ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY

MARITAL DYNAMICS IN THE FACE OF SERIOUS MENTAL ILLNESS: EXPLORING SPOUSAL EXPERIENCES, ADDIS ABABA, ETHIOPIA: QUALITATIVE STUDY

By: HANNA BEYENE

A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR A MASTER'S DEGREE IN CLINICAL PSYCHOLOGY

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ADVISORS

DR. WUBALEM FEKADU
(wubfek@gmail.com)
DR. ASNAKE LIMENHE
(asnakelimenhe@yahoo.com)

ACRONYMS

AMSH	Amanuel Mental Specialized Hospital
BPD	Bipolar Disorder
IPT	Interpersonal Psychotherapy
MDD	Major Depression Disorder
SHZ	Schizophrenia
SIM	Serious Mental Illness
TASH	Tikur Anbessa Specialized Hospital

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ABSTRACT

Background: Serious mental illnesses (SMI) including schizophrenia, bipolar disorder, and major depressive disorder can severely disrupt marriage. In Ethiopia, limited mental health support and stigma future complicated how couples navigate marriage and stigma further complicate how couples navigate marriage in the face of SMI. While the impact of SMI on marital adjustment is acknowledged in global literature, little is known about how these challenges unfold in the Ethiopian context.

Objectives: The study aimed to explore the marital dynamic and lived experience of couples managing SMI, with particular attention to emotional connection, communication, role functioning, and coping.

Method: A descriptive phenomenological qualitative study was employed. Twelve participants (people with SMI and spouses of people with SMI) were recruited through purposive sampling from Amanuel Mental Specialized Hospital and Tikur Anbessa specialized hospital in Addis Ababa. Data were collected through in-depth semi-structured interviews and analyzed thematically.

Result- three major themes emerged: (1) perception and experience of marriage, (2) emotional and relational life within the marriage, and (3) disruptions caused by the SMI. Spouses reported strained marital adjustment, especially when their partner's low self-efficacy limited emotional reciprocity and role sharing. Challenges included sexual dissatisfaction, parenting strain, financial hardship, and social stigma. Coping strategies ranged from spiritual practice to family role adaptation and efforts to maintain stability for the children.

Conclusion-SMI places significant strain on marital relationships, challenging both emotional and structural aspects of marriage. Interventions should address communication, self-efficacy, and broader support systems to strengthen marital stability in families affected by SMI.

INTRODUCTION

1.1 Background of the study

Marriage is a significant life event that is a cultural necessity and fundamental rights, which can represent social approval, reflect maturity, social status, and increase social support (1–3).

According to sociologists, marriage was defined as 1. ‘Marriage consists of the rules and regulations which define the rights, duties, and privileges of the husband and wife. George A. Lundberg (nd) 2.‘Marriage is more or less a durable connection between male and female, lasting beyond the mere act of propagation till after the birth of the offspring.’—Western Marck 3. ‘Marriage is a contractual agreement which formalizes and stabilizes the social relationship which comprises the family (4,5). Similarly, In Sub-Saharan African societies marriage has been a base that is evolving that is limited to biological and social reproduction which is dynamic and changeable over time. Marriage creates rights and obligations that are mutually accepted or anticipated (6).

According to The Revised Family Code in Ethiopia, ‘’marriage can be established in several ways, including civil, religious, and customary methods. A civil marriage is recognized when a man and woman present themselves to a civil officer and give their consent. Religious marriages are valid if conducted according to the specific rituals of either party's religion. Additionally, customary marriages hold validity when couples follow the traditional rites of their community. Furthermore, marriages that occur outside of Ethiopia are recognized, provided they comply with the laws of the respective location and do not contradict Ethiopian public morals (7)’’.

In the Journal of Abnormal Psychology, it was reported that mental disorders are often linked to marital dissatisfaction, with mental health impacting relationship quality (8,9) thus, Serious mental illness, such as bipolar disorder, schizophrenia, and Serious depression, can severely impair cognitive functions and normal life processes, which may lead to ongoing challenges in

marriage (10,11) These challenges are particularly evident in the marriage, where mental health issues often exacerbate conflicts, leading to disharmony between spouses (4).

Notably, several Studies highlighted the relationship between marriage and mental health can have a reciprocal effect, while many researchers support the benefits like social support, and security, conversely, some pinpoint negative impacts, seeing marriage as a crisis causing a mental illness and stressor for some vulnerable individuals (4,12–15). In certain communities, marriage is perceived as a potential solution to the challenges posed by Serious mental illness, with some believing that marriage can reduce stigma, share caregiving responsibilities, and offer emotional support to individuals with mental health struggles. However, these perceived benefits can often be undermined by the reality of managing mental illness within a marital context (1–3,12–18).

Caregivers often perceive that individuals with Serious mental illnesses can fulfill marital roles and responsibilities (19).However, Individuals with mental illness may often experience dissatisfaction within their marital relationships due to a variety of factors. These can include the avoidance of hospital visits, which may lead to a lack of necessary care and treatment. Non-adherence to prescribed medication can further exacerbate symptoms and affect relationship dynamics. Unemployment, as a result of mental health challenges, may contribute to financial strain and emotional stress. In some cases, long-term inability to marry or maintain a relationship may result from the ongoing effects of the illness. Divorce or separation can also occur as a result of the strain mental health issues place on the relationship. Additionally, ongoing marital conflict, poor communication, and emotional outbursts between spouses can further intensify the dissatisfaction within the marriage (14, 16).

The association between marriage and mental illness is complex. Systematic analyses have shown low marital adjustment in people with mental illness, leading to heightened marital conflict and a higher likelihood of separation and divorce (19–21). Conversely, some studies suggest that romantic relationships can reduce symptoms of mental illness and aid in recovery (22) (17).

Serious mental illness is associated with a higher risk of divorce and disrupted life trajectories, with detrimental effects on marriage and family life. These challenges not only affect the spouses but also have long-lasting impacts on children, leading to a decrease in family stability and overall well-being (2,23–25).

Given the complexities of marriage in the context of severe mental illness, it is essential to explore the expectations of individuals with mental illness and their partners. Understanding these dynamics can contribute to the stability of marriages and family. This study aims to investigate the experiences of individuals with Serious mental illness and their spouses regarding their marital relationships at Amanuel Mental Specialized Hospital (AMSH) and Tikur Anbessa Specialized Hospital (TASH).

1.2 Statement of the problem

Serious mental illness (SMI) is linked to marital dissatisfaction, with the quality of the marriage related to the adult health condition. There is a strong positive correlation between mental health and marital adjustment (26–29). Marital adjustment references how spouses adapt to each other and their new roles and responsibilities, which is a predictor of marital success and satisfaction (30,31).

A multinational study on mental disorders, marriage, and divorce across 19 countries (including India, Nigeria, China, Spain, and Italy) indicated that individuals with SMI face a significantly higher risk of divorce. This risk is influenced by a variety of factors, with the individual's perspective on the marital relationship being a key contributor. One of the most widely suggested factors for promoting recovery among individuals with SMI is addressing their personal needs, particularly in the area of intimate and sexual relationships. (21).

In Ethiopia, spouses of individuals with SMI often experience significant burdens, including emotional neglect, physical abuse, social isolation, and accusations of causing the illness. Women, in particular, face societal pressures that prevent divorce due to cultural norms. The

perception of marriageability and marital success for individuals with SMI is strongly shaped by societal expectations and community perspectives. In the Ethiopian context, for men, marriageability is often based on their ability to provide, and for women, it is largely dependent on their capacity to manage the household. The community generally views individuals with SMI as unreliable and inadequate for marriage, frequently rejecting marriages between individuals with SMI and those without (2).

Furthermore, individuals with SMI are often advised to marry others with similar conditions, based on shared communication styles. This belief can lead to individuals with SMI viewing themselves as unworthy of marriage, which can make it difficult for them to sustain long-term relationships or start their own families (23)(2).

This study aims to expand on existing research by exploring the effects of SMI on marriage, focusing specifically on the subjective experiences of both individuals with SMI and their spouses. It differs from previous studies by considering the experiences of both partners in the marriage, providing a more comprehensive understanding of how SMI affects marital life. This approach was help to uncover challenges and factors that influence the quality of life and treatment outcomes for individuals with SMI within the context of their marriage.

Previous studies have not sufficiently incorporated the perspectives of both individuals with SMI and their spouses on the effects of SMI within the context of marriage. This study seeks to address this gap, providing insights into how individuals with SMI and their spouses perceive their marital relationship and the unique challenges they face.

1.3 Significance of the Study

This study looks at the experiences and perspectives of people with Serious Mental Illness (SMI) and their spouses regarding their marriage at Amanuel Mental Specialized Hospital (AMSH) and Tikur Anbessa Specialized Hospital (TASH) in Ethiopia. SMI can have a significant impact on marriage, affecting emotional closeness, communication, and even sexual relationships. In Ethiopia, nearly 45% of first marriages end in divorce, and mental health issues are one of the

major factors contributing to marital problems. Unfortunately, mental illness is often stigmatized or not fully understood, making it even harder for couples to cope with these challenges. This research aims to explore on how couples living with SMI understand their relationship and how mental illness influences their marriage.

There is very little research that looks at how mental illness affects marriage, especially in Ethiopia, where mental health is often overlooked or misunderstood. Most studies do not focus on the dynamics between mental illness and marriage or the lived experiences of people with SMI and their spouses. This study seeks to fill that gap by exploring the experiences of both partners, looking at how they cope, what needs are unmet, and how they perceive their marriage. Understanding these factors were help us better support couples who are navigating the challenges of living with SMI.

This study is important because it can help improve how we support individuals with SMI and their marriages. By looking at the effects of SMI on emotional intimacy, communication, and sexual life, this research was provide a deeper understanding of the struggles couples face. The findings could help develop more effective, culturally appropriate interventions that take into account the specific needs of couples living with mental illness. These interventions could help reduce divorce rates and improve the stability of marriages, ultimately benefiting families and preventing the negative effects of marital breakdowns on children. By addressing these issues, this study could lead to better support, care, and overall well-being for people with SMI and their spouses.

LITERATURE REVIEW

1.4 Prevalence of SMI Marriage and Divorce

The relationship dynamics of individuals with Serious Mental Illness (SMI) are complex, with significant implications for their well-being. Studies show that romantic relationships are less common among people with SMI, with only 15.12% of this group being married, a rate lower than the general population. Additionally, being in a relationship can have a nuanced impact while it may exacerbate depression symptoms, it has also been shown to reduce psychosis symptoms (22).Gender differences also emerge, with men facing a higher level of stigma in romantic relationships than women (33).

The importance of relationships and social connectedness in the recovery process for people with SMI is well-documented. The low rate of romantic relationships raises concerns about the broader impact of social connections on recovery, making this an area to target for enhancing social and psychological recovery (33).

A 2023 systematic review highlighted regional variations in marriage rates among individuals with SMI. In South India, India, and China, marriage rates for people with SMI ranged from 59% to 70%, significantly higher than the 16% to 27% observed in Western societies, including Sweden (24). Research comparing rural and urban areas in China found that individuals with psychosis in rural areas were more likely to be married (71.3%) compared to their urban counterparts (55%)

Cultural and societal factors play a role in these regional differences. In countries like India and China, strong cultural expectations around family life and marriage contribute to higher marriage rates (24). In contrast, individuals with SMI in Western societies, such as Sweden, may face greater challenges in maintaining relationships due to stigma, healthcare access, and social factors (33). Divorce rates are also high among individuals with SMI.

Studies on individuals with schizophrenia show that many have been married at some point, but maintaining these marriages is difficult. In India, for example, 42% of individuals with schizophrenia who were married eventually divorced, with 70% of divorces occurring within the first two years of marriage (34).

