PREVALENCE OF PSYCHIATRIC MORBIDITY AND COPING STRATEGIES AMONG CAREGIVERS OF PATIENTS WITH ALCOHOL USE DISORDER: A CROSS-SECTIONAL STUDY

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Abstract:-
Background:- Alcohol Use Disorder (AUD) is a chronic relapsing condition that affects not only affected individuals but also their caregivers. Continuous caregiving responsibilities, social stigma, and the unpredictable course of the illness may adversely affect caregivers' mental health and coping abilities. However, data examining both psychiatric morbidity and coping strategies among caregivers of patients with AUD remain limited, particularly in the Indian context.
Objectives:- To assess the prevalence of psychiatric morbidity and the coping strategies employed by caregivers of patients with Alcohol Use Disorder.
Methods:- This cross-sectional observational study was conducted in the Department of Psychiatry at a tertiary care hospital in North India. A total of 100 primary caregivers of patients diagnosed with Alcohol Dependence Syndrome according to ICD-10 criteria were recruited consecutively. Sociodemographic information was collected using a structured proforma. Psychological distress was assessed using the General Health Questionnaire-12 (GHQ-12), psychiatric morbidity using the Mini International Neuropsychiatric Interview (MINI), and coping strategies using the Coping Strategy Indicator (CSI). Data were analyzed using IBM SPSS Statistics version 27.0.
Results:- The mean age of caregivers was 33.32 ± 9.99 years. Psychological distress was observed in 96% of caregivers, with 65% reporting mild distress and 31% reporting moderate distress. Major Depressive Episode and Dysthymia were the most common psychiatric disorders, each affecting 29% of caregivers. Generalized Anxiety Disorder and Non-Alcohol Psychoactive Substance Use Disorder were identified in 13% of participants, while Social Phobia was present in 10%. Regarding coping strategies, most caregivers demonstrated average levels of problem-solving (51%) and social-support-seeking coping (87%). Avoidance coping was prominent, with 34% of caregivers exhibiting high or very high levels.
Conclusion:- Caregivers of patients with AUD experience considerable psychological distress and a substantial burden of psychiatric morbidity, particularly depressive disorders. The frequent use of avoidance coping highlights the need for caregiver-focused psychological assessment, psychoeducation, and coping-skills interventions as part of comprehensive addiction treatment services.
Keywords:- Alcohol Use Disorder, Caregivers, Psychiatric Morbidity, Psychological Distress, Coping Strategies.
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Introduction

Alcohol Use Disorder (AUD) is a chronic relapsing disorder with significant medical, psychological and social implications. Although the adverse effects of AUD on affected individuals are well established, its impact extends beyond the patient and frequently affects family members who assume caregiving responsibilities. Family caregivers typically provide emotional support, monitor compliance with treatment, manage behavioral disturbances, and deal with financial and interpersonal issues related to problematic alcohol use. Consequently, caregiving in

the context of AUD is increasingly recognized as an important determinant of caregiver mental health.[1-3]

There is a significant psychological burden among family members of people with substance use disorders. A recent scoping review was conducted to show the negative impact of substance use disorders on caregivers in various areas, including emotional health, family functioning, social functioning and financial issues. Chronic stress, emotional distress, stigma and helplessness are often reported by caregivers.[2] Likewise, qualitative data indicate that family members can also suffer from continued psychological stress as they work to cope with the issues that come with supporting a loved one who has a substance use disorder.[4]

There is mounting evidence that caregivers of AUD patients are at risk of developing a group of psychiatric disorders. Common mental health problems (depression, anxiety, psychological distress, etc.) have been often experienced by caregivers of people with alcohol dependence. Studies focussing on caregivers of people with AUD found that psychiatric morbidity, namely anxiety and depression symptoms, was closely linked to higher caregiver burden.[1] Longitudinal evidence suggests that caregiver burden, depression, anxiety, and stress improve following treatment initiation, while resumption of alcohol use is associated with smaller improvements in caregiver outcomes.[5]

The psychological consequences of caregiving are influenced not only by caregiving burden but also by the coping strategies employed by caregivers. Coping is the cognitive and behavioral strategies that are employed to deal with a stressful situation and generally is divided into problem-focused coping and emotion-focused coping.[6] Adaptive coping strategies (problem-solving and seeking social support) are related to positive psychological adjustment and decreased distress, while maladaptive coping strategies (avoidance, disengagement) are related to negative psychological adjustment and increased distress.[7, 8] Coping behaviors are influenced by chronicity of the illness, stigma, family dynamics, and availability of social support systems among individuals' family members with substance use disorder.[4]

