (70%). Additionally, it was observed that women residing in 'Others' district have significantly the highest percentage of depression (96.2%). Regarding religion, Muslims (100%) and Christians (83.3%) had the highest symptom of depression. Further, women who use smokeless tobacco experience significantly higher symptoms of depression (88.2%), however, no such relationship was found for anxiety and stress.

For anxiety and stress, women of higher educational level experience higher symptoms, however, the result is not statistically significant. 62.5% and 60% of women who were educated till postgraduate & above and senior secondary level respectively experience higher symptoms of anxiety. Similarly, 59.4% and 56% of women with postgraduate & above and senior secondary level of education, respectively, have higher symptoms of stress. Anxiety is significantly associated with religion ($\chi^2 = 24.09$, $p < 0.05$), family income ($\chi^2 = 17.84$, $p < 0.05$), and history of abuse ($\chi^2 = 11.03$, $p < 0.05$). Symptoms of anxiety were higher among spouses with monthly income of rupees 1 Lakh & above (82.2%) when compared to the other income groups. Further, women with history of abuse have significantly higher symptoms of anxiety (64.4%) when compared to women with no such history (39.8%). Anxiety is also significantly higher, particularly among Christians (72.2%) when compared to other religious groups.

Factors such as working status, number of children, education, age and SLT had no relationship with anxiety. Stress showed a significant relationship with age ($\chi^2 = 13.08$, $p < 0.05$) and history of abuse ($\chi^2 = 4.92$, $p < 0.05$), with the highest stress levels observed among women aged 36–40 years (73.6%) and among women reported experiencing abuse (63.4%). No significant relationship was found between stress and education, working status, or SLT use. Regarding number of children, no significant association was observed with symptoms of depression, anxiety and stress. Regardless of the number of children, majority of women having no children (78.8%), one child (74.2%), two children (89.7%) and three and above children (78.8%) were found to be symptomatic of depression. For anxiety and stress, the percentage of women who were symptomatic were highest for women with no children (63.6%) and two children (60.3% and 61.8%) respectively.

Table 4.15: Chi-square test for Distress Tolerance and Psychosocial wellbeing and socio-demographic characteristics of women in the case group

Independent variables	Distress tolerance				Psychosocial wellbeing			
	Low		High		Low		High	
	N	%	N	%	N	%	N	%
Age	$\chi^2 = 1.54$				$\chi^2 = 18.44^*$			
25-30	34	60.7	22	39.3	42	75	14	25
31-35	38	70.4	16	29.6	30	55.6	24	44.4
36-40	34	64.2	19	35.8	43	81.1	10	18.9
41-45	22	59.5	15	40.5	16	43.2	21	56.8
Education	$\chi^2 = 1.41$				$\chi^2 = 19.92^*$			
8 th standard	23	62.2	14	37.8	27	73	10	27
Secondary	29	60.4	19	39.6	39	81.2	9	18.8
Senior secondary	17	68	8	32	16	64	9	36
Graduate	40	69	18	31	38	65.5	20	34.5
Post graduate and above	19	59.4	13	40.6	11	34.4	21	65.6
Working status	$\chi^2 = 1.11$				$\chi^2 = 3.25$			
Not working	85	61.6	53	38.4	96	69.6	42	30.4
Working	43	69.4	19	30.6	35	56.5	27	43.5
Duration of marriage	$\chi^2 = 1.06$				$\chi^2 = 13.05^*$			
Up to 5 years	43	68.3	20	31.7	33	52.4	30	47.6
6-10 years	31	64.6	17	35.4	40	83.3	8	16.7
11-15 years	35	59.3	24	40.7	41	69.5	18	30.5
16 years & above	19	63.3	11	36.7	17	56.7	13	43.3
No of children	$\chi^2 = 5.98$				$\chi^2 = 11.07^*$			
None	22	66.7	11	33.3	19	57.6	14	42.4
One	43	65.2	23	34.8	42	63.6	24	36.4
Two	37	54.4	31	45.6	54	79.4	14	20.6
Above three	26	78.8	7	21.1	16	48.5	17	51.5
Family income	$\chi^2 = 10.16^*$				$\chi^2 = 18.24^*$			
Up to 20,000	55	64	31	36	63	73.3	23	26.7
21,000-50,0000	26	49.1	27	50.9	36	67.9	17	32.1
51,000- 1 Lakh	26	812	6	18.8	23	71.9	9	28.1
Above 1 Lakh	21	72.4	8	27.6	9	31	20	69
District	$\chi^2 = 10.25^*$				$\chi^2 = 1.05$			

Imphal East	22	50	22	50	26	59.1	18	14.2
Imphal West	46	59	32	41	52	66.7	26	33.3
Others	60	76.9	18	23.1	53	67.9	25	32.1
Religion	$\chi^2 = 22.59^*$				$\chi^2 = 2.84$			
Sanamahism	23	40.4	36	59.6	37	64.9	20	35.1
Hindu	66	71.7	26	28.3	56	60.9	36	39.1
Muslim	28	84.7	5	15.2	24	72.7	9	27.3
Christian	11	61.1	7	38.9	14	77.8	4	22.2
SLT use	$\chi^2 = 1.78$				$\chi^2 = 3.29$			
No	73	68.2	34	31.8	64	59.8	43	40.2
Yes	55	59.1	38	40.9	67	72	26	28
History of abuse	$\chi^2 = 2.84$				$\chi^2 = 0.166$			
No	62	70.5	26	29.5	59	67	29	33
Yes	66	58.9	46	41.1	72	64.3	40	35.7

*p-value is less than 0.05

4.20 Socio-demographic Factors, DT and Wellbeing in the Case Group

The above table shows the relationship of socio-demographic characteristics and distress tolerance (DT) and wellbeing. Women's age was significantly related to wellbeing ($\chi^2 = 18.44$, $p < 0.05$), wellbeing is significantly higher among women of 41-45 years (56.8%) compared to younger age groups. However, no such relationship was found for DT. Wellbeing was also observed to be significantly highest for women who were educated till post graduate & above (65.6%) when compared to women with lower level of educational attainment ($\chi^2 = 19.92$, $p < 0.05$). Considering duration of marriage, no association was observed with distress tolerance, however, it was observed that only 16.7% of women married for 6-10 years had high wellbeing and the result is statistically significant ($\chi^2 = 13.05$, $p < 0.05$). Further, 78.8% of women with 3 or more children had low DT. More than half of women with 3 or more children had higher wellbeing (51.5%) in comparison to the rest of the groups ($\chi^2 = 11.07$, $p < 0.05$). Regarding family income, it was observed that higher income groups had significantly lower distress tolerance ($\chi^2 = 10.16$, $p < 0.05$); 81.2% and 72.4% of women with family income of rupees 51,000- 1 Lakh and Above 1 Lakh rupees had low DT. Whereas for wellbeing, 69% of women with income of rupees 1 Lakh and above have high wellbeing, which is significantly higher when compared to lower income groups ($\chi^2 = 18.24$, $p < 0.05$). Considering the district women belonged to, 50% of women residing in Imphal east district have high DT, while only 23.1% of women

belonging to 'Others' district has high DT and the result is statistically significant ($\chi^2 = 10.25$, $p < 0.05$). Further, 59.6% and 38.9% of women belonging to Sanamahism and Christian religion respectively have significantly high DT ($\chi^2 = 22.59$, $p < 0.05$) when compared to those who belonged Hindu (28.3%) and Muslim (15.2%). However, wellbeing has no significant association with religious affiliation of women. Also, no association was observed between wellbeing and district, however, only 14.2% of women belonging to Imphal east district have high wellbeing, which is lower compared to other groups. Further, smokeless tobacco use did relate significantly with DT and wellbeing. However, it was observed that 40.9% of women smokeless tobacco users have high DT, whereas 40.2% of non- smokeless tobacco users have high wellbeing. When considering history of abuse, 41.1% of women with history of abuse had high DT, whereas the percentage of high wellbeing among smokeless tobacco users and non- smokeless tobacco users are more or less the same (35.7% and 33% respectively).

Education was not associated with DT, however, women belonging to higher educational attainment reported higher level of DT (40.6%) in comparison to women with lower educational status. Considering the working status of women, no significant association was observed with both DT and wellbeing. However, DT was observed to be higher among non- working women (38.4%), whereas wellbeing was higher among working women (43.5%).