In low- and middle-income countries, individuals with SMI face significant socioeconomic challenges, contributing to both lower marriage rates and higher divorce rates (24). This suggests that while people with SMI may marry, sustaining long-term relationships is challenging, with illness symptoms, stigma, and external stressors undermining marital stability (34).

1.5. Marriage as Solution or Stress

The relationship between marriage and mental health remains complex. Existing literature highlights both positive and negative effects of marriage on mental well-being, with no clear consensus on whether mental illness causes marital problems or vice versa (35–37).

Several studies suggest that marriage can play a role in the recovery of individuals with serious mental illness (SMI), especially when individuals have realistic expectations about marriage's challenges and benefits (17, 32,38). Positive aspects include the sense of belonging, increased social desirability, and a feeling of independence after marriage. Additionally, many individuals report symptom improvement and adjustment to married life within 3 to 6 months of cohabitation. However, marriage can also bring about negative consequences, such as financial stress and rigid gender roles (17, 39). Couples in these situations often employ coping strategies like trust, communication, mutual understanding, and stress avoidance. The decision to have children can also strengthen the relationship (17, 40).

On the other hand, some studies indicate that marriage can trigger relapses and prolong periods of uncontrolled illness. Research also shows that male patients face fewer challenges compared to women, who often experience limited support and may face abandonment from both family and community. Women, in particular, are subject to stigma, as they are expected to marry

regardless of their mental health status. This societal pressure often leads women to conceal their illness, which may contribute to relapse (37).

In low- and middle-income countries, individuals with SMI face significant socioeconomic challenges, including lower marriage rates and higher divorce rates (24). Similarly, In these traditional societies, the chances of marriage or starting a family are lower for individuals with SMI, and women, in particular, may be blamed for the onset of mental illness. Furthermore, these individuals may be vulnerable to violence within their families or communities.

Studies from Ethiopia have explored the intersection of gender, marriage, and SMI, revealing that many individuals with SMI believe marriage can aid in treatment. Marriage is seen as beneficial for women in terms of access to healthcare and reducing the risk of abandonment. For men, marriage is often associated with a productive role in the community. However, self-stigma is prevalent, as many with SMI believe they are unworthy of marriage due to their condition. Culturally, it is accepted that women may cause mental illness if symptoms arise after marriage. Men, in turn, may divorce wives who develop mental illness, while women are expected to care for their husbands, facing social abandonment if they do not. Furthermore, divorced women often face unequal treatment (41).

In summary, in many African countries, the impact of SMI is profoundly challenging, with marriage seen as a means to gain a productive role, economic advantage, and healthcare access. However, negative consequences such as being blamed for causing mental illness, internalized stigma, and social isolation are common. This study aims to explore the subjective experiences of marriage among both genders, seeking to understand the challenges faced by couples and how these challenges impact stability and recovery.

1.6 Marital adjustment and Individuals with SMI

Marital adjustment, an aspect of social wellness (20), refers to the happiness and satisfaction between partners, including emotional and sexual adjustments (42,43) .Research shows that

marital quality significantly affects health outcomes (44)), and dissatisfaction can contribute to mental health issues. This section was review marital adjustment in individuals with serious mental illness (SMI), specifically Schizophrenia, Bipolar disorder, and Depression.

1.6.1 Marriage and Schizophrenia

Marriage requires social skills, but Schizophrenia, which can impair these abilities, is linked to lower marriage rates (45). Individuals with schizophrenia, depression, and bipolar disorder often report poorer marital adjustment than their spouses, with 96% of schizophrenia patients reporting high marital dissatisfaction (46). Wives have a lower quality of life and marital adjustment (47–49).

Studies have identified unmet needs in individuals with schizophrenia, including intimate relationships, sexual expression, and companionship. Recovery efforts should prioritize these key needs, especially relationship intimacy (38).

In conclusion, patients require support to address relationship challenges and fulfill their needs, which can also affect their spouses' quality of life. This study wasexplore the marital challenges faced by individuals with schizophrenia.

1.6.2 Marriage Adjustment and Bipolar Disorder

Studies suggest that individuals with bipolar disorder face high marriage rates but significant challenges in marital adjustment (50), therefore this literature wasreview studies that reflect bipolar impact on the marriage. This section reviews the impact of bipolar disorder on marriage, highlighting that patients with bipolar disorder have the highest divorce and infertility rates. Both patients and their spouses report low marital adjustment, with consistent findings across studies. Sexual satisfaction is also low, and sexual dysfunction is significantly associated with lifetime suicide attempts (51)

Furthermore, the consequences of bipolar disorder include stigmatization, social isolation, insecurity, and low trust, leading to dissatisfaction in sexual life and reduced fertility. Partners without the illness often experience self-sacrifice, caregiving burdens, and emotional and health problems (52).

In conclusion, both patients with bipolar disorder and their spouses face challenges that contribute to the high divorce rate and low marital adjustment. Understanding these challenges, including stressors and coping strategies, may help improve marital stability.'' Research from Africa also indicates that individuals with bipolar disorder experience poor social support, contributing to a lower quality of life (53). Community members are often uncomfortable being close to those with mental illness (25), though no studies specifically address marital adjustment. In sum, social distancing and stigma in sub-Saharan Africa can negatively impact the mental well-being of individuals with bipolar disorder and their marriages (25) .

1.6.3 Marital Adjustment and Major Depression with psychotic

Major depression disorder is highly associated with the marital status of individuals (54). Studies suggested that etiologically marital dissatisfaction can be related to major depression and dissatisfied spouses tend to have more major depression episodes, and almost 30% of MDE were linked with dissatisfaction in the marriage(9).

Consequently, the marriage of the depressed person is highly functionally impaired compared to the person with no depression plus a higher rate of parental history of divorce and separation and family death compared to a person with no depression (55). On the other hand high functional impairment and depression symptoms can be caused by marital conflict (56).

Some studies highlighted gender differences in facing challenges in their marital life, where female respondents were more prone to depression than men (57). Particularly couples who experience a lot of stress tend to have high levels of depression impacting their ability to adjust

and work on their marriage. It was suggested that mental health practitioners should be informed about the marital adjustment of an individual with depression and their spouse to seek intervention (58).

In the same way, studies in Ethiopia associate depression with being not married, having poor social support, and living alone (59). Therefore marital status has an association with depression as a result divorced people have a high chance of getting depressed (60).

In summary, major depression is linked with low marital adjustment in most countries but in Ethiopia depression is linked with divorce and singleness rather than depression in marriage. There is limited information that can be indicated about marriage and depression in Ethiopia. However, this study might reflect some of the challenges faced by individuals with depression and their spouses aim to show their subjective perspective that can fill the knowledge gap.

1.7 Impact of Serious mental illness

1.7.1 Impact of Serious mental illness on marital relationships

Couples reported that SMI negatively affected their relationship; the partner without SMI can be impacted by several factors mainly by stress and caregiver burden and a high chance of experiencing relationship dysfunction and divorce or separation (38). As a result, the adverse impact included change in social role, emotional instability, self-modification, and social distancing (39).

Partners of individuals with SMI experience distress, anger, anxiety, depression, and guilt associated with their partner's condition and severe caregiver stress (61). Similarly, studies pinpoint both partners expressing emotional instability and worsening mental illness which leads to fear in fundamental their lives (62). As a result dissatisfaction with marriage is caused by psychological stress which further strengthens their association (39, 52, and 62).

Behavioral patterns reported by couples include passivity, aggression, avoiding conflict, waiting for affection, isolation, and extreme loneliness (61,63). Consequently, the relationship may lose meaning and fail to meet expectations, including sexual and social needs (61). However, some studies suggest that couples can develop stronger emotional connections, mutual commitment, and good communication. Strategies such as self-directed, partner-directed, and couples-directed actions help manage mental health challenges in relationships (40). Supportive relationships have also been shown to facilitate recovery (17, 26, 38, 64).

In conclusion, while most studies highlight the negative effects of SMI on relationships, others emphasize the importance of recovery strategies and how couples can maintain a healthy relationship despite the challenges.

1.7.2 The Impact of Serious Mental Illness on Sexual Life in Marriage

Sexual issues are common in the general population, but they are slightly more prevalent among individuals with psychiatric conditions. This can lead to sexual insecurity, low self-esteem, unhappiness, and frustration, affecting both the quality of life and relationship functioning (65).

Several studies emphasize that sexual satisfaction plays a crucial role in marital satisfaction (66, 67). Individuals with serious mental illness (SMI) and their partners often experience difficulties in their sexual lives. Spouses of individuals with schizophrenia and recurrent depression report low sexual satisfaction, particularly in schizophrenia, where higher levels of sexual dysfunction correlate with greater dissatisfaction, contributing to poor marital adjustment (67) . Similarly, individuals with SMI report extreme dissatisfaction and unmet needs in terms of intimacy (23,38,68,69).

A systematic review in 2017 indicated that patients with bipolar have the highest divorce rate and infertility rate however bipolar patients and their spouses had low marital adjustment but they also highlighted the inconsistency in the findings regarding marital adjustment. Also, sexual satisfaction was rated low, and sexual dysfunction is significantly associated with lifetime

suicide attempts (59). Similarly, stigmatization led to social isolation, the unpredictability of the nature of the illness led to insecurity, low commitment, trust in each other, uncertainty about the future about their relationship, dissatisfaction with sexual life, and a lower chance of fertility.

The use of typical antipsychotics also affects sexual life for both genders. Men often report erectile and ejaculation dysfunctions, such as difficulty maintaining an erection, delayed ejaculation, and reduced libido, while women report reduced libido, orgasmic dysfunction, menstrual irregularities, and painful intercourse due to vaginal dryness (70). Recent studies consistently show that antipsychotics, particularly second-generation medications, can reduce sexual function, including ejaculation ability, and sexual disinterest is common in individuals on combination therapy (71–74).

In both high-income and low-middle-income countries, individuals with SMI are at a higher risk of engaging in sexual behavior compared to the general population. Factors such as psychiatric symptoms, drug use, social challenges, stigma, and childhood sexual abuse contribute to this increased risk (75–77). Women with SMI are particularly vulnerable to sexual violence within intimate relationships, while men are at greater risk of physical victimization (78).

Studies in Ethiopia have similarly found that individuals with SMI experience higher rates of hospitalization, internal stigma, and poor social support, all of which contribute to risky sexual behavior (91) Additionally, high rates of sexual dysfunction were reported among both men and women with SMI, with marital status, history of relapse, and poor quality of life being linked to sexual dysfunction (80)

1.7.3 The Impact of Serious Mental Illness on Socio-Economic

Serious mental illness (SMI) impacts both individuals with the condition and their families, particularly in low- and middle-income countries where caregivers face significant financial and social burdens (23, 81). These challenges extend to physical health problems, psychological distress, and socio-economic difficulties, such as lower marriage rates, higher divorce rates,

reduced access to food, and higher mortality rates among children due to nutritional deficiencies and poor school performance (23, 24, 81) .

The economic impact of SMI includes treatment costs, the inability to work, caregiving responsibilities, and the costs associated with treatment side effects, suicide, and stigma. People with SMI are disadvantaged in income-generating opportunities due to unemployment, leading to poverty and a substantial decline in wage income. Even after recovery, individuals often struggle with unemployment, income decline, and unmanageable debt, all of which are strongly linked to poor psychological well-being, mental disorders, and suicidal behavior.

Socially, the impact of SMI affects not only the individual but the entire household. Families experience lower marriage rates, higher divorce rates, weakened family structures, and strained family environments (82, 83).This also affects medication adherence, as financial constraints and a lack of understanding about mental illness may lead to misconceptions about care, resulting in poor medication-taking behaviors (84).