Although caregiver burden and quality of life among family members of individuals with AUD have received increasing research attention, fewer studies have simultaneously examined psychiatric morbidity and coping strategies, particularly in the Indian context.[2, 4] Understanding the prevalence of psychiatric morbidity and the coping mechanisms employed by caregivers is important for identifying vulnerable individuals and developing family-centered interventions that may improve both caregiver well-being and patient outcomes. Therefore, the present study aimed to assess the prevalence of psychiatric morbidity and the coping strategies employed by caregivers of patients with Alcohol Use Disorder attending a tertiary care teaching hospital.

Materials and methods:-

Study Design and Study Site

This cross-sectional observational study was done in the Department of Psychiatry at a tertiary care hospital in North India. The study was carried out after obtaining approval from the Institutional Ethics Committee. Informed consent was obtained from all participants before their enrolment.

Inclusion and Exclusion Criteria

Male patients who attended the inpatient and outpatient services in the psychiatry wards were systematically assessed Alcohol Use Disorder (AUD), including Alcohol Dependence Syndrome diagnosed according to ICD-10 criteria [9]. The patients with the diagnosis of Alcohol Dependence Syndrome were consecutively recruited during the study period and their caregivers were recruited as well. The study included primary caregivers aged 18–50, actively involved in patient care, who gave written informed consent. Caregivers under 18 years or over 50 years of age, caregivers with serious medical or surgical conditions, and those who refused to participate were excluded. Primary care giver was defined as the person in the family who took primary responsibility for the emotional, physical, financial or supervisory care of the patient.

Sample Size

The sample size was determined by the formula for estimating a single population proportion, $n = Z^2 P (1 - P)/d^2$. Assuming a 50% prevalence of psychiatric morbidity amongst caregivers, a confidence interval of 95% ($Z = 1.96$), and an absolute precision of 10% ($d = 0.10$), the minimum sample size required was determined to be 96. The sample size was rounded to 100 caregivers to improve precision and compensate for possible incomplete responses.[10]

Study Instruments

Eligible caregivers were interviewed individually in a private setting by trained investigators. Sociodemographic and clinical information were collected using a structured proforma. Psychological distress, psychiatric morbidity, and coping strategies were assessed using standardized instruments. Adequate time was provided to establish rapport and clarify questionnaire items whenever required. A structured sociodemographic proforma was used to collect information regarding age, sex, education, occupation, family type, locality, and socioeconomic status. Socioeconomic status was assessed using the revised B.G. Prasad Socioeconomic Classification.

The Mini International Neuropsychiatric Interview (MINI) was the instrument used to assess psychiatric morbidity, as a short structured diagnostic interview designed for the assessment of major psychiatric disorders based on the DSM-IV and ICD-10 criteria. The MINI has been shown to possess good validity and reliability when compared to longer structured diagnostic interviews. [11]

The Coping Strategy Indicator (CSI) was used to assess coping strategies. The CSI is a 33-item self-report questionnaire which assesses three components of coping: problem solving, social support seeking, and avoidance. There are 11 items for each dimension which are rated on a three-point Likert scale, with higher scores reflecting increased use of the coping style.[12]

Data Analysis

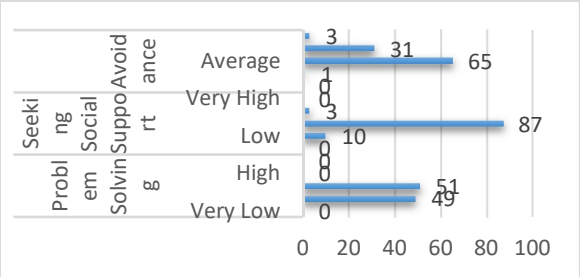
IBM SPSS Statistics version 27.0 (IBM Corp., Armonk, NY, USA) was used for the data entry and analysis. Continuous variables were summarized as mean ± standard deviation (SD) or median with interquartile range (IQR), as appropriate. Qualitative variables were presented as frequencies and percentages. The level of significance was $p<0.05$.

