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Association of Stress, Anxiety, Depression and Caregiving Burden among Caregiver of Adults with Substance Use Disorders (SUDs)

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Abstract

The aim of this study is to investigate the relationship between stress, depression, anxiety and caregiving burden among caregivers of adults diagnosed with substance use disorders (SUDs). The study employs a quantitative research method utilizing survey instruments. A sample of 150 caregivers, comprising spouses, parents, and siblings, providing care and support to adults with SUDs, was targeted. The sampling strategy involves purposive sampling to ensure representation across different familial roles and levels of caregiving burden. The primary scales used for data collection are the Depression, Anxiety and Stress scale (DASS-21) to assess the caregiving burden, caregiving burden questionnaire was used. The findings of the present study indicated positive relationship between depression, anxiety, stress and caregiving burden. The findings of this study can provide insights into the specific factors influencing the well-being of caregivers of individuals with SUDs, potentially informing interventions and support services tailored to their needs.

Keywords: Substance use disorder, caregivers, stress, depression, anxiety, family caregiving burden, subjective well-being.

Introduction

Substance Use Disorders (SUDs) are chronic, relapsing conditions that significantly impact individuals and their families. Globally, over 36 million people suffer from drug use disorders, and this burden is especially pronounced in low- and middle-income countries, where healthcare resources are scarce and stigma around addiction is pervasive (United Nations Office on Drugs and Crime [UNODC], 2023). In these contexts, much of the caregiving responsibility falls on the family, with limited institutional support. The role of caregiving for a person with an SUD often evolves into a long-term, stressful commitment that deeply affects the caregiver's mental, emotional, and even physical well-being (United Nations Office on Drugs and Crime [UNODC], 2023).

In Pakistan, the prevalence of substance use is increasing, with estimates suggesting that around 6.7 million people are drug dependent (UNODC, 2013). However, public health responses to address the needs of caregivers remain minimal. Caregivers are typically untrained family members—often mothers, spouses, or siblings—who are left to manage the consequences of addiction with little or no support. This caregiving responsibility is associated with a unique and often overwhelming form of psychosocial burden, including emotional exhaustion, social isolation, financial hardship, and deterioration of personal health (Sharma et al., 2020).

Caregivers of individuals with SUDs face particular challenges compared to caregivers of people with other chronic illnesses. These challenges stem from the unpredictable and often stigmatized nature of addiction. Caregivers may witness behavioral changes in their loved ones such as dishonesty, aggression, neglect of responsibilities, and criminal behavior, which can lead to chronic psychological distress (Orford et al., 2013). As a result, caregivers are at high risk of developing stress-related disorders, anxiety, and depression.

This study seeks to investigate the association between caregiving burden and psychological outcomes (stress, anxiety, and depression) among caregivers of adults with SUDs. The findings of this study can help bridge the gap in literature and inform culturally responsive policies and interventions aimed at improving caregiver well-being in Pakistan and similar contexts. Caregiving burden is defined as the multidimensional stress experienced by individuals who provide care to chronically ill persons (Zarit et al., 1980). In the context of SUDs, the burden is further complicated by the unpredictable and relapsing nature of the condition. Unlike caregiving for terminal illnesses or disabilities, addiction caregiving often involves cycles of hope and disappointment, compliance and relapse, further amplifying emotional exhaustion and caregiver helplessness (Orford et al., 2013; Velleman & Templeton, 2016).

Caregivers often find themselves in a paradoxical position: while they strive to support the recovery of their loved ones, they also endure severe emotional turmoil. This includes feelings of guilt, fear of relapse, financial strain, and social stigma. Peleg-Oren et al. (2008) documented that wives of substance-dependent men reported high levels of emotional suppression, hopelessness, and psychosomatic complaints. These emotional challenges accumulate over time, resulting in a chronic caregiving burden. Multiple studies have identified a strong link between caregiving burden and psychological distress. A study by Dąbrowska et al. (2020) highlighted that caregivers of individuals with SUDs exhibited higher rates of depression and anxiety than the general population. Caregivers report high levels of perceived stress due to both internal (e.g., emotional attachment) and external (e.g., financial obligations, caregiving tasks) stressors.