In summary, the socio-economic impacts of SMI include short-term issues like divorce, family cohesion problems, and treatment costs, as well as long-term effects such as reduced marriage rates, fewer employment opportunities, and increased food insecurity.

1.8 Theoretical framework

1.8.1 Interpersonal theory (IPT)

The rationale of this theory is that interpersonal relationships are significant for mental health, handling stress, and recovery (85, 86). The relationship between the onset of the disorder and interpersonal problems should be identified, aiming to reduce symptoms by identifying the triggers and potential social support that can help maintain symptoms. IPT was integrated attachment theory believing current interpersonal problems can reflect attachment disruptions, so the IPT 4 focus areas grief, role dispute, role transitions, and interpersonal deficits that focus on

current relations rather than historical origins, it also highlighted the social support can reduce the effects of interpersonal problem like loss or conflict by act as a protective of social connection in times of stress (87). Therefore it was adapted to the context and local culture of Ethiopian (88, 89)

1.8.2 Cognitive Behavioral Couples Theory

This model views Couples who are distressed lack the ability to identify regulate and express intense or negative emotions, are unable to change automatic thoughts, assumptions, interpretations, and standards as well as unaware of their behavior, emotions, thoughts, and feelings have on the relationship they are in(90) therefore couples with unrealistic expectations, dysfunctional attributions, and irrational assumptions can create a stressful situation which can cause negative behavioral interaction patterns, inappropriate or distorted cognitions, and problems with the experience and regulation of emotions(91). To have satisfaction in the relationship understanding life events, family-community factors, and individual behaviors and balancing positive emotions, thoughts, and behaviors is necessary (92)

1.8.3 Role Theory

George Herbert Mead's work in the early 20th century established the foundation for understanding social roles, focusing on how individuals engage through socially organized, reciprocal roles. Socialization involves learning and performing these roles while understanding societal expectations. Discrepancies in role expectations can lead to interpersonal issues and mental health problems (93).

According to Augustine Nwoye in 2006, Theory and Method of Marriage Therapy in
In Contemporary Africa, emphasized the importance of role theory in understanding African marriage dynamics. He argued that cultural expectations shape marriage roles, and using role

theory can help couples resolve conflicts by clarifying their responsibilities and improving communication (94).

A study found that marital satisfaction, stability, and adjustment depend on how well individuals fulfill their roles within the relationship (95). Similarly, a 2022 Ethiopian study highlighted gender roles, unmet expectations, and poor communication as major factors contributing to marital dissatisfaction (96).

In summary, marital adjustment and satisfaction are closely linked to how partners fulfill and understand each other's roles. Communication plays a key role in resolving conflicts. While marriage has been extensively studied sociologically, there is limited exploration from a clinical psychology perspective, particularly regarding mental health within marriage. This study aims to fill that gap.

RESEARCH QUESTIONS

How do individuals with SMI and their partners perceive their marital relationship and what are their experiences within their marriage?

OBJECTIVE

3.1 General objective

To explore the marital dynamics in the face of serious mental illness and spousal experiences, at Amanuel Mental Specialized Hospital (AMSH) and Tikur Anbessa Specialized Hospital (TASH).

3.2 Specific objective

1. To explore how spouses of individuals with SMI perceive their marital relationship, including, needs, satisfaction, emotional intimacy and communication.
2. To identify the specific challenges and stressors faced by both partners
3. To explore the coping strategies partners use to manage the challenges associated with their partner's conditions and marital relationship/maintaining the marital relationship

METHOD

4.1 Study Design

This study was used a phenomenological qualitative research design and an in-depth interviewing method. These designs can capture the essence of participant experiences, which helps in this research to gain deep insights into how individuals perceive (98), in-depth interview allows for semi-structured questions, encouraging participants to express their thoughts and feelings therefore this study design was address the experience of marriage of a person with Serious mental disorders and their partners.

4.2 Study Setting

The study was conducted at two healthcare institutions in Addis Ababa, Ethiopia: Amanuel Mental Specialized Hospital (AMSH) and Tikur Anbessa Specialized Hospital (TASH). AMSH is a key facility in Ethiopia for treating individuals with serious mental illnesses. It primarily serves an inpatient population, providing an ideal setting to explore how serious mental illnesses impact marital relationships. The high volume of outpatient visits at AMSH was also contributed to a diverse sample for the study. In the other hand, TASH the largest public referral hospital in Ethiopia offers specialized mental health care through its psychiatric unit. It serves a broad range of patients, including those with Serious mental disorders. The hospital's high outpatient volume allows for a wider range of cases to be included, enhancing the study's ability to explore the effects of mental illness on marriage.

The combination of AMSH and TASH provides a diverse patient population, ensuring a comprehensive understanding of the challenges faced by individuals with serious mental illness and their spouses in marriage. AMSH's focus on inpatient care and TASH's broad outpatient services allow the study to capture a variety of experiences.

4.3 Study period

The data was collected from April to May 2025

4.4 Study participants

This study involved individuals with serious mental illness, who are receiving care at the psychiatric units at AMSH and TASH, as well as their spouses. Eligible participants was include patients diagnosed with serious mental illnesses who are currently married, receiving outpatient and inpatient care at the designated hospitals, and who are willing to participate and their spouses, also willing to participate. Participants were recruited from the outpatient psychiatric units in these hospitals.

4.4.1 Eligibility criteria

The participants of this study were people with serious mental disorders who are receiving outpatient care at the psychiatric and psychotherapy unit at AMSH and TASH and their spouses. The participants who were included were patients who are diagnosed with serious mental illnesses and their spouses who are currently married.

4.4.2 Inclusion criteria

- Participant must be adults (18 and above)
- Participant who have clinical diagnoses of Serious mental illness and receiving treatment at the psychiatry and psychotherapy unit at
- Participant who are currently married and have been in this relationship for at least 1 or 2 years
- Participant and their spouses who can consent to involvement
- Participant who have only one person with the illness in the relationship

4.4.3 Exclusion criteria

- Participants who are acutely ill

4.5 Sample size and sampling technique

The study was purposely selected the participants considering their progress, diagnosis, age and gender (maximum variation). Though were stop when theoretical information saturation is reached, we plan to involve 12 participants, with the support of hospital staff; potential participants was identified and informed about the study by their treating physicians and healthcare providers. Upon expressing interest, participants were given detailed information about the study procedure, and their informed consent was obtained. The principal investigator was then conduct interviews with the participants who meet the inclusion criteria and provide consent.

4.6 Data collection

The interviews were conducted at AMSH and TASH. Participants were provided with informed consent before the interview. The interviews ware take place in person and was audio-recorded to ensure proper documentation. Basic demographic questions were asked first, including age, sex, education, and marital status. Following this, participants were interviewed one by one and alone to respect their privacy and encourage open communication. The primary data was collected using semi-structured in-depth interviews guided by topic outlines

The topic guides was refined and enhanced using an ongoing process of feedback and adjustment. Questions were worded directly and explanations were given as needed. The interviews was transcribed into Amharic and translated into English. All English translations were compared against the original Amharic transcriptions.

4.7 Data management and analysis

Data analysis was take place concurrently during the data collection period. The interviews were conducted using the Amharic language. The audio records was transcribed and then translated to the English language. The study was employ thematic analysis, following the procedures outlined by Braun and Clarke (2006) (97), to analyze the collected data. Interviews were audio-recorded, transcribed verbatim in Amharic, and cross-checked against the audio recordings for accuracy. Subsequently, the transcripts were translated into English.

Open code software was used for coding and data analysis. Subsequently, the principal investigator was code the respondent's words, phrases, sentences, and notes that was pertinent to the study's topic. The transcripts were not including any reference to identifying features. In papers drawing on the qualitative data, participant quotes was referred to by the identification number and efforts was made to ensure that the individual is not identifiable from the quote. The data was stored securely. Throughout the analysis, the researchers were maintained reflexivity and ensure that the themes are grounded in the participants' experiences and perspectives (97). This rigorous approach was facilitating a comprehensive understanding of the experiences of people with SMI and their spouses in their marriages within the Ethiopian context.

4.8 Ethical considerations

Before initiating the study, ethical clearance was sought from the Department of Psychiatry, College of Health Sciences, Addis Ababa University, and AMSH and TASH. Participants were provided with informed consent, during which a capacity assessment was occur. This assessment aims to evaluate each participant’s ability to understand the information provided about the study, the consequences of their participation, and to make an informed decision. Researchers was use a standardized capacity evaluation tool, The UBACC (University of California San Diego Brief Assessment of Capacity to Consent), to ensure participants' understanding and reasoning.

If a participant reports domestic violence or any kind of abuse within the context of the interview or expresses suicidal or homicidal thoughts, the researcher was assess their immediate risk using a trauma-informed approach, considering cultural sensitivity, while also explaining the limits of confidentiality and mandatory reporting to clinical supervisors at AMSH and TASH. The researcher were prioritized the participant's safety and document any disclosures accurately while referring them to the psychiatric unit. To maintain confidentiality, personal identifiers were omitted from the data, and information was only be accessible to the research team. Audio recordings were securely stored.

To address potential psychological distress related to discussing their marriage, participants was receive psycho-education about their experiences to normalize and destigmatize them. Researchers created a supportive environment during interviews, offering empathy and understanding. Participants were also be taught basic relaxation techniques to help manage distress during or after the interview process. For those experiencing significant mental distress, connections with their healthcare providers was facilitated to ensure appropriate care and support. These measures are in place to minimize potential harm and address any psychological distress that may arise from discussing their experiences within their marriage.

RESULTS

A total of 12 participants took part in the interviews, with seven from TASH and five from ASMH. Among them, eight were male. Seven participants were interviewed after being contacted through their phone numbers and invited along with their spouses. Two were interviewed during their inpatient stay. Two spouses were interviewed while accompanying their partners at the hospital, and one spouse was interviewed during a follow-up visit for her husband and daughter. Three females and one man (patients) and declined to part to participate in the study.

Table 1. Socio-Demographic Characteristic

Parameters	***Person with SMI***	***(n=6)***	***Spouses of person with SMI***	***(n=6)***
Diagnosis	*SHZ*	*1*		*3*
	BPD	*4*		*1*
	MDD	*1*		*2*
S(Male/female)	*Male 4/ female 2*		*Male 4/female 2*	
Mean Age(years)	*40*		*43*	
Education	*No formal education*	*3*		*3*
	Primary school	*2*		*2*
	Secondary school/above	*1*		*1*
Religion	*Muslim*	*4*		*3*
	Protestant	*1*		*2*
	Waaeqeffanna	*1*	*Orthodox*	*1*
Residence	*Addis Ababa*	*3*		*4*
	Outside form AA	*3*		*3*
Duration of illness (years)	*0-5 years*	*2*	*3- 6 years*	*3*
	6- 10 years	*3*	*7- 10 years*	*2*
	11+ years	*1*	*20 + years*	*1*
Duration of marriage	*5- 10 years*	*1*	*5-9 years*	*1*
	11- 20 years	*4*	*10- 19 years*	*4*
	31+ years	*1*	*20+ years*	*1*

BPD: bipolar disorder; MDD: major depressive disorder; SHZ: Schizophrenia

5.1 Perception of Being Married to a Person with SMI

Some participants got married after the onset of the illness, while others experienced the illness after marriage. The experiences and the decisions surrounding the marriage varied between the groups.

One participant reported that he got married to his wife to support her. This was because of his prior education and understanding of how the community often treats individuals with disabilities and mental health conditions, frequently belittling and regarding them as less equal. The spouse also stated that his knowledge and awareness of these issues played a significant role in forming their perspective on marriage.