Results:-

The average age of the caregivers was 33.32±9.99 years. The majority of the caregivers were males (59%), from joint families (59%), residing in rural areas (57%) and married (75%). Secondary school education was the most prevalent educational level (28%), while those with primary school education were 16%. Care givers who were illiterate, high school educated, graduates, and post-graduates constituted 14% of the sample each. The majority of the caregivers were self-employed (51%), followed by government employees (32%) and housewives (17%). According to the modified B.G. Prasad socio-economic classification, 23%, 20%, 22% and 15% were from the upper, upper middle, middle, and lower classes respectively (Table 1).

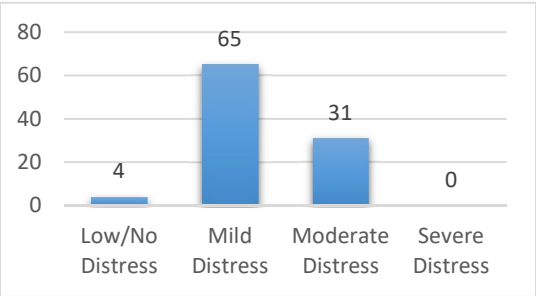
Table 1. Sociodemographic Characteristics of Caregivers (N = 100)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	Mean ± SD	33.32 ± 9.99	—
Gender	Male	59	59.0
	Female	41	41.0
	Total	**100**	**100.0**
Family Type	Joint	59	59.0
	Nuclear	41	41.0
	Total	**100**	**100.0**
Residence	Rural	57	57.0
	Urban	43	43.0
	Total	**100**	**100.0**
Marital Status	Married	75	75.0
	Unmarried	25	25.0
	Total	**100**	**100.0**
Educational Status	Illiterate	14	14.0
	Primary School	16	16.0
	High School	14	14.0
	Secondary School	28	28.0
	Graduate	14	14.0
	Postgraduate	14	14.0
	Total	**100**	**100.0**
Occupation	Housewife	17	17.0



	Self-employed	51	51.0
	Government Employee	32	32.0
	Total	**100**	**100.0**
Socioeconomic Status (BG Prasad)	Upper Class	23	23.0
	Upper Middle Class	20	20.0
	Middle Class	22	22.0
	Lower Middle Class	20	20.0
	Lower Class	15	15.0
	Total	**100**	**100.0**

Figure 1: Sociodemographic Characteristics of Caregivers (N = 100)



Out of 100 caregivers, 65% suffered from mild psychological distress, whereas moderate psychological distress was reported by 31% of caregivers. On the other hand, 4% of caregivers had low to no psychological distress. No participant suffered from severe psychological distress. In total, psychological distress was seen in 96% of caregivers (Table 2).

Psychological Distress Category	Frequency (n)	Percentage (%)
Low/No Distress	4	4.0
Mild Distress	65	65.0
Moderate Distress	31	31.0
Severe Distress	0	0.0
Total	**100**	**100.0**

Table 2. Distribution of Psychological Distress Among Caregivers (N = 100)

Figure 2: Psychological Distress Among Caregivers

The mean score for problem-solving coping was 21.99 ± 2.65. In terms of categorization based on norms, 51% of the caregivers scored in the average range for problem-solving coping, whereas 49% scored in the low range. No participants fell into the categories of very low, high, or very high scores in terms of their ability to problem-solve. The mean score for seeking social support was 21.87 ± 2.99. The majority of the caregivers (87%) had an average level of social support seeking, while 10% had low levels and 3% had high levels. No participants fell into the categories of very low or very high levels regarding their need for social support. The mean score for avoidance coping was 22.14 ± 2.82. Over half of the caregivers (65%) had average scores for avoidance coping, while 31% had high scores, and 3% had very high scores. 1% of participants had low avoidance coping scores, and none had very low scores (Table 3).

Table 3. Distribution of Coping Strategies Among Caregivers (N = 100)

Variables	Category	Frequency (n)	Percentage (%)
Problem Solving	**Mean ± SD**	21.99 ± 2.65	—
	Very Low	0	0.0

	Low	49	49.0
	Average	51	51.0
	High	0	0.0
	Very High	0	0.0
	Total	**100**	**100.0**
Seeking Social Support	**Mean ± SD**	21.87 ± 2.99	—
	Very Low	0	0.0
	Low	10	10.0
	Average	87	87.0
	High	3	3.0
	Very High	0	0.0
	Total	**100**	**100.0**
Avoidance	**Mean ± SD**	22.14 ± 2.82	—
	Very Low	0	0.0
	Low	1	1.0
	Average	65	65.0
	High	31	31.0
	Very High	3	3.0
	Total	**100**	**100.0**