Table 4.16: Psychological Distress and Psychosocial issues of women in the case group

Independent variables	Psychological distress			
	No		Yes	
	N	%	N	%
Type of dependence	$\chi^2 = 4.06$			
Alcohol	36	36	64	64
Opioid	23	23	77	77
Place of treatment	$\chi^2 = 5.34^*$			
RIMS	20	21.5	73	78.5
Drug de-addiction centres	39	36.5	68	63.6
Duration of dependence	$\chi^2 = 0.47$			
1-4 years	22	26.8	60	73.2
5-9 years	23	31.5	50	68.5
10 years & above	14	31.1	31	68.9
History of relapse	$\chi^2 = 0.00$			
Yes	54	29.5	129	70.5
No	5	29.4	12	70.6
Financial difficulties due to the husband's dependence	$\chi^2 = 2.21$			
Yes	50	32.1	106	67.9
No	9	20.5	35	79.5
Received emotional support/motivation	$\chi^2 = 9.43^*$			
Yes	12	26.4	61	83.6
No	47	37	80	63
Wish to receive counselling services?	$\chi^2 = 0.37$			
Yes	51	30.4	117	69.6
No	8	25	24	75
Shared experience with others?	$\chi^2 = 2.13$			
Yes	52	31.7	112	68.3
No	7	19.4	29	80.6
If yes, with whom?	$\chi^2 = 8.15$			
Close relatives	25	35.7	45	34.3
Close friends	22	33.8	43	66.2
Psychiatrist/Psychologist	4	28.6	10	71.4
None	7	21.9	25	78.1
Wives of other dependents in the hospital/centres	1	5.3	18	94.7
Changes in social participation/gathering	$\chi^2 = 1.06$			
No change	18	32.1	38	67.9
Have declined	37	29.8	87	70.2
Totally cut off	4	20	16	80

*p-value is less than 0.05

4.21 Psychological Distress and Psychosocial Issues in the Case Group

In table, chi-square test was conducted to explore the relationship between some specific experiences of women in the case group and psychological distress. Among the variables analysed, the place of treatment and emotional support were significantly related to psychological distress. Spouses of individuals undergoing treatment at RIMS reported a higher prevalence of psychological distress (78.5%) compared to those whose husbands were treated in drug de-addiction centres (63.6%) ($\chi^2 = 5.34$, $p < 0.05$). Additionally, women who reported receiving emotional support or motivation experienced significantly greater psychological distress (83.6%) compared to those who did not (63%) ($\chi^2 = 9.43$, $p < 0.05$).

Further, history of relapse, longer duration of dependence, and financial difficulties also corresponded with elevated distress, though the relationships did not meet statistical significance. Sharing experiences with others showed a trend toward reduced distress, especially when shared with close relatives (64.3% with high distress), compared to sharing with wives of other dependents (94.7% with high distress), though this association was not statistically significant. Other factors such as wish to receive counselling, social participation changes, and whether participants shared their experiences showed no statistically significant associations with distress levels ($p > 0.05$), though those who had totally cut off social participation reported the highest distress (80%).

Table 4.17: Depression, Anxiety and Stress and Psycho-social issues of women belonging to the case group

Independent variables	Depression				Anxiety				Stress			
	Low		High		Low		High		No		Yes	
	N	%	N	%	N	%	N	%	N	%	N	%
Type of dependence	$\chi^2 = 1.17$				$\chi^2 = 0.08$				$\chi^2 = 0.18$			
Alcohol	22	22	78	78	48	48	52	52	45	45	55	55
Opioid	16	16	84	84	46	46	54	54	42	42	58	58
Place of treatment	$\chi^2 = 1.44$				$\chi^2 = 7.60^*$				$\chi^2 = 4.54^*$			
RIMS	21	22.6	72	77.4	34	36.6	59	63.4	33	35.5	60	64.5
Drug de-addiction centres	17	15.9	90	84.1	60	56.1	47	43.9	54	50.5	53	49.5
Duration of dependence	$\chi^2 = 0.94$				$\chi^2 = 0.16$				1.73			
1-4 years	13	15.9	69	84.1	39	47.6	43	52.4	32	39	50	61
5-9 years	15	20.5	58	79.5	33	45.2	40	54.8	32	43.8	41	56.2
10 years & above	10	22.2	35	77.8	22	48.9	23	51.1	23	51.1	22	48.9
History of relapse	$\chi^2 = 3.20$				$\chi^2 = 0.25$				1.50			
Yes	32	17.5	151	82.5	87	47.5	96	52.5	82	44.8	101	55.2
No	6	35.3	11	64.7	7	41.2	10	58.8	5	29.4	12	70.6
Financial difficulties due to husband's dependence	$\chi^2 = 4.07^*$				$\chi^2 = 0.84$				0.08			
Yes	25	16	131	84	76	48.7	80	51.3	67	42.9	89	57.1
No	13	29.5	31	70.5	18	40.9	26	59.1	20	45.5	24	54.5
Received emotional support/ motivation	$\chi^2 = 4.83^*$				$\chi^2 = 0.04$				$\chi^2 = 1.98$			
Yes	8	11	65	89	35	47.9	38	52.1	27	37	46	63
No	30	23.6	97	76.4	59	46.5	68	53.5	60	47.2	67	52.8
Wish to receive counselling services?	$\chi^2 = 0.20$				$\chi^2 = 0.13$				$\chi^2 = 0.17$			
Yes	31	18.5	137	81.5	78	46.4	90	53.6	72	42.9	96	57.1
No	7	21.9	25	78.1	16	50	16	50	15	49.6	17	53.1
Shared experience with others?	$\chi^2 = 0.006$				$\chi^2 = 0.001$				$\chi^2 = 0.75$			
Yes	31	18.9	113	81.1	77	47	87	53	69	42.1	97	57.9
No	7	19.4	29	80.6	17	47.2	19	52.8	18	50	18	50
If yes, with whom?	$\chi^2 = 1.66$				$\chi^2 = 2.28$				$\chi^2 = 3.30$			
Close relatives	11	15.7	59	84.3	33	47.1	37	52.9	33	47.1	37	52.9
Close friends	13	20	52	80	33	50.8	32	49.2	28	43.1	37	56.9
Psychiatrist/Psychologist	4	28.6	10	71.4	4	28.6	10	71.4	4	28.6	10	71.4

None	7	21.9	25	78.1	15	46.9	17	53.1	16	50	16	50
Wives of other dependents in the hospital/centres	3	15.8	16	84.2	9	47.4	10	52.6	6	31.6	13	68.4
Changes in social participation/gathering	$\chi^2 = 3.87$			$\chi^2 = 2.15$			$\chi^2 = 3.48$					
No change	14	25	42	75	28	50	28	50	30	53.6	26	46.4
Have declined	23	18.5	10	81.5	54	43.5	70	56.5	48	37.8	76	61.3
			1									
Totally cut off	1	5	19	95	12	60	8	40	9	45	11	55

*p-value is less than 0.05

4.22 Depression, anxiety, stress and Psychosocial Issues in the Case Group

Chi-square test was conducted to examine the association between various substance-related, treatment-related, and psychosocial factors with depression, anxiety, and stress among the participants. Significant relationships were found between financial difficulties and depression ($\chi^2 = 4.07$, $p < 0.05$), between emotional support and depression ($\chi^2 = 4.83$, $p < 0.05$). Participants who reported financial difficulties due to their husband's substance dependence showed higher symptoms of depression (84%) in comparison to those who did not (70.5%). Similarly, those who received emotional support experienced higher symptoms of depression (89%) in comparison to women with no emotional support (76.4%). A significant relationship was observed between the place of treatment and anxiety ($\chi^2 = 7.60$, $p < 0.05$). Participants whose husbands were receiving treatment at RIMS reported a higher rate of anxiety (63.4%) than those treated in drug de-addiction centres (43.9%). Similarly, place of treatment were significantly related with stress ($\chi^2 = 4.54$, $p < 0.05$), with higher levels of stress among women of husbands treated at RIMS (64.5%) compared to de-addiction centres (49.5%).

While not statistically significant, some considerable trends were observed. A history of relapse, longer duration of dependence, and reduced social participation also corresponded with increased symptoms across all three domains. Women who were totally cut off from social gatherings had particularly high levels of depression (95%) and stress (55%). Other variables, including willingness to receive counselling, sharing experiences with others, and the specific person with whom experiences were shared, had no significant relationship with depression, anxiety, or stress ($p > 0.05$). However, distress levels were observed to be higher among women who reported sharing

experiences with psychiatrists/psychologists or wives of other dependents when compared to wives who did not report sharing experiences with others.