"*Especially for me, people with mental and physical disabilities; there are people who belittle this kind of people; I've had a lot of education in that area; I wanted to help people like this. Even marrying someone like that, becoming a spouse to someone like that. Yes, that's truly how I feel. For me, this is how they have to be helped. I feel devastated for them, and it really touches me. Why like this? I don't know. I think god heard my desire and gave me someone like that. Even this girl (his wife) I met her by chance. When she openly asked me (to have child), all of education was useful to me.[***Spouse of Person with SHZ, 47, male, 5 years in marriage]**

Others might not have married their partner specifically to offer support, but instead focused on their partner's strength rather than limitations. Participants expressed acceptance of their partner's condition and believed their partner would have done the same if the roles were reversed. Others spouses reflected on the uncertainty of how others might have responded in such a situation.

"In life, you start what you believe is possible, but in the middle, you might grow tired or even begin to hate it. It might work out or not that's how life is. E.g. -No one likes war, but if it happens and you fight well, you're called a hero. That's how I think. I don't look back with regret. Even in the middle of it all i achieved things; that are victory for me. But it's incomplete. Now it feels heavy couldn't finish it, still, form this marriage, I got children and a home, and I was able to feed my family. There were limits to what I could do. I don't regret because I don't know what might've happened if it had been me" **[Spouse of patient with SHZ, 42, female, 16 years in marriage]**

For other spouses, the onset of the illness as sudden, unexpected and difficult to make sense of. They focused less on questioning why it happened and more on how to help and support their ill partner. They viewed this as a test of the marital commitment, emphasizing patience, sacrifice, and shared responsibility. They also reflected on the number of years they had been married and the emotional connection that had developed in the world; relationship they could not abandon, regardless of the illness.

*''When you stay for long in the marriage, you get used to the other person and care about one another. That makes you think beyond the marriage so you sacrifice and hold on to things. Especially in the past two years, she was having a child and was sick; going thought is all that alone is difficult. So it becomes mandatory for partners to stay together and be patient.''***[Spouses of patient with MDD, 50, male, 17 years in marriage]**

Spouses commonly reported a desire to be buried together with their partner due to their advanced age, viewing this as a culturally significant event where the community reflects on the shared journey of the couple. Many spouses emphasized the importance of ending life alongside the person with whom they had spent most of their lives. This long standing connection was described as strengthening their role as caregivers. Spouses mentioned that, because their partners had no other caregivers, they felt uniquely responsible for their care, believing only they could fully understand and support their spouses. This belief was frequently linked to a sense of fate or divine purpose, especially when the illness affected their children.

*"After living with him for so many years, that's enough. Now it's death so from here on, it's just a matter of before and after. And also, our connection was formed in the childhood; we were children when we met. And I would say there's no one else I would leave him for, except myself. He has no sister or brother. No one else would take this kind of responsibility for a person with mental illness unless it's a wife, mother, or father. Fearing God who knows, maybe God gave him to me so I would care for him."[***Spouse of patient with SHZ, 60, female, 40 years in marriage]**

If she gets worse, she will be a witness when God takes us together. Until then I have to take care of her. It is very important that a husband and wife stay together until death. I'm telling you this based on the culture of the community I grew up in. when they (community members) see their death, they will be deeply touched, and they enjoy social life. So in this process, how many

years you lived together will be reflected.'' **[Spouse of patient with BPD, 81, male, 46 years in marriage]**

Participants with SMI did not speak negatively about their spouses or their marriages. Instead, they often described their partner as playing an important role in managing the illness. Participants mentioned that their condition had improved due to their spouse's involvement in daily care, such as helping them take medication, reminding them of appointments, and reducing sources of stress. Others mentioned how their spouses took over responsibilities in the home or helped them fulfill social or parenting roles during times of illness. Emotional support was also central being understood, cared for, encouraged, and given hope, which strengthened the marital relationship.

''His support gave me hope for the illness; he gave me hope and not losing hope from day to day: 'you will get better than this, 'he would say that. He is committed to making sure I don't lose hope. '' **[Person with MDD, 39, Female, 17 Years in marriage]**

"She makes sure I take the medication properly and follow up with my doctor. She also ensures that my money is not wasted. She understands many things well, and for this, I am very happy I got married." **[Person with BPD, 29, male, 6 years in marriage]**

Despite this support, many participants expressed that their deepest fear and a major source of stress during recovery was the possibility that their partner might leave them or seek divorce because they were no longer functional as they had been before the illness. They also worried about who would care for them, whether anyone would understand that they are ill, and believed that having their spouse and her family by their side was essential for recovery. Others described separations or divorces as a major reason their condition could worsen.

'*'For me, I am someone who values marriage. When I get out of here (AMSH in patient), if I can return my marriage to where it was; me, my children, and my marriage will be stable; then I will return to where I was, for sure.''* **[Person with BPD, 47, male, 16 years of marriage]**

''I have this concern that he might leave me. No matter what, I only have him; i have nothing else. I beg Allah that things do not get worse than this.'' **[Person with BPD, 42, 16 years of marriage]**

In contrast, one participant expressed regret about his marriage, feeling unprepared for its responsibilities due to his lifelong illness. While he had agreed to marry, he was not ready financially or emotionally, and his inability to fulfill roles as husband and father caused significant stress for himself, his wife, and their children. Similarly, other participants described marrying under family pressure, with their family hoping that having a spouse would help ensure they received proper care after treatment.

'' I wasn't thinking clearly. I didn't have a balanced thought. What is expected of me? What am I getting into? What responsibilities do I have? What have I prepared for financially, morally? I thought we would live together, but I didn't know how we would manage '' ***[Person with SHZ, 42, male, 16 years in marriage]***

5.2 Experience Of Emotional And Relational Life Within The Marriage

Spouses of people with SMI expressed clear expectations about their partners' roles in fulfilling household responsibilities, including cooking, cleaning and caring for the children. They also emphasized a desire for their spouses to actively participate in social events such as weddings, funerals, and important family matters. Participants wished to be able to play their own roles in their marriage simply "just a husband" and "just a wife" doing what was expected of them based on social and cultural norms. They reflected on how they had taken on both roles over time and expressed a strong emotional disconnection from their own identity, along with a sense of loss in the shared meaning of the marriage.

"… There are place where husbands, men, are supposed to be, like at weddings, at mourning gatherings at funerals, engagement ceremonies, weddings… I go alone and he's not with me that make me feel deeply. Sometimes I convince myself, saying, 'this is nothing,' and then I find the strength." ***[Spouse of person with SHZ, 60, female, 40 years of marriage]***

"I'm a very feminine woman. I want to be loved; I want men to do things for me. I want to be the supporter to care for my husband and manage the household. With everything I have, I want to support his growth. I want him to lead, and for me to follow behind. I've lost that." ***[Spouses of person with SHZ, 42, female, 17 years of marriage]***

Spouses expressed hope that their partners would improve or recover, with the expectation that they would return to their previous level of functioning. Many hoped for a return to life before the illness marked; by a peaceful household, stability, shared time, and a sense of mutual contribution to family life and happiness. Participants focused less on practical contribution and more on their partner's emotional well-being, expressing the hope that their spouse would be happy, healthy, and able to care for their children's psychological needs. All participants saw their partner's improvement as a pathway to relief and rest from long-term caregiving responsibilities.

"For her to recover and finish this treatment and get out, then all of us will be happy with what we have in the house and be united. For her to provide something and manage the house when she handles things, I get a break. You can't handle everything; you can't; so break is needed." **[Spouses of patient with MDD, 50, male, 17 years in marriage]**

In contrast, Spouses with SMI expressed feelings unable to function as they once did because of the illness. They reported a lack of capacity to manage responsibilities due to their condition not being fully under control, inability to handle stress and lack of motivation. They also mentioned that their ability to return to functionality was highly dependent on their partners.

Spouses with SMI reported that their partners felt frustrated with the duration of the treatment and frequently questioned when they would be the discharged so they could return to work. This situation often resulted in high dependency on the spouse, leading to increased frustration and prolonged care-seeking behavior.

"When my wife asks, 'why aren't you discharged yet? Why are they keeping you this long? I tell her it's the nature of the illness. I don't want to leave until they say I'm normal. I told her I want my discharge. My mother says the same because her husband (his father) is here with me, and she might be struggling. So they want me to get discharged quickly so I can return to work."[**Person with BPD, 29, male, 6 years in marriage]**

Participants expressed mixed experiences regarding emotional closeness in their marriages. Some described emotional connection as deeper and more essential than sexual intimacy, highlighting an unmet need to feel loved, supported and emotionally held. Others reported a lack of emotional reciprocity, which left them feeling unseen, neglected and emotionally isolated. Participants reflected on how much they valued emotional intimacy, even as it becomes difficult to maintain over time due to illness or relationship strain.

"*I want to be loved and want to be held very, very much; I seek someone who loves me; I deeply desire to be held; it is something I couldn't control. Love and being loved to be told 'I am here for you' and want something that holds me. I don't want him (my husband) these 2 years, but I want those things from whom and how, I don't know. This, I couldn't control****."*[Spouse of SHZ, 42, female, 16 years in marriage]**

Other spouses perceived emotional intimacy as directly linked to sexual intimacy. They described emotional closeness as a strategy used to initiate a sexual act. This supports the experience of others spouse, who saw emotional intimacy as the bridge between communication and love; where actions like talking about good times and sharing feelings helped create a mutually desired sexual experience.

"*I feel like emotional closeness in marriage is very important. That's the center of it all, following from love and good communication. In conversation, in everything, even in physical body language, it should be emotionally connected. I think emotion to emotion is what matters****."*** ***[Spouse of SHZ, 41, 17 years in marriage*]**

Spouses described emotional intimacy as knowing and doing things that please the other person. They expressed that understanding their partner's needs and providing what they enjoy created a sense of happiness and emotional connection. Emotional closeness came from their spouses showing concern, care, or support in everyday life.

"*I know the things he wants and his feelings. I know what to do, and I know what things to do for what kind of feeling. He likes it very much when he finds me at home, so I get home before him. When I pick up the phone when he calls, he likes that. When I cook and wait for him, he doesn't like it when someone else serves him food, so I serve what I've cooked; he will eat it. It makes him happy****." [Person with BPD, 42, female, 17 years in marriage]***

Spouses described communication both as a means of solving problems and, at times, as a source of conflict. Spouses described frequent and open conversations with their partners, speaking daily and sharing thoughts on many aspects of life. This regular communication helped them feel understood and emotionally connected. Others emphasized that even during times of conflict, communication served as a way to reconnect and work through problems together.

'*'Marriage can be stressful; it's like livelihood. Money shortage, children, social life can disturb you. Things that are not related to us (himself, his wife) can be challenging. How can we move past this? How do we win this? In what way do we defeat this? We have conversations about this thing… if not, it may put you in difficult places.''* ***[Person with BPD, 81, male, 47 years in marriage]***

However, others spouses described avoiding communication as a way to prevent conflict or emotional escalation. Many expressed that sensitive topics led to blame, verbal attacks, or misunderstanding. They avoided difficult conversations out of fear that conflict might trigger or worsen their partner's mental health condition. As a result, they withdrew from conversation entirely, which often led to further misunderstanding and emotional isolation.

*''We don't. It immediately turns into accusation "you say this, you said that"' It becomes a fight. It doesn't remain a discussion… Why would I talk if it just leads to conflict? She doesn't understand me. Talking has no point anymore… I just stay quiet and live…" [***Person with SHZ, 41, 17 years in marriage]**

'' For example, if I say too much, I feel like she'll get hurt or sick. If I see a mistake she made and talk to her, I think she'll get angry, so I just drop it. **[Spouses of person with BPD, 56, 17 years in marriage]**

5.3 Disruptions In Married Life Due To SMI

5.3.1 Sexual difficulties

Spouses reported a range of sexual difficulty. Others described a lack of sexual desire or absence of intercourse for years, while others reported heightened sexual desire that led to forced sexual acts. In others, sexual activity was completely absent. Male participants expressed that a lack of sexual reciprocity and mutual interest could be deeply hurtful. Others also described the difficulty of touching or initiating intimacy with a wife who showed no sexual interest. A few men shared that they had considered taking a second wife but decided against it, because of their children, fear of God, concern that their wife's condition could worsen and their own age.