Figure 3: Distribution of Coping Strategies

The most commonly reported disorders included Major Depressive Episode and Dysthymia, both found in 29% of the respondents. Generalized Anxiety Disorder and Non-Alcohol Psychoactive Substance Use Disorder were recorded in 13% of the subjects, while Social Phobia was diagnosed in 10% of caregivers. The disorder Suicidality, (Hypo)manic Episode, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Psychotic Disorder, Anorexia Nervosa, Bulimia Nervosa, and Antisocial Personality Disorder were not recorded for any caregiver.

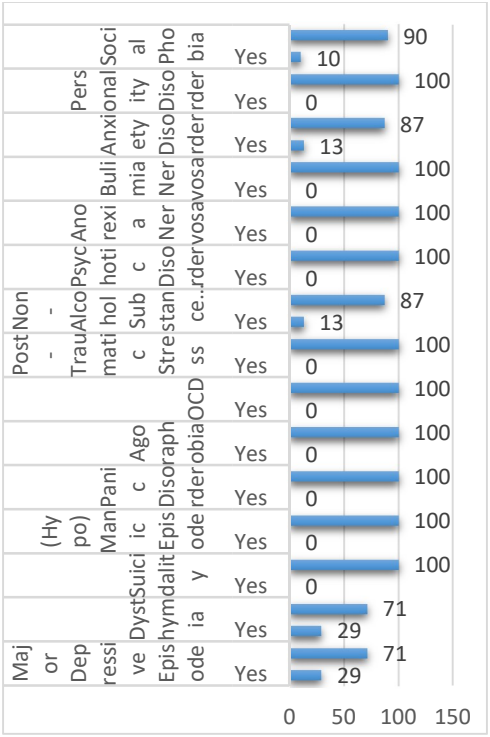
Depressive disorders were found to be the most commonly encountered psychiatric disorders among caregivers (Table 4).

Table 4. Psychiatric Morbidity Among Caregivers Assessed by MINI (N = 100)

Psychiatric Diagnosis	Category	Frequency (n)	Percentage (%)
Major Depressive Episode	Yes	29	29.0
	No	71	71.0
	Total	**100**	**100.0**
Dysthymia	Yes	29	29.0
	No	71	71.0
	Total	**100**	**100.0**
Suicidality	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
(Hypo) Manic Episode	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Panic Disorder	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Agoraphobia	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Obsessive-Compulsive Disorder	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Post-Traumatic Stress Disorder	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Non-Alcohol Psychoactive Substance	Yes	13	13.0
	No	87	87.0
	Total	**100**	**100.0**

Use Disorder			
Psychotic Disorder	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Anorexia Nervosa	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Bulimia Nervosa	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Generalized Anxiety Disorder	Yes	13	13.0
	No	87	87.0
	Total	**100**	**100.0**
Antisocial Personality Disorder	Yes	0	0.0
	No	100	100.0
	Total	**100**	**100.0**
Social Phobia	Yes	10	10.0
	No	90	90.0
	Total	**100**	**100.0**

Figure 4: Psychiatric Morbidity Among Caregivers Assessed by MINI



Discussion:-

The current study asssessed psychiatric morbidity and coping strategies among primary caregivers of patients with Alcohol Use Disorder (AUD). The results suggest that there is a significant psychological burden among caregivers, with the majority reporting psychological distress, almost one-third of participants meeting criteria for a depressive disorder and avoidance being the most commonly used coping strategy. The findings are presented in the context of the existing literature on psychological distress, psychiatric morbidity, and coping in the caregivers of people with AUD.