According to the transactional model of stress by Lazarus and Folkman (1984), stress arises when individuals perceive that the demands of a situation exceed their coping resources. In the case of SUD caregivers, this model is particularly relevant. The constant vigilance required to manage relapse risks, legal problems, or medical emergencies places caregivers in a state of hyper-alertness and chronic tension, which can eventually lead to burnout or depressive episodes. Furthermore, the caregiver's mental health can also be influenced by the caregiver-care recipient relationship. Parents of adult children with SUDs, for example, may experience a distinct form of grief known as "ambiguous loss," wherein the individual is physically present but psychologically absent due to addiction (Boss, 2007).

In collectivist cultures like Pakistan, caregiving is typically seen as a familial duty, often falling disproportionately on women. This cultural expectation, while rooted in social cohesion, can inadvertently lead to caregiver neglect. Women may forgo their own health needs, employment opportunities, and social lives to care for a substance-using relative (Sharma et al., 2020). Moreover, stigma surrounding addiction often silences caregivers, deterring them from seeking help or disclosing their distress (Velleman & Templeton, 2016).

These sociocultural factors interact with individual vulnerabilities (e.g., previous mental health issues) and structural barriers (e.g., lack of mental health services) to intensify psychological distress among caregivers. Unfortunately, Pakistan's healthcare infrastructure lacks comprehensive addiction services that include family and caregiver support, leaving caregivers isolated and unacknowledged. Despite the global acknowledgment of family burden in addiction treatment, the literature from South Asia, particularly Pakistan, remains sparse. Most studies focus on patients with SUDs, with limited investigation into the mental health of their caregivers. Even fewer studies have quantitatively explored the direct associations between caregiving burden and psychological symptoms such as anxiety, depression, and stress. Moreover, there is a lack of validated caregiver-specific interventions in this demographic. This research aims to fill these gaps by empirically examining the psychological profiles of caregivers and the caregiving burden they experience.

Methods

Objectives

- To investigate the relationship between stress, depression, anxiety, and caregiving burden among caregivers of adults with SUDs.
- To identify the differences on stress, depression, anxiety and caregiving burden among caregivers of adults with SUDs.

Hypotheses

- The level of caregiving burden is positively correlated with the severity of stress, depression, and anxiety among caregivers.
- Depression, anxiety, stress and caregiving burden have significant demographic differences among caregivers.

Research Design

This study employed a cross-sectional research design to assess the association of stress, depression, anxiety, and caregiving burden among caregivers of adults with substance use disorders (SUDs).

Sample

The study targeted a sample of 150 caregivers within age range of 18-65 years, including spouses, parents, and siblings, providing care and support to adults diagnosed with substance use disorders. Caregivers recruited from healthcare facilities, addiction treatment centers, and support groups to ensure a representative sample reflecting various caregiving contexts.

Instruments

The study utilized two validated instruments:

Family Care Burden Interview Schedule (FBIS)

The FBIS, developed by Pai & Kapur in 2001, in the field of family caregiving has been applied in studies since the late 20th century. This instrument encompasses items covering a spectrum of domains such as emotional well-being, financial strain, and disruptions to daily life. Responses to the FBIS items are typically scored on Likert-type scales, capturing the caregiver's agreement or disagreement with specific statements. The scoring may vary across studies, but generally, a higher score denotes a greater perceived burden. Alpha Reliability is 0.78.

Depression, Anxiety, Stress Scale (DASS-21)

This scale was developed by Lovibond & Lovibond in 1995.The self-report measure used in this study consists of 21 items and is designed to assess psychological distress (PD). The scale utilizes a 4-point rating scale, with response options ranging from 0 to 3. Alpha reliability is 0.93.

Procedure

Caregivers recruited from healthcare facilities, addiction treatment centers, and support groups. Participants provided the detailed information about the study, and informed consent was obtained. Caregivers completed the DASS-21 and FBIS questionnaires, providing information about their experiences, stress levels, and caregiving burden. All the collected data were kept confidential, with identifiers removed to ensure anonymity.