Table 4.18: Distress Tolerance, Psychosocial wellbeing and Psychosocial issues for women in the Case Group

Independent variables	Distress Tolerance				Wellbeing			
	Low		High		Low		High	
	N	%	N	%				
Type of dependence	$\chi^2 = 8.68$				$\chi^2 = 7.98$			
Alcohol	54	54	64	64	56	56	44	44
Opioid	74	74	26	26	75	75	25	25
Place of treatment	$\chi^2 = 4.93^*$				$\chi^2 = 0.10$			
RIMS	52	55.9	41	44.1	62	66.7	31	33.3
Drug de-addiction centres	76	71	31	29	69	64.5	38	35.5
Duration of dependence	$\chi^2 = 1.06$				$\chi^2 = 4.02$			
1-4 years	51	62.2	31	37.8	58	70.7	26	29.3
5-9 years	50	68.5	23	31.5	49	67.1	24	32.9
10 years & above	27	60	18	40	24	53.3	21	46.7
History of relapse	$\chi^2 = 0.35$				$\chi^2 = 0.005$			
Yes	116	63.4	76	36.6	120	65.6	63	34.4
No	12	70.6	5	29.4	11	64.7	6	35.3
Financial difficulties due to husband's dependence	$\chi^2 = 1.02$				$\chi^2 = 5.99^*$			
Yes	97	62.2	59	37.8	109	69.9	47	30.1
No	31	70.5	13	29.5	22	50	22	50
Received emotional support/motivation	$\chi^2 = 1.71$				$\chi^2 = 0.75$			
Yes	51	69.9	22	30.1	45	61.6	28	38.4
No	77	60.6	50	39.5	86	67.7	41	32.3
Wish to receive counselling services?	$\chi^2 = 6.86^*$				$\chi^2 = 0.63$			
Yes	101	60.1	67	39.9	112	66.7	56	33.3
No	27	84.4	5	15.6	19	59.4	13	40.6
Shared experience with others?	$\chi^2 = 1.28$				$\chi^2 = 0.30$			
Yes	102	62.2	62	37.8	106	64.6	58	35.4
No	26	72.2	10	27.8	25	69.4	11	30.6
If yes, with whom?	$\chi^2 = 7.24$				$\chi^2 = 7.61$			
Close relatives	47	67.1	23	32.9	50	71.4	20	28.6
Close friends	35	53.8	30	46.2	43	66.2	22	33.8
Psychiatrist/Psychologist	12	85.7	2	14.3	6	42.9	8	57.1
Wives of other dependents in the hospital/centres	11	57.9	8	42.1	9	47.4	10	5.6
None	23	71.9	9	28.1	23	71.9	9	28.1
Changes in social participation/gathering	$\chi^2 = 6.80^*$				$\chi^2 = 3.98$			
No change	34	60.7	22	39.3	34	60.7	22	39.9
Have declined	86	69.4	38	30.6	80	64.5	44	35.5
Totally cut off	8	40	12	60	17	85	3	15

*p-value is less than 0.05

4.23 DT, Wellbeing and Psychosocial Issues in the Case Group

Chi-square test was applied to explore the relationship between substance-related and psychosocial variables with distress tolerance and psychosocial wellbeing among women in the case group. A significant relationship was found between place of treatment and distress tolerance ($\chi^2 = 4.93$, $p < 0.05$), with participants whose husbands were treated at drug de-addiction centres reporting lower distress tolerance (71%) compared to those treated at RIMS (55.9%). Similarly, willingness to receive counselling services was significantly related to distress tolerance ($\chi^2 = 6.86$, $p < 0.05$); those who wished to receive counselling had lower distress tolerance (60.1%) in comparison to women who reported no such wish (84.4%).

Regarding wellbeing, financial difficulties was found to be a significant determinant ($\chi^2 = 5.99$, $p < 0.05$). Participants who reported financial difficulties due to their husband's substance dependence had lower psychosocial wellbeing (69.9%) compared to women with no financial issues (50%). Though not statistically significant, distress tolerance and wellbeing were both generally lower among those reporting a history of relapse or longer duration of dependence. Changes in social participation also had a significant relationship with distress tolerance ($\chi^2 = 6.80$, $p < 0.05$), where participants who were entirely isolated from social gatherings showed the lowest distress tolerance level (60%) and lowest psychosocial wellbeing (85%), though this latter observation was not statistically significant.

Although no associations were observed between sharing experiences and outcomes, trends indicated that those who shared with psychiatrists/psychologists had the lowest distress tolerance (85.7% low) and also lower wellbeing (57.1% high).

CHAPTER- V

DISCUSSION

The present study is a cross-sectional study conducted on Manipuri women to explore and compare the experience of symptoms of psychological distress, depression, anxiety, and stress among female spouses of alcohol and opioid dependents and an age-appropriate control group. Further, the study examined and compared the level of distress tolerance and psychosocial wellbeing of women in the case group and control group. The relationship between distress tolerance, psychopathology, and wellbeing was also investigated. The findings from the study have been discussed subsequently.

5.1 Husbands' Dependence and Psychopathological Symptoms in Spouses

Results of t-test and binary logistic regression analysis found that spouses of alcohol and opioid dependent men have significantly higher risks of experiencing psychological distress, depression, anxiety, and stress when compared to the control group. For psychological distress, the mean score obtained by the case group is 23.69, whereas the control group obtained a mean score of 19.59, and a significant difference was found between the two groups, as evidenced by a p-value of 0.000. For depression, anxiety, and stress, the case group had significantly higher mean scores (19.25, 9.81, and 15.93, respectively) when compared to the control group (6.17, 6.79, and 8.26, respectively), indicating that spouses of alcohol and opioid dependents experienced higher symptoms of depression, anxiety, and stress.

Findings from binary logistic regression analysis also suggest that women in the case group had a higher chance of having psychological distress, depression, anxiety, and stress when compared to women in the control group. It was observed that female spouses of alcohol and opioid dependents had 3.33 times higher chance of having psychological distress when compared to the other counterparts (OR= 3.33, 95% CI [2.18-4.99]). Also, women in the case group had higher risks of experiencing depression when compared to women in the control group (OR= 11.23, 95% CI [7.02-17.98]). Further, the odds of having anxiety were also significantly higher among spouses with alcohol and opioid dependent husbands when compared to the control group (OR= 1.96, 95% CI [1.31-2.92]). Considering stress too, women belonging to

the case group had 7.08 times higher risk of having symptoms of stress when compared to women whose husbands were not dependent on alcohol and other drugs (OR= 7.08, 95% CI [4.40-11.37]).

The observations are consistent with previous studies conducted in India and across the globe; women living with drug and alcohol dependent husbands experienced a wide range of psychopathological symptoms, mostly in the form of depression, anxiety, stress, and unspecified psychological distress (Di Sarno et al., 2021; Birkeland et al., 2018; Bischof et al., 2022; Ahmad Shahril, Arshat, & Adnan, 2022; Vivekanandan, Preethi, Saha, & Jhamuna, 2024; Micheal, Abd-Elmaksoud, Farag, & El Bakry, 2024). These studies have highlighted the mental health burden women bear as a result of their husbands' drug and alcohol dependence.

Studies using case-control comparison between wives of substance dependents and non-substance dependents reported similar findings. For instance, in a study conducted in Uganda among married women with substance-dependent husbands, the symptoms of depression were significantly higher (75%), when compared to women whose husbands were not dependent on any substance (25%). The study also explored other characteristics of male spouses that significantly determine the symptoms of depression among women, such as age, unemployment, and extramarital affairs; however, husbands' drug dependence was observed to have the strongest association with wives' depressive symptoms (Kaggwa et al., 2021). Additionally, Kahrazee et al., (2018) also explored the experience of stress and depression among wives of men with substance dependence and non-substance dependence. The findings from the study showed a significant difference between the two groups in depression and fear of negative evaluation. Also, women with dependent husbands were found to engage more in emotion-oriented coping strategies rather than problem-focused coping. The reason for engaging in emotion-oriented coping strategies may be attributed to the experience of distress among these women, and the need to alleviate the distressing emotions may be more important for such women than solving problems. Hence, the present study should have also looked at the coping skills of women to help them learn and practice adaptive coping skills. This will further assist them in handling the distressful emotions and feelings in a more appropriate and effective way.

Additionally, a recent systematic review and meta-analysis study also showed that wives of opioid dependent men, when compared to non-dependent men, had an increased risk for experiencing depression and anxiety. Such women also have a higher

risk of having obsessive-compulsive disorder, phobias, paranoid thoughts, psychotic episodes, and social dysfunction (Ramezani, et al., 2024). This study constitutes a novel contribution by looking at the different mental health disorders such women experience apart from depression, anxiety, and stress. Hence, it becomes imperative to assess a wide range of mental health disorders among wives of alcohol and substance-dependent men, especially in a state like Manipur, where the menace of drug and alcohol dependence is one of the highest in the country.