'*'She would say, I'm tired, and I would do it forcefully. She fears me sometime when it happened repeatedly, she would get exhausted. I don't maybe that's nature.''* ***[Person with BPD, 81, male, 47 years in marriage]***

''You just tolerate it. When a man puts his hand on his wife and she's not happy, his spirits dies… if my wife wanted a solution, she could get me another wife. But if I suggested that, it would cause so many problems much worse things could happen." ***[Spouse of person with BPD, 56, male, 17 years in marriage]***

Similarly, participants reported lack of desire and having no intercourse for years, but also added that their spouse had separated their sleeping arrangements for years. Others reported experiencing insults and emotionally hurtful words for initiating sexual acts. In these cases, the sexual act was seen as a way to stabilize the marriage rather than an emotionally driven act. Afterward, participants reported feeling shame, humiliation and self-hate. Most women reported

that not fulfilling their husband's sexual needs might lead to him getting another wife, which is religiously allowed. Out of fear, they stated that they had intercourse they didn't want or desire, just to make their husbands happy and prevent them from going outside the marriage.

"*Once in a while, even if I'm not happy doing it, it may be necessary. Just to make him happy so he doesn't go outside to someone else. I don't want to open the door for that. I would do it without any feeling or desire.****"*** **[Person with MDD, 39, female, 17 years in marriage]**

"*We stopped having a sexual relationship two years ago... I wasn't doing it out of sexual desire it was just to avoid making things worse between us. There are a lot of hurtful things if i insisted on having sex; it would happen in way that felt disgusting, then I would hate myself****."*** **[Spouse of person SHZ, female, 41, 17 years in marriage]**

Only one participant mentioned strategies that helped him manage these sexual difficulties within his marriage. He mentioned using religious practices to control his desire, having intimate conversations to reassure his desire, being patient, and caring for her emotions. Other individuals stated they had no sexual problems.

''The good thing was when you return to religion and to yourself. Firstly, I fast on Monday and Thursday. When you fast, you control yourself and avoid unnecessary things. Secondly, it's about understanding and seeing the timing of her feelings when and how. Third, if you can get the timing right, you can have sex. The main thing is returning to yourself and to religion… it's still necessary, and I'm somehow trying to reach her feelings meaning because for it to be mutual, that has to happen.'' **[Spouse of MDD, 50, male, 17 years in marriage**

5.3.2. Parenting and surviving as one

Spouses described the strain of raising children while managing the effects of serious mental illness (SMI) in the household. Bringing a partner to the city for treatment often required physical separation from children, which caused distress for both the caregiver and the affected parent. The separation sometimes worsened symptoms and created a painful conflict between caring for a spouse and meeting the needs of children. Others tried to reduce the burden on the ill

partner by temporarily separating her from the child, but this raised concerns about lost attachment.

"*We have been here (ASMH) for the past 2 months. I have seen improvement, but she is still not like before; if she can't get better fast, my child can be influenced. I am losing two things; I don't want to lose her(his wife) and my child who is missing us; I don't know how to sit here; my mind is not right after she (his wife)sees her child through the phone and she gets sick for two days,,,***"** **[Spouse of Person with SHZ, 47, male, 5 years in marriage]**

'' * The child was supposed to be with his mother and breastfed, but because she was sick, he stayed with me and was bottle-fed. I didn't know much about bottle feeding it was new and difficult. I had to take over…. She was afraid the child would lose attachment to her, but we had no choice."* **[Spouse of person with MDD, 50, male, 17 years in marriage]**

Children did not receive the care and support they needed physically or emotionally. Some took on caregiving responsibilities; children took parents to appointments, looking after siblings, and managing household chores. This disrupted their education and development. Spouses described delays in identifying their children's health problems and failing to support their schooling. These reflections were expressed with strong feelings of regret.

"*Because I'm sick, housemaids don't stay long, so my daughter and son had to do all the housework from a young age, baking Injera, cleaning, cooking, and washing clothes. They also missed or stopped their studies to care for younger siblings or take me to the hospitals, especially the older ones, who skipped class for several days*."**[Person with MDD, 39, 17 years of marriage]**

"*My second child repeated a grade twice, and my third had a lazy eye. I only noticed it after 13 years;one of his eyes doesn't see. That really disturbed me. If I had been with him, I would have noticed it earlier, and he would have been treated. They're hyperactive. I've been called from school multiple times. That hurt me. In my life, what I regret most is not being fruitful in raising them.****" [Spouses of person with SHZ, 42, female, 17 years of marriage]***

Children were also a reason spouses stayed together. Divorce was sometimes suggested to reduce the burden on children, but it was avoided after the children showed physical signs of stress.

Parents described difficulty deciding how to protect their children while managing the illness. Others regretted having children due to the impact the illness had on the family. They stated they avoided divorce because the person with SMI could not manage alone, and they feared that the children would suffer more or be placed at risk in the future.

"*The children were affected. I tried to protect them, but it was inevitable. One started grinding her teeth, the other wet the bed. I began drinking, chewing chat, and talking on the phone a lot. If I didn't have kids, I would have stayed and handled his mental health. Raising the kids separately could have helped me, but I'm not sure he could manage alone. If we separate and he fails, the children will witness that and that would be another burden for them.****" [Spouses of person with SHZ, 42, female, 16 years of marriage]**

Spouses described how children became caregivers and household helpers to support the ill parents or assist the well parent. This disrupted both their schooling and emotional growth. Some parents expressed regret. Others said they prepared their children to be strong and self-reliant. Parents coped by trying to build resilience within the family.

"*We shaped our kids to be like us so they could manage on their own and be strong. Everyone took care of themselves and helped around the house. We learned how to handle problems and close the gap. What we've seen is the family itself can solve the problem, that's the most important thing,***'' [Spouse of person with MDD, 50, male, 17 years of marriage]**

An additional participant described a shared sense of loss between spouses where the husband had wanted children, but the wife refused due to concerns about her husband's mental illness. Also she expressed lasting regret.

"*When we were young, we could have children; but I saw his mental health condition, so I was preventing myself from having a child and for this, he (her husband) always blames me. I feel very deeply hurt. I regret this for my entire life. Wish I had children who stand beside me, I always regretted it.***'' [Spouses of person with SHZ, 60, female, 40 years of marriage]**

5.3.3 Economical threat

Spouses described facing general economic hardship. Those with SMI shared that their illness prevented them from working, leaving them financially dependent on their partners.

"I** have never been without money… I used to be good at what I do… but now, that's gone. We don't have money anymore… I ask him (husband) for money… I'm begging… I become a beggar. It's very hard. I used to support him, but now I don't do anything without him knowing… my hands and legs are tied.. I have no moral." [Person with BPD, 42, female, 16 years of marriage]**

Spouses reported difficulty balancing caregiving with work responsibilities. Their partner's dependence limited their ability to earn income, especially when family support was unavailable. Some believed that if family members helped care for their ill partner, they could generate income; however, being the sole caregiver kept them tied to the home and restricted from work. Requests for support from organizations often went unanswered. In some cases, others attempts were made to exploit their vulnerable situation.

"*If I go somewhere for work, I might not find her when I come back because her health is not stable. I asked her family to look after her when I'm away, but they don't want to get involved.***" [Spouse of person with SHZ, 37, male, 5 years of marriage]**

"**I am disappointed by the country and my family. When things got worse, I asked people for help telling them about my husband (person with SHZ for over 25 years) and that I have 4 children. But people in those positions asked for money or sexual favors. They tried to use my failure as an advantage against me.**" [Spouse of person with SHZ, 42, female, 17 years of marriage]

Financial difficulties remain a major challenge for spouses. Participants described strategies to maintain financial balance and prevent worsening strain. A sense of male obligation to manage economic responsibilities led to extra efforts to keep the household afloat.

"*As a man, you can't afford to fall too low financially, so I have to balance things. I try to avoid problems and smooth things out.****"*** **[Spouse of person with MDD, 50, male, 17 years of marriage]**

5.3.4 Navigating community relationship

The relationship spouses had with the community was closely tied to whether they disclosed their partner's condition. Attempts were often made to hide the illness to avoid stigma. At the same time, spouses experienced both difficulties and support from the community related to serious mental illness.

Spouses often kept their partner's condition hidden, even from close family members, including parents and neighbors. Several reasons were given for this. The most common reason was fear of being stigmatized. Others believed that people would not understand them and would view them differently. Another reason was the desire to be seen, treated, and respected as a normal married couple in the community. For some, disclosing the illness felt more like exposing or shaming their spouse rather than simply sharing information. Loss of the hope in the community's ability to provide help was also mentioned.

'' They would stigmatize us… you're the one who is in the fire due to the problem and you're the one suffering, but they would stigmatize you... that I can't carry. No one knows except family. Society doesn't have awareness, so we fear they may stigmatize us, so it's hidden.'' **[Spouses of person with SHZ, 60, female, 40 years of marriage]**

Experiences with community members were mixed, having both positive and negative impacts on marriages. Community views on mental illness played a major role in how marital relationships were managed. Common community attitudes included suggestions to separate based on beliefs that people with serious mental illness are dangerous, sexually incapable unproductive, untreatable, spiritually cursed, or unable to have children. These views reinforced hiding the illness and loss of hope in the community.

"They would say to her, '' how can you live with someone who eats his hair, who talks nonstop? They told her, ''you have children go live with them. Don't suffer with him. He won't live long,

he's going to die.'' She used to tell me these things when I get better." **[Person with BPD, 81, male, 47 years in marriage]**

"Why are you married to someone so ill and disabled? She's an Amanuel user… how can you be with her?'' they said. '' you should marry someone who can work like you, who can support you.'' This came from close friends and even my family. I told them, 'This doesn't concern you. If you think like that, stay away from me… if it were up to them, we wouldn't still be together." **[Spouse of Person with SHZ, 47, male, 5 years in marriage]**

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In contrast, support was reported from community members who understood the situation. This included emotional encouragement, financial help, and advice. Flexibility at work or time off to care for an ill spouse was also described as helpful.

''Many men, women. And elders told us we should stay together. They said, ''he's the father of your children he gave you a good life, no one lived like you. If you leave him just because he's ill, it's a sin.' That's what people would say.'' **[Person with BPD, 81, male, 47 years in marriage]**

DISCUSSION

This study explored how marital dynamics are shaped by SMI, based on the lived experiences of both people with SMI and their spouses. For most, the illness became central to the marriage, reinforcing patterns of dependency and affecting the ill partner's sense of self-efficacy. Spouses often made major life adaptations, taking on more responsibilities and emotional caregiving in hopes that their partner would return to their previous level of functioning. What helped couples endure these challenges was their mutual commitment and emotional bond. Unlike many earlier studies, this research includes interviews with both people with SMI and their spouses, across diverse backgrounds. This provided insight into how marital relationships are maintained across variations in illness onset, duration of marriage, and age.

One of the findings was that marriage played a supportive role in managing illness. Spouses were actively involved in medication reminders, attending appointments, reducing stress, and providing emotional encouragement. People with SMI feared divorce or abandonment, viewing marriage as both emotional support and a practical aid for recovery and stability. These findings align with previous qualitative studies (17,32,40), including research in Ethiopian and other contexts. Overall, both spouses and individuals with SMI remained committed to the relationship, driven by different expectations; spouses hoped for recovery and return to functionality, while individuals with SMI relied on the marriage for ongoing care and a sense of self-efficacy.