Results

Descriptives, frequencies and correlation analysis were used to analyze the results.

Table 1

Mean, Standard Deviation and Alpha Coefficient of Depression, Anxiety and Stress Scale - 21 Items (DASS-21) & Family Burden Interview Schedule (FBIS-25) scale (N=150).

Scales	N	M	SD	Range	α
DASS-21	150	15.10	2.14	21.0	.91
FBIS	150	32.86	3.02	0-50	.84

Note: DASS=Depression Anxiety and Stress Scale; FBIS=Family Burden Interview Schedule; M=mean; SD=standard deviation; α=Alpha reliability.

Table 1 presents the value of arithmetic mean, standard deviation and alpha coefficient of reliability estimate. The data is mildly deviated from its mean. The reliability of all the scales used to measure study variables depicts excellent values of alpha reliability in our sample i.e. Depression, Anxiety and Stress Scale - 21 (DASS-21) & Family Burden Interview Schedule (FBIS-25), are .91 & .84 respectively.

Table 2

Correlation Matrix for all the Variables used in the study (N = 150).

Variables	N	M	SD	1	2
1. DASS 21	150	15.10	2.14	-	
2. FBIS	150	32.86	3.02	.450**	-

Note: DASS=Depression Anxiety and Stress Scale, FBIS=Family Burden Interview Schedule. **p < .01.

Table 2 describes inter-correlations among variables. Result suggests that there is moderate positive association (r = .450) between psychological distress (depression, anxiety and stress) and caregiving burden among caregivers of adults with SUDs.

Table 3

Gender based differences on all assessment scales (N = 150)

	Male N=107		Female N=43			
Variables	M	SD	M	SD	t	p
DASS-21	14.86	2.06	15.67	2.27	-2.10	.002
FBIS	33.04	3.12	32.39	2.76	1.19	.004

Note: *p .05. **p < .01.

Results in Table 3 demonstrate the mean differences on study variables against gender in Substance and other addicted patients. The mean difference is found to be significant ($p < .05$). It implies that males were higher on caregiving burden as compared to females. Moreover, females scored higher on psychological distress.

Discussion

This study explored the association between caregiving burden and psychological distress—specifically stress, anxiety, and depression—among caregivers of adults with Substance Use Disorders (SUDs). The findings reflect significant associations, supporting existing research while offering crucial insights specific to the Pakistani socio-cultural context. The emotional, cognitive, and behavioral impacts of caregiving in the face of addiction are considerable, affecting caregivers' well-being in profound and often invisible ways.

Caregiving burden is not a singular experience but a constellation of emotional, psychological, physical, social, and financial pressures (Zarit et al., 1980). In the context of SUDs, this burden is intensified by the complex behaviors associated with addiction, such as manipulativeness, secrecy, legal troubles, aggression, or withdrawal. Caregivers must often manage crises, navigate relapse, provide financial support, and absorb social stigma—all of which can lead to chronic stress responses. The emotional burden is exacerbated by ambiguous loss—a concept introduced by Pauline Boss (2007)—in which caregivers grieve for someone physically present but emotionally or psychologically absent due to substance use. This ambiguous grief, often unresolved and unacknowledged, is linked with prolonged depression and emotional fatigue.

The significant positive correlations observed between caregiving burden and psychological symptoms of stress, anxiety, and depression are consistent with the diathesis-stress model, which suggests that chronic environmental stressors like caregiving can trigger psychological dysfunction in vulnerable individuals. This triad of psychological distress often functions cyclically—stress increases anxiety, anxiety deepens depressive symptoms, and depression reduces coping capacity, thereby increasing perceived burden. Caregivers may develop anticipatory anxiety, continuously worrying about relapse, overdose, or violent behaviors. Such hypervigilance places them in a sustained state of sympathetic nervous system activation—leading to poor sleep, irritability, cognitive fatigue, and somatic symptoms (Dąbrowska et al., 2020). Additionally, caregivers often experience learned helplessness—a sense that no matter how much they try, their efforts to support their loved one do not lead to sustained recovery. This perceived loss of control is a key predictor of depression and has been identified in multiple caregiver studies (Peleg-Oren et al., 2008; Orford et al., 2013).