Psychological Distress

In the current study, high prevalence of psychological distress was found among the caregivers. 96% of them had some degree of distress, and most of them had mild to moderate distress symptoms. The results indicate that caregivers of people with Alcohol Use Disorder (AUD) endure significant emotional stress, stress fatigue and psychological stress, which align with other studies showing that caregivers of people with substance use disorders often suffer from chronic stress, emotional fatigue and psychological strain. According to Swanepoel and Geyer, the effects of substance use disorders are not just limited to those

who use substances, and their effects impact caregivers in emotional and social, leading can cause emotional distress.[2]

Results of the Indian studies are in corroboration of the present study, in which prevalence of high distress levels were reported. Kumar et al. reported that the burden and emotional distress due to alcohol dependence was strongly related to stigma associated with the problem, as caregivers described being constantly concerned, socially discriminated against, and feeling helpless.[13] The same, Shekhawat et al. found moderate to high caregiver burden in wives of substance dependent individuals, which could endanger their psychological health, as a result of the care giving responsibilities.[14] Another study by Vaishnavi et al. found that there was also significant burden on caregivers of patients with alcohol dependence syndrome especially in their economic status, interpersonal relationships and family functioning.[15]

While no severe psychological distress were found, a large percentage of caregivers had mild-to-moderate distress. Lack of severe distress does not equate with lack of clinically significant psychopathology, as structured diagnostic assessment often revealed the presence of depression or anxiety disorders. This is consistent to what Kumar et al reported, which linked low family support and living in nuclear families with increased caregiver burden and decreased quality of life of the spouses of individuals with alcohol dependence.[16] However, it is important to note that simply not having a high score on the GHQ-12 does not mean that they will not have clinically significant psychopathology. The high rates of depression and anxiety disorders found in this study in the context of structured psychiatric assessment suggest that psychological stress and psychiatric illness can coexist among carers of people with AUD.

Psychiatric Morbidity

The psychiatric disorders found in caregivers through diagnostic evaluation with the MINI were Major Depressive Episode and Dysthymia, with 29% of the population diagnosed with each disorder. GAD and Non-Alcohol Psychoactive Substance Use Disorder were seen in 13% of caregivers and Social Phobia was reported by 10%. None of the participants fulfilled diagnostic criteria for suicidality, psychotic disorders and several other psychiatric disorders interviewed.

The predominance of depressive morbidity observed in the present study is consistent with previous research among caregivers of individuals with Alcohol Use Disorder (AUD). A higher caregiver burden was significantly associated with symptoms of depression and anxiety and depressive symptoms were significant predictors of caregiver burden among caregivers of patients with AUD, as reported by Vadher et al.[1] A similar study by Rajpurohit et al. found that depression, anxiety and stress were severely elevated among the caregivers of alcohol-dependent patients at baseline, and that these scores improved significantly after the caregiver was engaged in treatment and became abstinent.[5] Collectively, these findings suggest that caregiver psychological health is closely linked to the severity and course of the patient's illness. However, because the present study employed a cross-sectional design, the temporal relationship between caregiver psychiatric morbidity and patient-related factors such as treatment status, relapse, or abstinence could not be determined.

One of the important results of the present study was the prevalence of Non-Alcohol Psychoactive Substance Use Disorder among 13% of caregivers. This can be a sign that some caregivers use unhealthy coping strategies when dealing with the chronic stress they may experience as a caregiver. Although conducted among caregivers of individuals with Alzheimer's disease and related dementias, Hernandez Chilatra et al. reported that greater reliance on avoidance coping and greater difficulties in emotion regulation were associated with an increased likelihood of hazardous drinking among caregivers.[17] These findings suggest that maladaptive coping responses may increase vulnerability to substance use behaviours in individuals exposed to chronic caregiving stress.

The psychiatric morbidity found in the present study is also reflective of the evidence provided by the caregivers of those with other chronic diseases. In patients with cirrhosis, caretakers had significant symptoms of anxiety and depression, and there was a significant correlation between caregiver burden and psychological morbidity.[18]

Caregiver distress was also found to go beyond the depressive symptoms, as generalized anxiety disorder and social phobia were also identified. Anxiety-related conditions may be caused by chronic uncertainty, interpersonal conflict, and relapse concerns for people with AUD and their caregivers. This finding is consistent with previous reports of increased anxiety symptoms in caregivers with high burden of caregiving.[1, 5]

The elevated rates of dysthymia also may reflect the chronic nature of caregiving stress for AUD, as emotional stress can be chronic, but not necessarily related to acute caregiving crises.

Coping Strategies

Regarding coping, the majority of caregivers had a moderate level of problem-solving coping and social-support-seeking coping, while avoidance coping had a greater proportion of higher levels with approximately one-third of caregivers having high or very high levels of avoidance coping. This finding is in line with the transactional model of stress and coping proposed by Lazarus and Folkman, which suggests that individuals are more likely to adopt emotion-focused coping strategies, including avoidance-oriented responses, when stressors are perceived as difficult to control or modify.[6] As Alcohol Use Disorder (AUD) is a relapsing disorder, avoidant responses can become common over time in the lives of caregivers who have repeatedly tried to change the drinking behaviour of their patients.