However, the above studies are cross-sectional in nature, and hence it is unsafe to establish a temporal relationship between the husband's alcohol and opioid use and experience of psychopathological symptoms. Nevertheless, the findings highlight the need to address the mental health issues of women with alcoholic or drug-abusing husbands; this will ultimately help in lowering the mental health burden of women in a state like Manipur.

5.2 Distress Tolerance and Wellbeing among Spouses

The findings from the present study suggest that female spouses of alcohol and opioid dependents had significantly lower levels of distress tolerance compared to the control group; results of the t-test revealed that the mean score of distress tolerance was significantly lower among spouses in the case group (43.86) in comparison to the control group (51.61) ($p < 0.005$). Also, binary logistic regression analysis was also conducted, and it was observed that women belonging to the case group had 62.5% fewer chance of having high distress tolerance when compared to the control group ($OR = 0.375$, 95% CI [0.25-0.56]). The reason for women in the case group to have lower distress tolerance may be attributed to the findings documented in existing literatures that lower distress tolerance is significantly correlated with higher psychopathological symptoms (Bernstein et al., 2011; Akbarii et al., (2021). Hence, low distress tolerance among these women could be attributed to the experience of higher levels of psychological distress and elevated levels of depression, anxiety, and stress. Therefore, husbands' dependence is not only associated with higher psychopathology but also lower distress tolerance among women. Hence, it is important that such women get behavioural intervention not only to alleviate the psychopathological symptoms, but also to help them improve their perceived ability

to tolerate distress. Such a module will be effective in the overall improvement of mental health and psychosocial wellbeing among women.

Previous studies have explored the determinants of lower distress; Chowdhury et al., (2018) reported that lower distress tolerance scores were significantly linked to personality factors; conscientiousness and higher levels of neuroticism. However, such factors were not explored in the present study, and hence, no personality factors can be established. It may be helpful to explore the same in future studies to examine the trait factors related with lower distress tolerance among spouses of male substance dependents. Further, exposure to violence was reported to have a significant relationship with lower distress tolerance (Heleniak et al., 2021). In the present study, women in the case group have a higher prevalence of physical and psychological abuse in comparison to the control group, and this may be the reason behind lower distress tolerance among these women. However, more extensive studies should be conducted in this area to draw a valid conclusion. Further, factors such as stressful life events and daily stress were negatively related to distress tolerance (Zhong, Huang, Wang, & Xu, 2023; Macatee et al., 2013). Stressful life events may range from chronic illness, death of near ones, loss of a job, social isolation, domestic violence, etc. Living with alcohol and drug-dependent husbands is considered very stressful, and such women go through daily hardships in different domains of life. For instance, in the study, 78% of wives of alcohol and drug-dependent men were reported to face financial hardships, while more than half (56%) reported having a history of abuse. Such negative experiences of life may have contributed to lower distress tolerance among women in the case group.

Further, it was also observed that the mean score of psychosocial wellbeing was significantly lower among spouses in the case group (45.53) in comparison to women in the control group (48.88). Studies conducted worldwide have reported similar findings; husbands' drug and alcohol use was negatively related with spouses' well-being and quality of life (Balaganeshan & Ragupathy, 2019; Kumari & Prakash, 2017; Bunga et al., 2022).

Wellbeing encompasses the psychological and social functioning of an individual and results from the study established that the majority of women in the case group experienced financial difficulties (78%), decline in participation in social events (62%) and experienced violence (56%). Additionally, majority of such women lacked access to mental health support from hospitals or drug de-addiction centres

(63.5%) and a massive 84% of such women wished to get counseling services to deal with the psycho-social issues related to husbands' dependence. Hence, these could have impacted the well-being of women in the case group.

5.3 Distress Tolerance and Psychopathology

Findings from linear regression analysis showed that distress tolerance had a significant negative correlation with depression ($R=-0.48$), anxiety ($R=-0.53$), and stress ($R=-0.53$). The linear regression model suggests that distress tolerance significantly and negatively predicted depression, anxiety, and stress among women ($p=0.000$). Additionally, it was observed that 23.5% of the variance in depression is explained by distress tolerance. Further, 40.8% and 39.1% of the variance in anxiety and stress, respectively, is predicted by distress tolerance. Previous studies conducted in this area reported similar findings; distress tolerance was reported to negatively predict depression, anxiety, and stress, indicating that lower distress tolerance is linked to psychopathology (Felton et al., 2017; Akbari et al., 2022; Bernstein et al., 2011).

However, in a systematic review study by Leyro et al., (2011), it was highlighted that lower distress tolerance may not necessarily be linked to psychopathology and vice versa. The study further proposes that high distress tolerance may indicate prolonged suffering, which may further lead to maladaptive coping skills and psychopathology. This is especially important for women living with dependent family members, as they developed codependency over time and have a tendency to suppress their own emotions and sufferings while taking the role of major caretakers (Vederhus et al., 2019). Nevertheless, consistent findings over the years have established that distress tolerance is negatively associated with various forms of psychopathology, including anxiety, depression, post-traumatic stress disorder, stress, etc. (Tanguy, Kaur, & Asnaani, 2024; Qi et al., 2019; Bernstein et al., 2011).

5.4 Distress Tolerance and Wellbeing

Results from the present study also suggest that distress tolerance positively predicted psychosocial well-being among women ($R=0.337$). Although the association is weak, the result is statistically significant ($p=0.000$). Previous studies reported similar findings; low distress tolerance is linked to lower quality of life and well-being (Saputra et al., 2024; Azizmohammadi et al., (2019). Additionally, El- Ashry et al.,

(2023) have also reported that improving distress tolerance can promote meaningful change in one's wellbeing. Talebi, Naderi, Bakhtiyarpour, and Safarzadeh (2020) also reported that higher distress tolerance is linked to improved wellbeing and vice versa. The research further suggested that wellbeing training can be made more effective by enhancing distress tolerance among individuals. Hence, it can be established that distress tolerance is an important factor associated with both psychopathology and wellbeing among individuals, and behaviour intervention aimed at alleviating distress and improving overall functioning should incorporate distress tolerance training in the module. This is especially important for women with alcohol and opioid dependent husbands, as their level of distress tolerance is significantly low. Therefore, more exhaustive research should be conducted to explore how a women-centric distress tolerance training can be developed and incorporated into already existing behavioral modules for the treatment of various psychopathological syndromes. This will ultimately help in alleviating distress and improving the psycho-social functioning of women.

5.5 Socio-demographic Factors and Psychological Distress

Results indicated significant factors affecting psychological distress were different for women in the case and control groups. In the present study, factors such as education, district, working status, family income, and use of smokeless tobacco had no relationship with psychological distress.

For the control group, factors such as younger age, religion, and history of abuse were significantly related to psychological distress. Results showed that women belonging to younger age groups experience higher symptoms in comparison to their older counterparts. The highest symptoms of psychological distress were observed among women belonging to the age range of 36-40 years (59.1%), while the oldest age group of 41-45 years had significantly lower symptoms of psychological distress (32.7%). Previous research observed similar findings; younger age groups (ranging from early 20s to 40s) displayed higher symptoms of psychological distress (Kaur et al., 2021; McLaughlin et al., 2007). Women of younger age may have additional burden which can lead to poor mental health outcomes, such as caregiving burden, elevated stress, adjustment issues, work-life balance, etc., hence, there is an urgent need to conduct more in-depth studies to explore the possible factors unique to women of younger age group.

Religious affiliation was also found to have a significant association with psychological distress among women in the control group. Christians (76.5%) and Muslims (58.3%) reported having higher psychological distress when compared to Hindus (38.3%) and women who follow Sanamahism (35.7%). The variation in the experience of psychological distress among these religious groups may be reflective of the socio-cultural differences and religious expectations that could affect the mental health of individuals.

Experience of violence is also significantly associated with psychological distress; women who experience abuse in the family had higher symptoms of psychological distress (77.8%) when compared to women with no such history (36.4%). Other studies also reported similar findings; exposure to violence or abuse significantly predicted psychological distress and other mental health issues among women (Aye et al., 2020 & Hisasue et al., 2020).