In Pakistan, caregiving is deeply rooted in cultural and religious values. Islamic and familial norms emphasize responsibility, patience, and sacrifice, especially for women. While these values may foster resilience in some, they can also perpetuate internalized pressure, discouraging caregivers from expressing distress or seeking help. Mothers, wives, and sisters of individuals with SUDs often carry the bulk of caregiving responsibilities while simultaneously managing household roles, societal expectations, and in some cases, economic hardship. Intersectionality theory highlights how overlapping identities (e.g., gender, class, caregiver status) intensify vulnerability. A woman caregiver in a lower-income household, for example, is more likely to suffer from untreated mental health symptoms due to compounded stigma, lack of resources, and limited autonomy. Moreover, addiction-related stigma operates at multiple levels: individual (shame, guilt), family (loss of status), and societal (social exclusion). This stigma not only isolates caregivers but also obstructs their access to mental health care, reinforcing a cycle of silent suffering.

Internationally, studies from both Western and Eastern contexts echo similar findings. For example, in the United Kingdom, Velleman and Templeton (2016) found that family members of individuals with SUDs had rates of anxiety and depression 2–3 times higher than the general population. In India, found that caregiving burden was highest among women and those caring for individuals with polysubstance dependence. These findings support the transnational nature of caregiver distress, though contextual factors such as health infrastructure, social support systems, and cultural coping strategies vary widely (Orford et al., 2013). This study adds to the global discourse by providing data from Pakistan, a country with limited mental health resources, high stigma, and a familial caregiving model. It reinforces the need to contextualize caregiving burden within sociocultural realities when designing interventions (Sharma et al., 2020).

Limitations and Future Research Directions

Despite its contributions, this study has several limitations:

- It restricts the ability to establish causality between caregiving burden and psychological distress.
- These are susceptible to recall bias and social desirability, especially in stigmatized contexts.
- The study may not capture the diversity of caregivers in terms of socioeconomic status, ethnicity, and urban/rural location.

Future research should aim to:

- Use longitudinal designs to track changes in caregiver distress over time and in response to interventions.
- Conduct qualitative studies to explore coping strategies, caregiver narratives, and cultural interpretations of burden.
- Examine moderating variables such as social support, religiosity, resilience, and care recipient characteristics (e.g., type of substance used, duration of use).
- Pilot and evaluate culturally adapted interventions such as Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or family resilience training specifically for caregivers.

Implications

- Addiction treatment programs must integrate family-focused components. Screening caregivers for psychological distress during the intake process of a client with SUD should become routine. Interventions such as family therapy, caregiver psychoeducation, stress management programs, and group counseling can significantly reduce psychological symptoms and improve coping.
- Mental health professionals, general practitioners, and addiction counselors need to be trained in culturally sensitive communication and caregiver support strategies. Brief interventions for caregivers can be delivered in outpatient settings or through digital platforms.
- the strong influence of community and religious structures in Pakistan, partnerships with mosques, community leaders, and NGOs could facilitate non-stigmatizing support networks for caregivers. Peer support groups or informal helplines can be established to provide emotional relief and practical guidance.
- Caregivers should be recognized as stakeholders in national addiction policies. This includes the development of caregiver support programs under national health plans, financial subsidies, respite care options, and inclusion in decision-making regarding the patient’s treatment.

Conclusion

The association between caregiving burden and psychological distress among caregivers of adults with SUDs is both statistically and clinically significant. Caregivers in this context experience unique and sustained stressors that demand targeted attention in healthcare, community, and policy domains. Recognizing caregivers not as invisible supporters but as integral to the addiction recovery ecosystem is a critical step forward. Addressing their psychological well-being is not only a matter of compassion and ethics but also essential for sustainable treatment outcomes in addiction recovery.

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