This study found that marital adjustment was a major challenge for couples, particularly in maintaining a stable and satisfying marriage over time. Spouses of people with SMI often emphasized the unmet need for role fulfillment within the marriage. Those who were not ill expressed a longing to simply be themselves in their expected role as husbands or wives, rather than constantly compensating for the changes. At the same time participants with SMI described the difficulty of meeting these expectations. They often felt unable to fulfill their roles due to the unpredictable nature of their condition, emotional fatigue, and limited stress tolerance. Some expressed that their ability to recover and resume their role was strongly dependent on their partner's ongoing support.

This finding is consistent with prior research (76, 47, 49), which reported that SMI leads to poor marital adjustment, high dissatisfaction, and reduced the quality of life. Spouses often felt stuck in a caregiving role and experienced unhappiness due to loss of shared identity, romantic connection, and day-to-day marital life. The impact of SMI often shifted the spouses who were not ill into a caregiver role, to the point that the sense of marital partnership was weakened or lost.

Building on the desire for role fulfillment, all spouses highlighted the emotional strain that came with prolonged caregiving and unmet emotional needs within the marriage. Emotional closeness, including feeling loved, understood, and supported; was often seen just as important, if not more so, than practical contributions. However, maintaining this closeness become increasingly difficult as the illness progressed. Spouses without illness shared a sense of emotional isolation and disappointment, often feeling that their partner was no longer able to meet them emotionally. At the same time, people with SMI reported emotional fatigue, low motivation, and limited stress tolerance, making it hard to reciprocate.

Emotional disconnection further complicated couple's ability to adjust and sustain a satisfying relationship. Marital adjustment was weakened by unmet intimacy needs in people with SMI (38,58), while their partners often faced emotional neglect within marriage (52,59,60). These dynamics reinforce the gap between emotional needs and capacity in the relationship, making it harder for both partners to experience a sense of closeness and stability.

Sexual difficulties were commonly reported by both individuals with SMI and their spouses. Participants described a lack of sexual desire, long periods without intercourse, and emotionally painful responses to sexual advances. Women engaged in unwanted sex out of fear that their husband might seek another wife, while some men experienced hurt when intimacy was rejected or absent. In a few cases, partners slept in separated spaces for years, and sexual activity became a duty rather than an expression of closeness. Participants described specific coping strategies, such as religious restraint, emotional reassurance, intimacy conversations, abstinence, and patience, which were used to manage sexual challenges within the marriage.

These findings are similar to previous research showing that sexual dissatisfaction is widespread among people with SMI, with contributing factor including medication side effects, stigma and emotional disconnection (23,66,74). Prior studies have also highlighted gendered experienced such as women's vulnerability to coercion and men's distress from rejection and the emotional cost of unmet intimacy needs. In this study, coping strategies were often shaped by silence, fear, or separation, especially among women.

This study found that SMI placed significant strain on parenting roles and family dynamics. Spouses often described being torn between caring for the ill partner and raising children. The impact led to distress, separation from children during acute stage of the illness, and feeling of guilt over unmet needs. The long term impact included children becoming caregivers themselves. managing household responsibilities, missing school or sacrificing their own development to help sustain the family. Parents in these situations expressed deep regret about the quality of care they were able to provide and worry about their children's future, while others described long term sadness about having or not having children under such circumstances.

Despite these challenges, some families developed coping strategies, including intentionally raising their children to be strong and independent, assigning household roles, or giving children to family members. Spouses considered divorce to prevent their children from the impact of SMI. However, they chose to stay in marriage to raise their children with both parents present and out of concern that separation would cause future harm. These family-level responses point to a form of shared adaption, where emotional resilience and practical responsibility were distributed across members.

These findings align with previous research showing that children of parents with SMI often assume caregiving roles, participate in farm work or income generation, and experienced disruption in schooling, including frequent absenteeism or dropping out altogether (23, 50, 51). The burden is often more severe in low- income setting where formal social support is lacking (3). Consistent with prior studies, this research found that the caregiving burden is gendered. Women, in particular, may feel trapped in marriage due to the cultural acceptability of divorce

for men, which can intensify their emotional and parenting strain (50). However, this study also highlights early independence in children and aspects of family unity less frequently addressed in the existing literature. These findings highlight the importance of family oriented mental health service, educational supports for children in caregiving roles, and parenting intervention that address both emotional and practical burden in the households affected by SMI.

Spouses of individuals with SMI faced ongoing economic hardship, often intensified by the caregiving role. The findings highlighted that the partner's inability to work placed the financial burden solely on them. This limited their capacity to engage in income-generating activities, especially in the absence of external or family support. Being tied to the home as the sole caregiver created a double strain; emotional and financial. Others faced rejection or exploitation when seeking help from institutions or community. Despite these difficulties, coping strategies were used, such as carefully managing financial stress, taking on extra responsibilities, or fulfilling the culturally expected male provider role. Participants also received support from work or extended family members.

These findings are consistent with studies showing that families affected by SMI, particularly in low-income settings, face serious financial challenges linked to unemployment, caregiving demands, and stigma (23, 81, 82). Prior literature also noted broader effects such as reduced access to food, increased child mortality, poor school performance, and weakened family cohesion (24, 83). While economic pressure was widely reported in both previous research and the current study, participants in this context emphasized their lack of formal support and emotional toll of maintaining constant financial and household stability (84).

Community relationships strongly shaped the couples' experience. Spouses avoided disclosing the illness, even to family, due to fear of stigma, shame, or being treated differently. Community attitudes that view people with SMI as dangerous, unfit, or cursed discourages disclosure and deepened feelings of isolation. Spouses faced pressure to divorce while others struggled with being perceived as failing in traditional marital roles. Although some found emotional support, others felt that meaningful help was unavailable.

This reluctance to disclose aligns with other studies showing that stigma can lead to social withdrawal and limited access to both formal and informal resources (23, 50). However, this study adds the non-disclosure was not only a response to stigma but also a coping strategy to protect the marriage and preserve social status. Similarly, while therapy was recognized as potentially helpful, participants viewed financial and caregiving constraints as more immediate concerns. These findings point to the need for integrated community-based services that address both relational and economic needs and that are accessible, low- stigma, and sensitive to its impact of stigma.

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LIMITATIONS

This study of the study limitation; First, although participants were in Addis Ababa (AMSH and TASH), which serve both urban and rural populations, the sample size was small and may not fully reflect the diversity of marital experience across region and relationship types. There was also gender imbalanced, with more male spouses and more male patients with SMI represented. This may have shaped which theme came through more strongly, particularly around caregiving and household responsibility. In addition, some eligible participants especially women chose not to participate, like due to the sensitive nature of the interviews. Finally, because the study explored personal topics such as mental illness, sexuality, and marital challenged, some participants may have withheld information or shaped their responses to be socially accepted. Despite these limitations, they study offers valuable insight into how couples experience and managed serious mental illness within marriage in the Ethiopian context.

CONCLUSION

This study explored the marital dynamic and spousal experiences in the context of SMI. Across economical, relational, and caregiving domains, spouses described high level of emotional burden, role strain, and relational disruption. Sexual dissatisfactions, parenting challenges, financial hardship, and social isolation were recurrent themes. Despites theses pressure, spouses demonstrated various coping strategies such as emotional restraint, family adaption, selective disclosure to preserve the marriage and maintain the household stability. However, spouses most did so with minimal external support. These finding underscore the need for cultural grounded and family oriented interventions that address both the emotional and practical realities of living with SMI in marriage.

RECOMMENDATION

Based on the findings of the study, it is evident that SMI has impacts on marital dynamic, emotional well-being, and household function. Spouses other carry significant emotional, practical, and financial burdens with limited support. The following recommendations aim to inform clinical practice and community support.

1. Support marital adjustment and self- efficacy in clinical practice – mental health professional should actively support individuals with SMI in building self-efficacy within their martial roles. This includes fostering a sense of emotional responsibility, relational capacity, and practical contribution to family life. Couples may benefit from therapeutic support that improved communicational, stress managing, and emotional connection. Including souses in clinical care thought joint consultations or psycho educational can help identifying unmet needs and promotes shared coping with the relationship.

2. Address the economical strain- spouses providing care often face reduced opportunities for income generation due to full-time caregiving demands. Financial and livelihood interventions such as targeted assistance, flexible income generation programs, and collaboration with local organization can help ease the household burden. Emotional support is essential not only for family stability but also for sustaining ongoing mental care and treatment adherence.

3. Address stigma- stigma and fear of negative judgment prevent many spouses from disclosing the illness even to close family members. Awareness organization, community education, and engagement of religion and local leaders can help shift harmful belief about SMI. Creating safe environments for disclosure can reduce isolation and increased access to social and practical support. Health providers should be sensitive to these concerns and support families in navigating disclosure in culturally appropriate ways.

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APPENDIX

Annex I

Capacity to consent to the study

Potential Participant Name: _____ Date: _____

The UBACC (University of California San Diego Brief Assessment of Capacity to Consent) is a tool designed to assess an individual's capacity to provide informed consent. Here's a list of the UBACC items:

Understanding

- Understanding the purpose of the study.
- Understanding the risks and benefits of participating.
- Understanding that participation is voluntary.

Appreciation

- Appreciating that there are alternatives to participation.
- Appreciating the implications of participation (e.g., financial costs, time commitment).

Reasoning

- Reasoning about the information provided (e.g., weighing risks and benefits).
- Demonstrating a logical thought process.

Expressing a Choice

- Clearly stating a choice to participate or not participate.
- Providing reasons for the choice made.

Each item is typically scored on a scale, often from 0 to 2, with higher scores indicating better capacity to consent.

Assessment Items:

1. Does the individual understand he/she would be participating in research and that research is voluntary?

   Yes No

2. Does the individual understand what washappen to him/her if he/she decides to participate?

   Yes No

3. Does the individual know how long he/she was in the research study?

   Yes No

4. Can the individual explain one or two risks associated with the research study?

   Yes No

5. Can the individual explain what he/she should do to stop being in this research study?

   Yes No

6. Does the individual know who to contact if he/she experiences problems or has questions about the study?

   Yes No

7. Interventional studies: Can the individual explain what alternatives there are if he/she chooses not to participate?

   Yes No

INVESTIGATOR EVALUATION:

1. Does the individual express a choice about whether or not to participate?

   Yes No

2. Does the individual have the decision-making capacity to give informed consent for this study?

   Yes No

Annex II

Informed Consent

My name is Hanna Beyene. I am a second-year clinical psychology trainee at Addis Ababa University. I am conducting a research titled "marital dynamics in the face of severe mental illness: exploring spousal experiences at Amanuel mental specialized hospital and Tikur Anbessa specialized hospital at Addis Ababa, Ethiopia."

You are invited to participate in a research study about you and your spouse's experiences in your marriage during the illness.

Purpose of the Study: The purpose of this study is to explore the experience and perspective of individuals with serious mental illness and their spouses in marriage among patient at Amanuel Mental Specialized Hospital and Tikur Anbessa Specialized Hospital in Addis Ababa Ethiopia. I was asked you questions about your subjective experience regarding the illness and your marriage.

Procedures: If you agree to participate, you was interviewed briefly. The interview was asked you about the challenges and stressors in your marriage due to the illness, and your perspective on your marriage. The interview was take approximately 50 to 60 minutes to.

Benefits of Participation: There are no direct benefits to participating in this study. However, your participation may help us gain a deeper understanding of individuals with serious mental illness and their spouse's experiences and perspective on marriage. This knowledge can empower individuals by validating their experiences and fostering a sense of understanding. Additionally, the research can identify culturally relevant coping mechanisms that individuals utilize to manage these phenomena.