Whereas for the case group, fewer years of marriage ($\chi^2 = 6.97, p < 0.05$) and the number of children ($\chi^2 = 15.2, p < 0.05$) emerged to be significant factors affecting psychological distress. Women who were married for less than 5 years (79.4%) and 6-10 years (72.9%) have higher psychological distress when compared to women who were married for longer years. The early years of marriage are accompanied by adjustment issues, financial difficulties, and other married life-related issues, particularly among women (Bradbury et al., 2000), and such factors may be responsible for women having a higher level of psychological distress. Further, number of children also had a significant relationship with psychological distress among women in the case group; 91% of women with no children have high psychological distress. A recent study in India showed that pregnancy-related complications were reported to be the highest in the state of Manipur (Hijam et al., 2025). The inability to bear children is a huge public health issue and is often associated with distress, stigma, and humiliation (Greil et al., 2011). These factors can eventually lead to adverse mental health outcomes among women.

5.6 Socio-demographic Factors, Depression, Anxiety, and Stress

Considering the determinants of depression, anxiety, and stress, chi-square test was applied to explore the socio-demographic characteristics associated with symptoms of depression, anxiety, and stress. Results showed that some significant socio-demographic determinants of depression, anxiety, and stress are common for

women in both the case and control group. However, some significant factors of depression, anxiety, and stress were observed to be different for women in the case and control. Among the various factors studied, only history of abuse had significant relationship with all the three mental health outcomes, i.e., depression, anxiety, and stress. All the above factors have been discussed subsequently.

Women who experienced abuse or violence in the family had a significant relationship with symptoms of depression, anxiety and stress. Among women in the control group, symptoms of depression (66.7%), anxiety (70.4%) and stress (48.1%) was significantly higher among women with a history of abuse ($p < 0.05$). Considering women in the case group, women with history of abuse had significantly higher symptoms of anxiety (64.4%) when compared to women without such a history (39.8%) ($\chi^2 = 11.03, p < 0.05$). Similarly, women with history of abuse had significantly higher symptoms of stress (63.4%) when compared to the other counterparts (47.7%) ($\chi^2 = 4.92, p < 0.05$). However, it was observed that history of abuse did not have any significant association with depression among women in the case group, nevertheless the symptoms of depression was higher among women who experienced abuse (84.8%). Previous studies reported similar findings; Devires et al., (2013) highlighted that exposure to abuse or intimate partner violence predicted symptoms of depression, anxiety, stress, and PTSD. A study conducted in India also confirmed that wives of men with alcohol dependence syndrome with a history of intimate partner violence were more prone to have common mental health disorders (Hudge et al., 2022).

The findings also showed that monthly family income had a significant relationship with symptoms of depression, anxiety and stress among women belonging to the control group ($p < 0.05$). However, in the case group, family income had a significant relationship with symptoms of anxiety, but not with depression and stress. Among women in the control group, it was observed that lower family income (up to 20,000 rupees) had significantly higher symptoms of depression (44.8%), anxiety (51.7%) and stress (26.7%). Financial difficulties is related with hardships in life and research have reported that low socio-economic status significantly predicted adverse mental health issues among women (Kanougiya, Daruwalla & Osrin, 2024). A study by Annajigowda et al., (2016) also highlighted that higher income quintile is negatively associated with symptoms of common mental disorders among women in India. Contrastingly, it was observed that women with higher income in the case group

had higher symptoms of anxiety (82.2%) when compared to women with lower income. High socio-economic status is usually considered a protective factor against mental health issues; however, findings from the present study showed that despite having financial resources, husbands' dependence can cause significant distress among women, irrespective of high socio-economic status.

Age and working status were found to be significant determinants of depression among women in both the case and the control group ($p < 0.05$). In the control group, symptoms of depression was significantly higher among women aged 25-30 years (50%) and 36-40 years (45.5%) ($\chi^2 = 14.14$, $p < 0.05$). Similarly, for women in the case group, women aged 25-30 years experienced significantly higher symptoms of depression ($\chi^2 = 10$, $p < 0.05$). Age was also a significant determinant of symptoms of stress among women in the case group; women belonging to the age group of 25-30 years (60.7%) and 36-40 years (73.6%) had higher symptoms of stress when compared to older age groups. The findings are in line with previous studies conducted in the area of mental health; women of 25-34 years had higher risks of having anxiety and depression (Amin et al., 2025), women under the age of 35 were more affected by anxiety disorders (Remes et al., 2016) and early adulthood in women had higher chance of having depression, which can be exacerbated by life stress, conflicting social roles, employment issues, etc., (Leach et al., 2008). Hence, it becomes imperative to conduct more extensive research to uncover the factors associated with adverse mental health outcomes, which may be unique to younger women.

Additionally, the working status of women was significantly related to depression in both the case and the control group. It was observed that non-working women (86.2 %) had higher symptoms of depression when compared to working women (69.4%) in the case group ($\chi^2 = 7.91$, $p < 0.05$). Similarly, among women in the control group, the symptoms of depression were significantly higher among non-working women (36.4%) when compared to working women (20.5%) ($\chi^2 = 6.19$, $p < 0.05$). Financial independence was reported to be a significant predictor of negative mental health outcomes among women; lack of employment and poor financial resources can lead to reduced self-efficacy and increased dependency, further leading to serious mental health issues (Kuehner, 2003). Yang, Niu, Amin, & Yasin (2024) reported similar findings; mental disorders, particularly depression and anxiety, were positively associated with unemployment. Hence, in terms of depressive symptoms,

lack of financial independence affected women in the case and control groups equally, highlighting the pervasive effect of lack of economic independence on women's mental health.

Further, religion had a significant association with symptoms of depression and anxiety among women in the case group; however, no such relationship was found among women in the control group. Considering depression, Muslims and Christians were significantly observed to have higher symptoms when compared to other religious affiliations ($\chi^2 = 11.01$, $p < 0.05$). Similarly, women belonging to Christian religion were also observed to have significantly higher symptoms of anxiety (72.2%) ($\chi^2 = 24.09$, $p < 0.05$) when compared to the other counterparts. The heightened symptoms of depression and anxiety among these religious groups can be attributed to the socio-cultural differences and religious expectations that could affect the mental health of women.

Some significant socio-demographic factors of depression were exclusive to women in the case group, such as educational level, duration of marriage, place of residence (district), and use of smokeless tobacco. Women with a lower level of education had a significantly higher level of depression when compared to women with higher level of education. Women educated till senior secondary (96%) and secondary level (87.5%) have significantly higher symptoms of depression ($\chi^2 = 25.59$, $p < 0.05$). A study by Debnath Sandooja & Kishore (2023) showed similar findings; women with a low level of education had a higher risk of having depression. In the study, women with a higher level of education had lower depressive symptoms, signifying that education can be a protective factor against women having adverse mental health outcomes. Further, women who were married for 6-15 years had higher symptoms of depression ($\chi^2 = 9.27$, $p < 0.05$) compared to women who were married for longer years. Younger or mid-marriage phase may be accompanied by responsibilities, adjustment issues, reproductive health issues and burden, especially among women, and these factors might have been linked to higher mental health issues. Also, the place of residence was found to be significantly associated with depression; women belonging to districts other than Imphal East and Imphal West had significantly higher symptoms of depression ($\chi^2 = 23.5$, $p < 0.05$). The district 'Others' consists of some remote districts of Manipur, such as Thoubal, Kakching, and Bishnupur. This shows the role of geographical heterogeneity, mostly in relation to access to services, infrastructure, lack of awareness, and poor transport facilities that

can have an impact on women's mental health in Manipur. Furthermore, it was also observed that women who use smokeless tobacco significantly experienced higher symptoms of depression (88.2%) ($\chi^2 = 5.81$, $p < 0.05$). This finding is supported by a recent study conducted in India, where smokeless tobacco consumption was linked to higher odds of having depression (Kiran et al., 2025). This is especially important for female spouses of alcohol and opioid dependents, as they have significantly high levels of depression, anxiety, and stress, and smokeless tobacco use may have been associated with women's effort to alleviate distress and frustration.

5.7 Socio-demographic Factors and Distress Tolerance

Results indicated that distress tolerance was significantly associated with family income ($\chi^2 = 10.16$, $p < .05$), district ($\chi^2 = 10.25$, $p < .05$), and religion ($\chi^2 = 22.59$, $p < .05$) among women in the case group. Women with low monthly income and belonging to certain religious groups, particularly Muslim and Hindu, demonstrated a higher prevalence of low distress tolerance compared to their counterparts.