The greater reliance on avoidance coping observed in the present study is consistent with previous research among family members of individuals with substance use disorders. When caregiving were longer and more emotionally demanding, caregivers often switched between active engagement and withdrawal behaviours, as reported by Petra et al.[7] Likewise, Kumar et al. reported that stigma surrounding alcohol dependence influenced help-seeking and caregiving decisions, often resulting in delayed or avoided treatment-seeking and the concealment of alcohol-related problems.[13] These factors could be related to the increased use of avoidance strategies seen in caregivers in the present study.

Although most participants exhibited average levels of problem-solving and seeking social support, avoidance coping was the tendency. This discovery could be due to the availability of informal support system, especially since most of the caregivers were from joint families. Even with high levels of caregiving burden, social and familial support can help to facilitate the use of adaptive coping mechanisms. Similar results are found in intervention studies. The authors of the study, Ashmitha et al., showed that psychoeducation and psychosocial interventions had a significant effect on improving coping skills, psychological well-being, and stress management among caregivers with SUDs, indicating the modifiability and sensitivity of coping behaviours to targeted interventions.[19]

The present study has important clinical implications. The moderate dependence of avoidance coping, combined with the observed psychological distress and psychiatric morbidity indicates the need for caregiver-focused interventions as an integral component of AUD care. Caring for others and learning to find a way to cope may be included in strengthening problem-solving skills, increasing social support networks, and decreasing the reliance on avoidant coping, which can lead to better wellbeing for carers. Nevertheless, the cross-sectional design of the present study does not allow a conclusion of causal relationship between coping-styles and psychiatric morbidity. Within the study group there was a joint occurrence of avoidance coping and psychological distress but the direction of this relationship was not discernible and future research should ideally be longitudinal in order to confirm these relationships.

Strengths and Limitations

The present study has a several strengths. To increase the reliability and comparability of the findings, standardized and validated questionnaires were employed to examine psychological distress, psychiatric morbidity and coping strategies, such as the GHQ-12, MINI and Coping Strategy Indicator (CSI). Using the MINI, a structured diagnostic interview, allowed the detection of psychiatric disorders rather than symptom-based screening measures only. Moreover, this simultaneous assessment of psychological distress, diagnosable psychiatric morbidity, and coping strategies in the same group of caregivers allows a comprehensive assessment of the psychological impact of caring for people with Alcohol Use Disorder (AUD), which is a relatively under-explored area in the Indian context. However, some restrictions must be taken into consideration when interpreting the results. It has to be recognised that a cross-sectional design does not allow for any causal or temporal inferences to be drawn between psychiatric morbidity, psychological distress and coping strategies. The findings might not be generalizable because of the study being performed in a single tertiary care teaching hospital. While the sample size was appropriate for the study aims, it prevented detailed subgroup analysis and multivariable modelling for identification of independent predictors. The findings may be limited to the group of male patients with Alcohol Dependence Syndrome in this study as the caregivers were all for male patients. Additionally, the aged range of participants (18-50 years) meant older caregivers who may have caregiving challenges differently were not included. Finally, psychological distress and coping strategies were measured with self-report instruments, which are subject to recall bias and social desirability bias, despite making every effort to collect data in a way that is private and confidential.

Conclusion:

The present study demonstrated a high prevalence of psychological distress and psychiatric morbidity among caregivers of patients with Alcohol Use Disorder. Depressive disorders emerged as the most common psychiatric conditions, while generalized anxiety disorder, social phobia, and non-alcohol psychoactive substance use disorder were also identified in a notable proportion of caregivers. Although most caregivers reported average levels of problem-solving and social-support-seeking coping, avoidance coping was frequently utilized at higher levels. These findings highlight the substantial psychological burden experienced by caregivers and underscore the need for routine assessment of caregiver mental health within addiction treatment services. Incorporating caregiver-focused psychological support, psychoeducation, and coping-skills interventions may help improve caregiver well-being and contribute to better overall treatment outcomes for individuals with Alcohol Use Disorder. The findings also support the need for larger multicentric longitudinal studies to further clarify the relationship between caregiving burden, psychiatric morbidity, and coping strategies

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