The findings can directly inform the development of culturally sensitive interventions tailored to the specific needs of individuals experiencing serious mental illness in Ethiopia.

Risks of Participation: There are no known risks associated with participating in this study. However, some people may feel uncomfortable answering questions about their experiences about the illness in their marriage.

Confidentiality: All information collected in this study was kept confidential. Your name was not be used in any reports or publications. Only the principal investigator and the research team were access to your data.

Right to Withdraw: You have the right to withdraw from this study at any time without penalty. If you decide to withdraw, you can simply stop participating and no further data was collected from you.

Voluntary Participation: Your participation in this study is voluntary. You are free to choose whether or not to participate. If you choose to participate, you can withdraw at any time without penalty.

If you agree to participate, you were asked to have an interview. The interview was explored about your Experiences with the illness in your marriage. The interview was approximately taken 50 to 60 minutes to complete.

Before participating in this study, the necessary information concerning the study that is the purpose of the research, procedures, risk and/or discomforts with their solutions, benefits, privacy and confidentiality, and freedom to withdraw is provided for me in a well-organized way.

Name_____Signature_____

Witness_____signature_____

Principal Investigator: Hanna Beyene

Advisors: Dr. Wubalem Fekadu

Dr. Asnake Limenhe

Phone – (+251)936993646

Email- hannabeyene12721@gmail.com

Address of Department of Psychiatry clinical psychology program, Addis Ababa University:

Phone- (+251)118962052

If you are willing to participate in the study, you was given a copy of the information sheet and you was asked to sign an informed consent form.

Annex III

Informed Consent Form

I have read and received information and understood the information provided about the research, procedure, risks, benefits and that participating in the research wasnot affect my treatment at this hospital. I am informed that an audio was recorded during the interview and that the researcher wasensure my confidentiality. I consent to participate voluntarily in the research of marital dynamics in the face of severe mental illness: exploring spousal experiences receiving care in this hospital.

Participant's Signature _____ Date _____

Annex IV

Interview Guide

For The Individual with SMI

Date: _____

Identification Number: _____

Thank you for agreeing to participate in this study.

Demographic Information:

- Age: _____
- Sex: _____ (Male/Female)
- Residence: _____ (Urban/Rural)
- Religion: _____
- Marital duration: _____ (how many years in marriage)
- Educational Status: _____ (Highest level of education completed)
- Occupation: _____ (Current or most recent occupation)

Clinical Information:

- Diagnosis: _____ (Specific diagnosis related to severe mental illness)
- Site of Treatment: _____ (Facility name and type)
- Treatment Modality: _____ (All current treatment approaches)
- Treatment Duration: _____ (Total time in current treatment)
- Current State: _____ (In remission/Partial remission/Acute state)
- Duration of Illness: _____ (Total time experiencing serious mental illness)

Readiness/Willingness

- How willing were you to get married when you did?
    - Did your mental health condition influence your decision?

- Were you worried you won't be able to get married?

- How ready do you think you were to be married? Considering your mental health condition at the time?
  - Were there aspects of marriage you felt ready?
  - Were there aspects of marriage you felt less ready?
- What are your thoughts on the decision to get married at that time, considering your mental health condition?
  - Looking back, how do you feel about that decision?

➢ When you got married and decided to stay in the marriage, did you experience any pressure from family or society to marry or stay married?

- How did your mental health affect that family and social pressure?
- What are your feelings about staying in the marriage?

Perceptions of marital relationship

- Can marriage be a cure or solution for your mental illness?
- Can marriage help improve your mental health?
- Can marriage worsen your mental illness?
- What makes your marriage unique compared to others?
- What are your thoughts on seeking professional help for your marriage?

Needs and Expectations

- What do you need from your marriage?
- What are your expectations regarding the relationship?
- Can you identify any unmet needs you have in your marriage?
- How important are these unmet needs to you?

Emotional Intimacy

- How do you view emotional intimacy in your marriage?
- How do you express emotional intimacy with your partner?
- How would you describe your emotional connection to your partner?

Communication

- How do you communicate with your partner?
- Do you feel understood by them?
- Are you able to express your concerns openly?

Challenges and Coping

- Have you faced any challenges in your marriage related to SMI? If so, could you list them?
- Are there challenges related to interpersonal relationships, social interactions, sexual issues, financial problems, or raising children?
- How did you cope with these challenges? Were there any aspects that felt unmanageable?
- Do you think these challenges have affected your role as a husband or wife?
    - How have they impacted your responsibilities in the marriage?
    - If yes, can you explain how?
    - If no, can you say why not?
    - How do you perceive the balance of support and responsibility in your marriage?
    - How do you view the overall impact of these challenges on your spouse?
        - Are you worried about your marriage?
        - Do you think you need professional help?

For the partner/without SIM

Date:_____

Identification Number:_____

Thank you for agreeing to participate in this study.

Demographic Information:

- Age: _____
- Sex: _____ (Male/Female)
- Residence: _____ (Urban/Rural)
- Religion: _____
- Marital duration: _____ (how many years in marriage)
- Educational Status: _____ (Highest level of education completed)
- Occupation: _____ (Current or most recent occupation)

Readiness/Willingness

- When did you become aware of mental health condition your partner was facing?
    - Did that affect your feelings about the marriage?
- Knowing what you know now, what are your thoughts on the decision to marry someone with SMI?
    - Looking back, how do you feel about that decision?
- Did you experience any pressure from family or society to marry or stay in the marriage?
    - How did that pressure affect your decision and your feelings about staying married?

Perceptions of marital relationship

- What do you think about being married to someone with Serious Mental Illness (SMI)?
- How do you feel about your partner's mental health challenges?
- How do you perceive the balance of support and responsibility in your marriage?
- What are your thoughts on seeking professional help for your marriage?

Needs and Expectations

- What do you need from your marriage?
- What are your expectations regarding the relationship?
- Can you identify any unmet needs you have in your marriage?
- How important are these unmet needs to you?

Emotional Intimacy

- How do you view emotional intimacy in your marriage?
- How do you express emotional intimacy with your partner?

Communication

- How do you communicate with your partner?
- Do you feel understood by them?
- Are you able to express your concerns openly?

Challenges and Coping

- What specific challenges have you encountered in your marriage due to your spouse's Serious Mental Illness (SMI)?
- Can you share any particular difficulties you've faced in your relationship related to their SMI?

- Have you experienced challenges in areas such as social interactions, intimacy, financial responsibilities, or parenting?
- What strategies or coping mechanisms have you found helpful in managing these challenges? Were there any aspects that felt especially overwhelming?
- Do you believe that these challenges have influenced your role as a wife or husband?
    - In what ways have they impacted your responsibilities in the marriage?
    - If they have, could you explain how?
    - If not, why do you think that is?
- How do you perceive the overall impact of these challenges on yourself?
    - Are you worried about your marriage?
    - Do you think you need professional help?

የመረጃ ቅጽ (ለተሳታፊዎች)

ጤና ይስጥልኝ፤ እኔ ሐና በየነ እባላለሁ። በአዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የሁለተኛ አመት የስነ-ልቦና ህክምና (Clinical Psychology) ሰልጣኝ ነኝ። እንደ ስልጠናው አንድ አካል በአማኑኤል የአዕምሮ ህክምና ሆስፒታል እና በጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል በክትትል ላይ ያሉ ከፍተኛ የአዕምሮ ሕመም ታካሚዎች የትዳራቸውን ሁኔታና አመለካከት ለመዳሰስ ታስቦ የተዘጋጀ መጠይቅ ነው።

አላማ ፡- የዚህ ጥናት ዓላማ ህሙማን እና የትዳር አጋራቸው በትዳር ላይ ያላቸውን ልምድና የትዳር እይታ በመዳሰስ፤ የአዕምሮ ሕመም ትዳር ላይ ያለውን ገጽታ ለመረዳት የሚያስችል ጥናት ነው። ስለሆነም እርስዎም በዚህ ጥናት በመሳተፍ ከፍተኛ የአዕምሮ ሕመም ጥናት ላይ የበኩልዎን አስተዋጽኦ ያደርጋሉ።

ሂደቶች፡ በዚህ ጥናት ከተስማሙ ስለ ከፍተኛ የአዕምሮ ሕመም ታካሚዎችና የትዳራቸው ሁኔታ ላይ በተያያዘ ከ 50-55 ደቂቃ የሚፈጅ ቃለ-ምልልስ እናደርጋለን።

የተሳትፎ ጥቅም ፡- ይህ ጥናት ለአንተ/ች ቀጥተኛ የሆነ ጥቅም ላይኖረው ይችላል። ነገር ግን በከፍተኛ የአዕምሮ ሕመም ታካሚዎች የትዳራቸው ውስጥ የሚያሳልፉትን የሕይወት ገጽታ በጥልቀት ለመረዳትና በዚህ ዙሪያ ለሚሰሩ ጥናቶች እንደግብዓት ያገለግላል።

በፈቃደኝነት ላይ የተመሰረተ ተሳትፎ፡- ለዚህ ጥናት ከተመረጡ፤ በፍቃደኝነት ላይ የተመሰረተ የስምምነት ቅጽ እንዲሞሉ ይጠየቃሉ። በዚህ ጥናት ውስጥ ያለዎት ተሳትፎ በፈቃደኝነት ነው። ለመሳተፍ ወይም ላለመሳተፍ የመምረጥ ነፃነት አለዎት። በጥናቱ ላለመሳተፍ ከወሰኑ፤ መረጃ በምንሰበስብበት ወቅት ራስዎን ከጥናቱ ማግለል ይችላሉ። በዚህም ምክንያት በእርስዎ ላይ ምንም አሉታዊ ተጽዕኖ አይኖረውም።

የጥናቱ አደጋዎች ፡- በዚህ ጥናት ውስጥ ያለዎት ተሳትፎ ምንም ዓይነት ስጋት ወይም ደህንነትዎ ላይ አደጋ አይኖረውም።

ሚስጥራዊነት፡- በዚህ ጥናት ውስጥ የሚሰበሰቡ መረጃዎች በሙሉ በሚስጥር ይቀመጣሉ። ስም በማንኛውም ሪፖርቶች ወይም ህትመቶች ውስጥ ጥቅም ላይ አይውልም። ዋናው መርማሪ እና የምርምር ቡድኑ ብቻ መረጃው ይኖራቸዋል።

ስለ ጥናቱ ተጨማሪ መረጃ ማግኘት ከፈለጉ ወይም የሚያሳስብዎት ነገር ካለ የጥናቱን ዋና ተመራማሪ ያግኙ።

ሃና በየነ +251 936 992 646

ኢሜል- hannabeyene12721@gmail.com

አማካሪዎች: ዶ/ር ውብአለም ፍቃዱ

ኢ.ሜል wubfek@gmail.com

ዶ/ር አስናቀ ልመንህ

ኢሜል- asnakelimenhe@yahoo.com

በአዲስ አበባ ዩኒቨርሲቲ የሳይካትሪ ክሊኒካል ሳይኮሎጂ ፕሮግራም ክፍል አድራሻ፡-

ስልክ +251 118-962-052

በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ የመረጃ ወረቀቱ ቅጂ ይሰጥዎታል እና እንዲፈርሙ ይጠየቃሉ።

በመረጃ የተደገፈ የስምምነት ቅጽ

መረጃውን አንብቤና ተረድቼ ተቀብያለሁ። እናም ስለ ምርምሩ፣ ሂደቱ፣ አደጋው፣ ጥቅሞቹ እና በምርምሩ ውስጥ መሳተፌ ምንም አይነት ጉዳት እንደማይደርስብኝ አንብቤ ተረድቻለሁ።