For women in the control group, family income ($\chi^2 = 7.94$, $p < .05$) and history of violence ($\chi^2 = 11.99$, $p < .05$) had a significant relationship with distress tolerance. Women from higher-income households (above ₹1 lakh) demonstrated higher distress tolerance compared to those from lower-income groups. This may be attributed to the buffering effect of economic stability, which reduces chronic stress and enhances psychological resilience (Chen & Miller, 2012). Recent studies also support this finding, showing that financial security is positively associated with coping resources and psychological well-being, particularly among women in vulnerable contexts (Kuehner, 2023; Amin et al., 2025).

Exposure to violence was found to significantly reduce distress tolerance, with women who had a history of violence reporting higher levels of distress tolerance. This aligns with previous research indicating that interpersonal violence undermines emotion regulation capacities, leading to maladaptive coping and heightened psychological distress (Munoz-Rivas et al., 2021).

5.8 Socio-demographic Factors and Wellbeing

Factors such as age, education, duration of marriage, number of children, and family income were significantly associated with wellbeing among women in the case group.

Psychosocial wellbeing varied significantly across age groups ($\chi^2 = 18.44, p < .05$). Women aged 41–45 years had higher wellbeing compared to younger age groups. Younger women may experience greater adjustment difficulties in marriage, financial instability, and childcare burdens, which may influence their overall wellbeing (Amin et al., 2025). Whereas, older women may develop stronger coping strategies and wider social support networks, leading to better psychological outcomes (Kuehner, 2013). Education was strongly related to psychosocial wellbeing ($\chi^2 = 19.92, p < .05$).

Women with postgraduate or higher education showed higher wellbeing compared to those with secondary or senior secondary education. The protective role of education against mental health issues has been reported (Pal, Parmar & Sharma, 2025) and higher education was found to foster self-efficacy and autonomy, buffering against stressors (Amin et al., 2025). Marriage duration showed a significant relationship with wellbeing ($\chi^2 = 13.05, p < .05$). Women married for 6–10 years had the lowest level of wellbeing when compared to their other counterparts. Financial stress and midlife marital issues have been linked to loneliness, and psychological distress, especially among women (Wickrama & O’Neal, 2021).

Wellbeing also varied significantly with the number of children ($\chi^2 = 11.07, p < .05$); women with two children reported having the highest level of wellbeing. Family income was also found to have a significant association with psychosocial wellbeing ($\chi^2 = 18.24, p < .05$). Women with low monthly income (up to 20,000 rupees) reported having the lowest wellbeing, while those from higher income groups (more than 1 Lakh rupees) reported significantly higher level of wellbeing. Similar to the findings, a previous study reported that financial insecurity has been repeatedly shown to increase vulnerability to depression, anxiety, and reduced quality of life (Pal, Parmar & Sharma, 2025).

For women in the control group, factors such as place of residence (district), religion, and history of violence emerged as significant factors associated with wellbeing. Women belonging to Imphal West district had higher wellbeing when compared to women residing in Imphal East district ($\chi^2 = 8.18, p < .05$). Further,

women following Sanamahism (83.9%) and Hinduism (82.6%) had significantly higher wellbeing when compared to their other counterparts ($\chi^2 = 9.92$, $p < .05$). However, this finding should be taken with caution as the proportion of Muslims and Christians is very small in the study. Nevertheless, the finding showed that religious beliefs and affiliations can either enhance or lower well-being among women.

Further, it was also observed that women with a history of abuse had significantly lower wellbeing ($\chi^2 = 28.77$, $p < .05$). Studies have reported similar findings; women experiencing abuse or intimate partner violence have significantly lower wellbeing and also have higher risks of developing serious mental health disorders in the long run (Devires et al., 2013; Aye et al., 2020 & Hisasue et al., 2020).

5.9 Psychological distress and Psychosocial issues of women in the case group

Spouses of individuals undergoing treatment at RIMS reported a higher prevalence of psychological distress (78.5%) compared to those whose husbands were treated in drug de-addiction centres (63.6%) ($\chi^2 = 5.34$, $p < 0.05$). These findings reflect the differences in treatment settings, support structures, and accessibility of psychosocial interventions. Additionally, women who reported receiving emotional support or motivation experienced significantly greater psychological distress (83.6%) compared to those who did not (63%) ($\chi^2 = 9.43$, $p < 0.05$). This counterintuitive result may suggest that emotional support is more often offered reactively in response to already elevated distress levels.

Duration of dependence and history of relapse did not significantly influence the distress levels, suggesting that the chronicity of dependence alone may not be as impactful as the broader psychosocial factors in shaping women's mental health outcomes. Regarding social participation, most women reported a decline or complete withdrawal from gatherings, indicating the pervasive stigma and social exclusion associated with substance dependence in families.

5.10 Depression, anxiety, stress, and Psycho-social issues of women in the case group

Among women in the case group, significant associations were observed between financial difficulties and depression ($\chi^2 = 4.07$, $p < 0.05$), as well as between emotional support and depression ($\chi^2 = 4.83$, $p < 0.05$). Participants who reported

financial difficulties due to their husband's substance dependence showed higher symptoms of depression (84%) compared to those who did not (70.5%). Financial difficulties caused by husband's dependence showed a significant association with depression, which is consistent with global and Indian literature. Economic strain not only reduces a family's resilience but also exacerbates women's vulnerability to depression and psychological distress (Amin et al., 2025).

Further, women who received emotional support had higher symptoms of depression (89%) than those who did not (76.4%). This unexpected finding implies that emotional support may have been provided as a reaction to an already intensified distress among women. Hence, an effective spousal support system should be developed and incorporated into already existing treatment modules of drug and alcohol dependence in hospitals and drug de-addiction centres.

A significant association was also found between the place of treatment with anxiety ($\chi^2 = 7.60$, $p < 0.05$) and stress ($\chi^2 = 4.54$, $p < 0.05$). Participants whose husbands were receiving treatment at RIMS reported a higher level of anxiety (63.4%) and stress (64.5%) than those whose husbands were treated in drug de-addiction centres. This may be attributed to the variations in treatment environment, accessibility of psychosocial support, and the chronicity of dependence cases typically referred to hospitals. Hence, future research should explore the reason why female spouses of men seeking treatment in hospitals were more prone to having psychopathological symptoms.

5.11 Distress Tolerance, Wellbeing, and Psychosocial issues of Women in the Case Group

Spouses of husbands receiving treatment at drug de-addiction centres (60.1%) were associated with lower distress tolerance compared to those attending at RIMS (84.4%). This may indicate that women whose husbands require specialized de-addiction services experience heightened psychological strain, reflecting the chronic and severe nature of their partner's dependence.

Another important observation is that women who expressed willingness to receive counselling services had significantly lower distress tolerance compared to those who did not ($\chi^2 = 6.86$, $p < 0.05$). This finding may suggest that greater openness to mental health services often emerges in response to heightened distress and decreased ability to tolerate distress. Further, patterns of social participation also

showed a significant association with distress tolerance; women who had totally withdrawn from social gatherings displayed higher distress tolerance (60%) ($\chi^2 = 6.80$, $p < 0.05$). Regarding wellbeing, a significant association was observed with financial difficulties ($\chi^2 = 5.99$, $p < 0.05$). Participants who reported financial difficulties due to their husband's substance dependence had lower psychosocial wellbeing (69.9%) compared to those who did not (50%). The findings is supported by previous studies; greater financial resources were linked to higher wellbeing (Hubbard et al., 2014) and improved quality of life (Mahendru et al., 2022).

CHAPTER- VI

SUMMARY, RECOMMENDATIONS & CONCLUSION

6.1 Summary

The study found that wives of alcohol and opioid dependent men experienced significantly higher levels of psychological distress, depression, anxiety, and stress compared to women with non-dependent husbands. Logistic regression analysis showed that these women were at substantially higher risk for having common mental health disorders, particularly for depression (OR= 11.23, 95% CI [7.02-17.98]) and stress (OR= 7.08, 95% CI [4.40-11.37]).

Distress tolerance was significantly lower among wives of alcohol and opioid dependent men (OR= 0.375, 95% CI [0.25-0.56]), with results indicating that low distress tolerance strongly predicted higher levels of depression ($R=-0.48$), anxiety ($R=-0.53$), and stress ($R=-0.53$), while also being associated with reduced psychosocial wellbeing ($R=0.337$). The majority of women in the case group also reported financial hardships, social withdrawal, and higher rates of abuse, with most expressing a need for counselling support.

History of abuse was commonly observed in both the case and control groups (although the prevalence is much higher in the case group). Hence, religious and community leaders, health care workers, and officials of law-enforcing agencies should be sensitised to the issue as they can play a pivotal role in reducing the prevalence of violence or abuse among women.

Socio-demographic analysis revealed that younger age, shorter duration of marriage, childlessness, lower income (in controls), and history of abuse were significant factors influencing poor mental health outcomes. Interestingly, even women from higher-income households in the case group reported high anxiety, suggesting that husbands' dependence outweighs the protective effect of financial resources.

Overall, the findings highlight the severe psychological burden borne by women with alcohol and opioid dependent husbands in Manipur. This underscores the urgent need for women-centric interventions that address psychopathology, enhance distress tolerance, and improve psychosocial wellbeing.

6.2 Limitations

The present study has certain limitations; being cross-sectional in nature, temporal relationship cannot be established. Women may be experiencing other painful life events and being a quantitative study, those issues were not explored. Since the sample size is small, generalization of the findings may not be safe, however, it highlights the need to conduct more extensive studies in this area, covering all the districts of the state.

6.3 Recommendations

Future research should also focus on employing qualitative research methodology such as in-depth interviews and focus group discussions. Such efforts will uncover other major issues of women associated with husband's dependence and yield a more exhaustive data. Further, from an intervention point of view, it may be helpful to study the coping skills of women and to study the relationship with distress tolerance. This will explore whether high or low distress tolerance is associated with adaptive or maladaptive coping skills and eventually help in developing a tailored, appropriate and effective behavioural intervention module for female spouses. The findings from the study also showed that majority of spouses in the case group wished to receive mental health support, and those few who got, still had very high distress. Hence, it becomes imperative to improvise the mental health services provided in hospitals and drug de-addiction centres. Also, spouse's mental health program should be incorporated in the already existing treatment module for substance dependence, focusing on improving psychopathological symptoms and improving distress tolerance.

6.4 Conclusion

Findings of the study underscore the need to address the core underlying factors associated with psychopathology and reduced psychosocial well-being among women, i.e. husband's alcohol and opioid use, younger age, and exposure to psychological and/or physical abuse. Providing psycho education and community outreach programs through local clubs and women's organisations can be helpful. Also, it is important that wives of drug and alcohol dependents have access to mental health services in

hospitals and drug de-addiction centres to deal with the distress associated with husbands' dependence. Additionally, women should be informed about Tele Manas (free psychiatric tele-consultations), which was launched in Manipur. Ensuring all the above will eventually inculcate help-seeking behaviour among women.

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ANNEXURE

Informed consent form

Study Title: *Assessment of psychological distress, tolerance and well being of female spouses of alcohol and opioid dependents*

Declaration: My name is _____ and

1. I confirm that I have read the Participant Information Sheet for the above study or it has been read out to me and I have had the opportunity to ask questions and understood the same.
2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
3. I understand that my identity will not be revealed in any information released to third parties or published.
4. I agree not to restrict the use of any data or results that arise from this study provided such a use is only for scientific purpose(s).
5. I agree to voluntarily take part in the above study.

.....
Participant's Signature and date

.....
Dated signature of the interviewer
(For researcher)

Assessment of psychological distress, tolerance and well-being of female spouses of alcohol and opioid dependents

Participant Information Sheet

Let me introduce myself, my name is Meena Hijam. I am a doctoral student at the Department of Psychology, Nagaland University, Kohima. I am conducting a research study entitled, “*Assessment of psychological distress, tolerance and well-being of female spouses of alcohol and opioid dependents*”. You are kindly invited to be part of this research.

Rational: Reports of WHO have shown that psychological distress and common mental disorders are more prevalent among women. Among many other factors, husband’s use of alcohol and other drugs have found to be a significant determinant of why women are more prone to mental illness. Manipur has a very high prevalence of alcohol and opioid use disorders and hence the findings of this study will help in exploring the mental health issues experienced by women. Further, it will also help in investigating important areas that need to be targeted while developing appropriate intervention strategies for female spouses.

Objectives: The objective of the study is to assess the psychological distress and the capacity of women to tolerate distressful feelings/emotions. The study will also explore the psychosocial well-being of female spouses. Further, the determinants as well as the relationship between the above-mentioned psychological constructs will also be studied.

Methods: The study is a cross sectional design comprising of female spouses of alcohol and opioid dependents and a control group comprising of female spouses whose husbands are not dependent on alcohol, opioid or any other drugs, except nicotine. Data will be collected from the Department of Psychiatry in RIMS and from various drug- de addiction centers in Manipur. Women in the control group will be purposively selected from the community.

Risks and Benefits: The interview does not involve any major risk. Although there are no other direct benefits to your participation, your answers will provide very important information that will help us understand the mental health status of female spouses. It will also further help in developing appropriate behavioral strategies to help women cope better.

Confidentiality: The interview will be conducted in a private setting. All the information provided by you will be kept confidential. Your name will not be shared with anyone. The only form that will include ‘name’ is the consent form, which will be stored safely and it will not be linked to anywhere else. Although, the summary results or data from this study may be reported/published, your identity will be kept confidential at all times.

Voluntariness: Your participation in this study is entirely voluntary and you may refuse to participate without giving any reasons just now or even during the interview.

Do you have any Questions? Thank you very much

You may also contact: Meena Hijam, Research Scholar, Department of Psychology, Nagaland University, Kohima.

Email ID: meenahijam19@gmail.com

Name of the Supervisor: Dr Thiyam Kiran Singh, Professor, Department of Psychology, Nagaland University, Kohima.

Assessment of psychological distress, tolerance and well-being of female spouses of alcohol and opioid dependents

For Control Group

Records ID

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Household information

State	Manipur									
District	Imphal East:	1								
	Imphal West:	2								
	Bishnupur:	3								
	Thoubal:	4								
	Kakching:	5								
	Others:	6								
	(If Others, please specify)									
Address										
Place of residence	Rural:	1								
	Urban:	2								
Date			/			/	2	0	2	

Section 1: Socio-demographic Profile

Q. No.	Questions & Filters	Coding categories				
1	Age (in completed years)	<table border="1"><tr><td></td><td></td></tr></table>				
2.	Number of children	None: 1 One: 2 Two: 3 Three: 4 Four and above: 5				
3.	Highest education completed	Educated till 8 th standard : 1 Educated till secondary level: 2 Educated till senior secondary level: 3 Graduate : 4 Post graduate and above: 5				
4.	Duration of marriage	<table border="1"><tr><td></td><td></td></tr></table> <table border="1"><tr><td></td><td></td></tr></table> Year (s) Month (s)				
5.	Occupation					

6.	Religion	Meitei: 1 Christian: 2 Muslim: 3 Others: 4 (If others, Specify.....)	
7.	Family monthly income	Amount in rupees (Approx.)	
8.	Do you use any type of smokeless/smoke tobacco (<i>kwa zarda, kom kwa, talab, khaini, paan masala, bidi, cigarettes, etc</i>)?	Yes: 1 No: 2 (If yes, please specify the name/type.....))	
9.	Have you ever experienced any kind of abuse/violence in the family?	Yes: 1 No: 2	
10.	If yes, please choose from the following;	1.Physical abuse: (<i>pushing, slapping, kicking, hair pulling, choking, hitting, shoving, grabbing, causing injuries</i>): (Please tick from the options above)	1
		2.Emotional/Psychological abuse: (<i>excessive shouting/yelling, use of abusive language, humiliation, emotional blackmail, neglect, threats to harm, insulting/blaming, criticizing, social isolation</i>): (Please tick from the options above)	2
		3.Both:	3
11.	Who are the main perpetrators?	1.Husband	1
		2.Mother/Father in laws	2
		3.Other Relatives	3
		(If other relatives, please specify)	
12.	Hardships/challenges experienced in life (in general) makes you;	Stronger/Empowered	1
		Weaker/Demotivated	2
		Can't say	3

Assessment of psychological distress, tolerance and well- being of female spouses of alcohol and opioid dependents

For Case Group

Records ID

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Household information

State	Manipur										
District	Imphal East: 1 Imphal West: 2 Bishnupur: 3 Thoubal: 4 Kakching: 5 Others: 6 (Specify.....)										
Address											
Husband seeking treatment in	JNIMS: 1 RIMS: 2 Drug de- addiction centers/NGOs: 3 (Specify.....)										
Date visited	<table border="1"> <tr> <td></td><td></td><td>/</td><td></td><td></td><td>/</td><td>2</td><td>0</td><td>2</td><td></td> </tr> </table>			/			/	2	0	2	
		/			/	2	0	2			