በመጠይቁ ተመራማሪዎቹ ሚስጥራዊነቱን እንደሚጠብቁልኝ ተነግሮኛል። ስለሆነም የከፍተኛ የአዕምሮ ሕመም ታካሚዎች የትዳራቸውን ሁኔታና አመለካከት ላይ ለሚደረገው ጥናት/ምርምር በፈቃደኝነት ለመሳተፍ ተስማምቻለሁ::

የተሳታፊ ስም_____

የታካሚው ግላዊ መረጃ

ቀን_____

መለያ ቁጥር_____

በቅድሚያ መጠይቁን ለመሙላት ፈቃደኛ ስለሆኑ አመሰግናለሁ።

እድሜ_____

ጾታ_____ (ሴት/ ወንድ)

የሚኖሩበት አካባቢ _____ (ከተማ/ገጠር)

ሀይማኖት_____

የትምህርት ደረጃ _____ (አንደኛ ደረጃ/ ሁለተኛ ደረጃ ት/ቤት)

የትዳር ሁኔታ _____ (አላገባውም /አግብቻለው /ተፋትቻለው /አጋሬ በህይወት የለም/ችም)

የስራ ሁኔታ _____

የሆስፒታል መረጃ

1. የምርመራ ውጤት_____
2. ህክምና የሚከታተሉበት ቦታ_____
3. የህክምና ጊዜ ቆይታ_____
4. ህመሙ ያለበት ደረጃ_____
5. የህመሙ ቆይታ_____
6. ተኝተው ታካሚ ኖት ወይስ እየተመላለሱ ነው የሚታከሙት_____

ዝግጁነትና ፈቃደኝነት

- ትዳር ለመያዝ ምን ያህል ፈቃደኛ ነበሩ
    - ህመምዎስ ለዚህ ውሳኔ ምን ተፅዕኖ ፈጥሮብዎታል
    - የትዳር መያዝ እና አለመያዝ ሁኔታ አሳስቦዎት ያውቃል
- ከህመምዎ አንጻር ለትዳር ምን ያህል ዝግጁ ነበሩ?

- የትኛው የትዳር ክፍል ላይ ዝግጁ ነበሩ?
- በየትኛው የትዳር ክፍል ላይስ ዝግጁ አልነበሩም?

- ከሀመምዎ አንጻር የትዳር ሕይወት ለመመስረት በወሰኑት ውሳኔ ላይ ምን ይሰማዎታል?
    - በትዳር ያሳለፉዋቸውን ጊዜያቶች ወደኋላ ሲመለከቱ ውሳኔዎ ላይ ምን ይሰማዎታል?
- ትዳር ሲመሰርቱ ወይም በትዳር ለመቆየት ሲወስኑ በቤተሰብ ወይም በማህበረሰቡ ተጽዕኖ ይደርስብዎት ነበር?
    - በትዳር ሕይወት ውስጥ ለመቆየት ቤተሰብዎ ወይም ማህበረሰቡ ከሀመምዎ አንጻር ምን ዓይነት ጫና ይፈጥርብዎት ነበር?
    - በትዳርዎ ውስጥ በመቆየትዎ ምን ይሰማዎታል?

ትዳርን በተመለከተ

- ትዳር ለአዕምሮ ጤና መፍትሔ ይሆናል ብለው ያስባሉ?
- ትዳር የአዕምሮ ጤና ሁኔታን ያሻሽላል ብለው ያስባሉ?
- ትዳር የአዕምሮ ጤናን ያባብሳል ብለው ያስባሉ?
- ትዳርዎ የባለሙያ እርዳታ ያስፈልገዋል ብለው ያስባሉ?

ፍላጎት

- ከትዳርዎ ምን ይጠብቃሉ?
- ከትዳር የሚጠብቁዋቸውን ነገሮች ሊጠቅሱልኝ ይችላሉ?
- ምን ያህል አስፈላጊ ናቸው?
- በትዳርዎ ውስጥ ያልተሟላልዎት ፍላጎቶች አሉ? ካሉ ሊዘረዝሩልኝ ይችላሉ?
- ያልተሟላበት ምክንያት ምን ሊሆን ይችላል ብለው ያስባሉ?
- ስላልተሟላልዎት ፍላጎት ምን ይሰማዎታል?

የስሜት ቀረቤታ

- በስሜት የጠለቀ ቀረቤታን እንዴት ያዩታል?
- ከትዳር አጋርዎ ጋር ያለዎትን የስሜት ቀረቤታ እንዴት ይገልጹታል?

የንግግር ዘይቤ

- ከትዳር አጋርዎ ጋር የንግግር ዘይቤዎ ምን ይመስላል?
- የትዳር አጋርዎ የሚረዳዎት ይመስልዎታል ?
- በትዳርዎ ውስጥ ሐሳብዎን በነጻነት መግለጽ ይችላሉ?

አስጨናቂ ሁኔታ እና የመቋቋሚያ ዘዴዎች

- በትዳርዎት ላይ ህመምዎ ምን አይነት ተጽዕኖ ፈጠረብዎት?ሊዘረዝሩልኝ ይችላሉ?
- እነዚህ ተጽዕኖዎች የትዳር ሕይወትዎ ላይ ምን የሚፈጥሩ ይመስልዎታል?
- ያጋጠመዎት ተጽዕኖዎች ማሕበረሰባዊ ሕይወትዎ፣ በግብረ-ስጋ ግንኙነትዎ፣ በኢኮኖሚካል እንዲሁም ልጆችን በማሳደግ ሂደት ላይ ተጽዕኖ ነበረው?
- እነዚህን ተጽዕኖዎች እንዴት ተቋቋሚቸው? ሊቋቋሚቸው ያልቻሉአቸውስ ተፅዕኖዎች ነበሩ?
- እነዚህ ተጽዕኖዎች የሚስት ወይም የባል ድርሻዎ ላይ ምን ችግር ፈጠረብዎ?
- የትዳር ኃላፊነትዎ ላይ ተጽዕኖ ነበረው? ከነበረው/ካልነበረው ሊያብራሩልኝ ይችላሉ?
- የትዳርዎን ሚዛናዊነት በመደጋገፍና በኃላፊነት ደረጃ እንዴት ያይታል?
- እነዚህ ሁሉ ተጽዕኖዎች የትዳር አጋርዎ ላይ የሚፈጥረው ችግር አለ ብለው ያስባሉ?
    - ትዳርዎ የባለሙያ እርዳታ የሚያስፈልግዎት ይመስልዎታል?
    - የትዳርዎ ሁኔታ ምን ያህል ያሳስብዎታል?

የባለትዳሩ ግላዊ መረጃ

ቀን_____

መለያ ቁጥር_____

በቅድሚያ መጠይቁን ለመሙላት ፈቃደኛ ስለሆኑ አመሰግናለሁ።

እድሜ_____

ጾታ_____ (ሴት/ ወንድ)

የሚኖሩበት አካባቢ _____ (ከተማ/ገጠር)

ሀይማኖት_____

የትምህርት ደረጃ _____ (አንደኛ ደረጃ/ ሁለተኛ ደረጃ ት/ቤት)

የትዳር ሁኔታ _____ (አላገባውም /አግብቻለው /ተፋትቻለው /አጋሬ በህይወት የለም/ችም)

የስራ ሁኔታ _____

ዝግጁነትና ፈቃደኝነት

- የትዳር አጋርዎን የአዕምሮ የጤና ሁኔታ መቼ አወቁ? ባወቁ ጊዜ ምን ተሰማዎት?
- በትዳር አጋርዎ የአዕምሮ ጤና አንጻር፤ በትዳር ውሳኔዎ ላይ ምን ያስባሉ? በውሳኔዎ ምን ይሰማዎታል?
- ትዳር ሲመሰርቱ ወይም በትዳር ለመቆየት ሲወስኑ በቤተሰብ ወይም በማህበረሰቡ ተጽዕኖ ይደርስብዎት ነበር?
- በትዳር ሕይወት ውስጥ ለመቆየት ቤተሰብዎ ወይም ማህበረሰቡ ከትዳር አጋርዎ ህመም አንጻር ምን ዓይነት ጫና ይፈጥርብዎት ነበር ?
- በትዳርዎ ውስጥ በመቆየትዎ ምን ይሰማዎታል?

ትዳርን በተመለከተ

- የአዕምሮ ጤና ችግር ካለበት ሰው ጋር ትዳር በመመስረትዎ ምን ያስባሉ?
- ስለ ትዳር አጋርዎ የአዕምሮ ጤና ሁኔታ ምን ይሰማዎታል?
- ትዳርዎ የባለሙያ እርዳታ ያስፈልገዋል ብለው ያስባሉ?

ፍላጎት

- በትዳርዎ ውስጥ ያልተሟላልዎት ፍላጎቶች አሉ?
- ካሉ ሊዘረዝሩልኝ ይችላሉ?
- ያልተሟላበት ምክንያት ምን ሊሆን ይችላል ብለው ያስባሉ?
- ስላልተሟላልዎት ፍላጎት ምን ይሰማዎታል?

የስሜት ቀረቤታ

- በስሜት የጠለቀ ቀረቤታን እንዴት ያዩታል?
- ከትዳር አጋርዎ ጋር ያለዎትን የስሜት ቀረቤታ እንዴት ይገልጹታል

የንግግር ዘይቤ

- ከትዳር አጋርዎ ጋር የንግግር ዘይቤዎ ምን ይመስላል?
- የትዳር አጋርዎ የሚረዳዎት ይመስልዎታል ?
- በትዳርዎ ውስጥ ሐሳብዎን በነጻነት መግለጽ ይችላሉ?

አስጨናቂ ሁኔታ እና የመቋቋሚያ ዘዴዎች

- በትዳር አጋርዎ የአእምሮ ህመም ምክንያት በትዳር ሕይወትዎ ላይ ምን አይነት ተጽዕኖዎች ፈጠረብዎት? ሊዘረዝሩልኝ ይችላሉ?
- ያጋጠመዎት ተጽዕኖዎች ማሕበረሰባዊ ሕይወትዎ፣ በግብረ-ስጋ ግንኙነትዎ፣ በኢኮኖሚካል እንዲሁም ልጆችን በማሳደግ ሂደት ላይ ተጽዕኖ ነበረው?
- እነዚህን ተጽዕኖዎች እንዴት ተቋቋሚቸው? ያልተቋቋሙት ተፅዕኖዎች ነበሩ?
- እነዚህ ተጽዕኖዎች የሚስት ወይም የባል ድርሻዎ ላይ ምን ችግር ፈጠረብዎ?
- የትዳር ኃላፊነትዎ ላይ ተጽዕኖ ነበረው? ከነበረው/ካልነበረው ሊያብራሩልኝ ይችላሉ?
- የትዳርዎን ሚዛናዊነት በመደጋገፍና በኃላፊነት ደረጃ እንዴት ያይታል?
- እነዚህ ሁሉ ተጽዕኖዎች በእርስዎ ላይ የሚፈጥረው ችግር አለ ብለው ያስባሉ?
    - የባለሙያ እርዳታ የሚያስፈልግዎት ይመስልዎታል?
    - የትዳርዎ ሁኔታ ምን ያህል ያሳስብዎታል?

Declaration of original work

I, the undersigned, declare that this thesis report is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

If proven otherwise, I understand that appropriate actions will be taken based on the Senate Legislation of Addis Ababa University and the Guidelines provided by the Ministry of Education.

Name of Investigator: _____

Signature: _____

Date of submission: _____

This thesis has been submitted for examination with my approval as University Supervisor

Name and Signature of the first Supervisor _____

Name and Signature of the second supervisor _____