Section 1: Socio-demographic Profile

Q. No.	Questions & Filters	Coding categories		
1.	Age (in completed years)	<table border="1"> <tr> <td></td> <td></td> </tr> </table>		
2.	Number of children	None: 1 One: 2 Two: 3 Three: 4 Four and above: 5		
3.	Highest education completed	Educated till 8 th standard: 1 Educated till secondary level: 2 Educated till senior secondary level: 3 Graduate: 4 Post graduate and above: 5		
4.	Duration of marriage (in months/years)			
5.	Occupation			
6.	Religion	Meitei: 1 Christian: 2 Muslim: 3 Others: 4 (Specify.....)		
7.	Family monthly income (in rupees)			
8.	Do you use any type of smokeless/smoke tobacco (<i>kwa zarda, kom kwa, talab, khaini, paan masala, bidi, cigarettes, etc</i>)?	Yes: 1 No: 2 (Please specify)		

Section 2: Brief case history

Q. No.	Questions & Filters	Coding categories	
1.	Husband's dependence	Alcohol: 1 Opioid: 2	
2.	Duration of husband's alcohol/opioid dependence (in years/months)		
3.	a) History of relapse?	Yes: 1 No: 2	
	b) If yes, how many times		
4.	Do you experience financial difficulties as a result of your husband's alcohol/opioid dependence?	Yes: 1 No: 2	
5.	Any changes in participating gatherings with relatives/acquaintances/ friends as a result of your husband's alcohol/opioid dependence?	No change : 1 Have declined: 2 Totally cut off: 3	
6.	Do you receive any emotional support/motivation from psychiatrists/ psychologists/ other staffs during your husband's treatment?	Yes: 1 No: 2	
7.	Do you wish to receive counselling services/ talk to professionals to help cope better?	Yes: 1 No: 2	
8.	a) To seek support and understanding, do you often share your experience of living with your alcohol/opioid dependent husband to others?	Yes: 1 No: 2	
	b) If yes, with whom do you share the most?	i Close relatives 1 ii Close friends 2 iii Psychiatrists/ psychologists at the hospital/de-addiction centres 3 iv Others 4 (If others, specify.....)	
9.	Have you ever experienced any kind of abuse/violence in the family?	Yes: 1 No: 2	
10.	If yes, please choose from the following;	1. Physical abuse: (pushing, slapping, kicking, hair pulling, choking, hitting, shoving, grabbing, causing injuries): (Please tick from the options above) 2. Emotional/Psychological abuse: (excessive shouting/yelling, use of abusive language, humiliation, emotional blackmail, neglect, threats to harm, insulting/blaming, criticizing, social isolation): (Please tick from the options above) 3. Both	1 2 3
11.	Who are the main perpetrators?	1. Husband 1 2. Mother/Father -in -laws 2 3. Other Relatives 3 (If other relatives, please specify)	
12.	Hardships/challenges experienced in life (in general) makes you;	Stronger/Empowered 1 Weaker/Demotivated 2 Can't say 3	

K10 Test

These questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been .

1. During the last 30 days, about how often did you feel tired out for no good reason?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

2. During the last 30 days, about how often did you feel nervous?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

4. During the last 30 days, about how often did you feel hopeless?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

5. During the last 30 days, about how often did you feel restless or fidgety?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

6. During the last 30 days, about how often did you feel so restless you could not sit still?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

7. During the last 30 days, about how often did you feel depressed?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

8. During the last 30 days, about how often did you feel that everything was an effort?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

10. During the last 30 days, about how often did you feel worthless?				
1. None of the time	2. A little of the time	3. Some of the time	4. Most of the time	5. All of the time

DASS21

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree or a good part of time
- 3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down (to relax after being tired/ exhausted)	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

Distress Tolerance Scale

Think of times that you feel distressed or upset. Circle the item that best describes your beliefs about feeling distressed or upset. Please answer regarding your feelings of distress 'in general', that is, on the average.

Strongly Disagree	Mildly Disagree	Agree and Disagree Equally	Mildly Agree	Strongly Agree	
1	2	3	4	5	1. Feeling distressed or upset is unbearable to me.
1	2	3	4	5	2. When I feel distressed or upset, all I can think about is how bad I feel.
1	2	3	4	5	3. I can't handle feeling distressed or upset.
1	2	3	4	5	4. My feelings of distress are so intense that they completely take over.
1	2	3	4	5	5. There's nothing worse than feeling distressed or upset.
1	2	3	4	5	6. I can tolerate being distressed or upset as well as most people.
1	2	3	4	5	7. My feelings of distress or being upset are not acceptable
1	2	3	4	5	8. I'll do anything to avoid feeling distressed or upset.
1	2	3	4	5	9. Other people seem to be able to tolerate feeling distressed or upset better than I can.
1	2	3	4	5	10. Being distressed or upset is always a major ordeal for me.
1	2	3	4	5	11. I am ashamed of myself when I feel distressed or upset.
1	2	3	4	5	12. My feelings of distress or being upset scare me.
1	2	3	4	5	13. I'll do anything to stop feeling distressed or upset.
1	2	3	4	5	14. When I feel distressed or upset, I must do something about it immediately.
1	2	3	4	5	15. When I feel distressed or upset, I cannot help but concentrate on how bad the distress actually feels.
Strongly Disagree	Mildly Disagree	Agree and Disagree Equally	Mildly Agree	Strongly Agree	

FLOURISHING SCALE

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Below are 8 statements with which you may agree or disagree. Using the 1–7 scale below, indicate your agreement with each item by indicating that response for each statement.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

_____ I lead a purposeful and meaningful life

_____ My social relationships are supportive and rewarding

_____ I am engaged and interested in my daily activities

_____ I actively contribute to the happiness and well-being of others

_____ I am competent and capable in the activities that are important to me

_____ I am a good person and live a good life

_____ I am optimistic about my future

_____ People respect me



DEPARTMENT OF PSYCHIATRY
REGIONAL INSTITUTE OF MEDICAL SCIENCES, IMPHAL, MANIPUR
(An Autonomous Institute under Ministry of Health & Family Welfare, Govt. of India)

No.05/Psy/R-DC/2021-RIMS: 304

Imphal, the 27th July 2022

To

Dr Thijam Kiran Singh
Associate Professor,
Department of Clinical Psychology
School of Medical and Paramedical Sciences
Mizoram University, A Central University, Aizawl

Subject: Permission to carry out Data Collection and research work of Ms. *Meena Hijam*, Ph.D. Scholar, Dept. of Clinical Psychology, Mizoram University, Aizawl

Sir,

Vide reference to your letter no. Nil dated 27.07.2022 in regard to the above mention subject. It is to inform you that Ms. *Meena Hijam*, Ph.D. Scholar, Dept. of Clinical Psychology, Mizoram University, Aizawl is allowed to carry out *data collection and research work* on the topic - "*Assessment of psychological distress, tolerance, and well-being of female spouses of alcohol and opioid dependents*" in the Department of Psychiatry, Regional Institute of Medical Sciences (RIMS), Imphal w.e.f. 13th August 2022.

She is allowed to carry out her data collection & research work in accordance with the norms & protocols of the Institute.

With regards.

Yours sincerely,

R.K. Lenin Singh
27/07/22
(Dr. R K Lenin Singh)
Professor & Head
Dept. of Psychiatry
RIMS, Imphal
Professor & Head
Department of Psychiatry
Regional Institute of Medical Sciences
Imphal-795004, Manipur

✓ Copy to:

- Ms. *Meena Hijam*, Ph.D. Scholar,
Dept. of Clinical Psychology,
Mizoram University, Aizawl, Mizoram

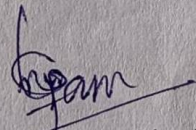
**GOVERNMENT OF MANIPUR
DIRECTORATE OF SOCIAL WELFARE**

To Whom It May Concern

Imphal, the 14th August, 2023

No.9/270/2020-SW (MIS): This is to certify that Ms. Meena Hijam is a doctoral student at the Department of Clinical Psychology, Mizoram University, Aizawl, as per document submitted to this office. She is conducting a research for Ph.D. entitled **“Assessment of psychological distress, tolerance and well-being of female spouses of alcohol and opioid dependents”**. She wishes to collect data from female spouses of males who are undergoing treatment for opioid dependency at drug treatment centres run by NGOs and Department.

You are therefore, requested to extend your kind cooperation in all possible ways without violation of extant norms on client's rights.



(Ngangom Uttam Singh)
Director (Social Welfare)
Manipur .

Copy to:

1. All the Chief Functionaries of Integrated Rehabilitation Centre for Addicts (IRCAs)
2. Project Coordinator Cum vocational Counsellor of Anouba Mangal TRUST Centre, Sunusiphai, Bishnupur.
3. All Chief Functionaries of TRUST Centres, Manipur.
4. Guard Files.