The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 14, Issue 3, July- September, 2026
DIP: 18.01.099.20261403, DOI: 10.25215/1403.099
https://www.ijip.in

Research Paper

Psychological Distress and Caregiver Burden among Oncology Patients and Caregivers

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ABSTRACT

Objective - To look into psychological distress in oncology patients, try to evaluate how heavy the caregiver burden feels for primary caregivers, then investigate the connection between patient distress and that caregiver burden as a whole. **Method –** A cross sectional quantitative study was carried out with 40 oncology patient–caregiver dyads, and they were taken via purposive sampling. For psychological distress we used the Hospital Anxiety and Depression Scale (HADS), and for caregiver burden we used the Zarit Burden Interview (ZBI-12). Then, we ran descriptive statistics, did Chi-square tests, used Pearson correlation, and also did multiple regression analyses, all through SPSS Version 26. **Results** - In the study, patients showed clinically relevant anxiety, with a mean of 12.55, and depression, mean = 11.23, which seemed fairly consistent across the sample. Meanwhile caregivers described a moderate to high burden (Mean = 28.32). Also, the time spent caregiving was linked to greater psychological distress ($\chi^2 = 28.45$, $p < .001$). When we looked at the relationship between the two outcomes, there was a clear positive correlation between patient psychological distress and caregiver burden ($r = .72$, $p < .001$). Then, in the regression analysis, psychological distress came out as the strongest predictor of caregiver burden ($\beta = .934$, $p < .001$). **Conclusion** - The psychological distress seen in oncology patients appears strongly connected to caregiver burden. Because of this, routine mental health screening, plus family-centered psychosocial supports, should be built into oncology services so that both patients and caregivers get better, not just one group.

Keywords: *Psycho-Oncology, Neoplasms, Psychological Distress, Anxiety, Depression, Caregiver Burden, Oncology, Mental Health, Quality of Life*

When doctors announce that a patient has cancer, this whole situation becomes sort of immediate and major, like a real medical emergency, and it touches the patients entire daily life not just the sickness. The family system, as a whole, gets shaken up because of this occurrence, which acts like a sharp disturbance, even if nobody says it out loud. Modern oncology is doing remarkable things now, it has gained unprecedented results for extending patient lifespans, but still, doctors have to keep ongoing treatment for this long-lasting condition. And then there's the healthcare side that doesn't always get attention—familial caregivers. They are the essential people who quietly keep the

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Received: May 19, 2026; Revision Received: August 13, 2026; Accepted: August 17, 2026

system going, even though they are often seen as “unrecognized” support. Still, this kind of essential work has to be done by someone, and it brings several physical disadvantages along with psychological strain. Because of this, examining the psychological distress that oncology patients experience, along with the caregiver burden that follows, needs urgent public health focus, particularly during these periods of economic growth and cultural change in India. Indian society depends on family members to provide care for sick relatives because Western healthcare systems use formal institutional support and hospice care and paid nursing services. The cultural values of collectivism and familial duty and filial piety create deep cultural roots which sustain this dependency. In India assuming the role of a caregiver represents an unspoken social duty which people must fulfill because it serves as an implicit requirement of Indian society.

The empirical evidence collected from Indian oncology centers demonstrates the impact of shared trauma on patients. Daycare chemotherapy unit studies show that patient and caregiver psychological states match each other because of an "empathy loop" phenomenon. While patient distress develops from physical symptoms which include pain and treatment side effects, caregiver distress emerges from three factors which include anticipatory anxiety and family health concerns and feelings of helplessness. Although they experience different emotional triggers, both groups show equal levels of deep emotional sadness and worry through their emotional responses.

The existing infrastructure of India creates additional challenges for the affected population. Families in India face financial crises because they need to pay out-of-pocket for medical expenses because only a small number of people have health insurance coverage. The combination of high treatment expenses together with lost income from caregivers leads families to take on medical debt which serves as the main reason for developing clinical anxiety that persists over time. The situation worsens through pediatric oncology because rural patients face two main challenges diagnosis delays and difficulties reaching advanced medical facilities which lead to extra emotional and physical exhaustion.

THEORETICAL FRAMEWORK

Researchers, generally need well established psychological frameworks to make sense of what’s happening here. In the Indian oncology setting, it can be helpful to lean on The Stress and Coping Theory, Lazarus and Folkman created it. The idea is that cancer patients often feel psychological distress when what their bodies require exceeds the coping resources they actually have available. From there, Indian caregivers, assess the threat level, and that perception shapes mental health outcomes. In practice, caregivers tend to choose between two coping paths, one is adaptive and problem focused this often looks like seeking medical information research and the other is maladaptive, which tends to involve self blame, sort of turning inward, rather than taking action.

The Multidimensional Burden Model explains caregiver distress by showing how it affects four different areas of their lives.

1. Physical: People experience chronic fatigue and sleep deprivation which leads to psychosomatic illness.
2. Psychological: Anticipatory grief and anxiety together with clinical depression show high rates of occurrence.
3. Social: People experience extreme social isolation because they cannot leave their home roles and they do not have enough time to participate in community activities.

4. Financial: The most intense financial stressor in developing nations exists under the term "financial toxicity."

Rationale

The field of biomedical oncology in India has achieved significant progress while the necessary psychosocial infrastructure for patient and family support remains in a state of extreme underdevelopment. Previous research has made critical strides. Recent studies keep backing up this idea that caregiver burden is becoming more and more visible in oncology settings. There's also research in Indian populations, where caregivers seem to report notable psychological distress, and it's often connected to financial strain plus a longer caregiving duration, like prolonged time in the role (Menon et al., 2022; Sharma et al., 2022). Systematic reviews have gone further, showing that caregiver burden tends to travel along with depression anxiety and also a lower quality of life across different cancer groups, basically everywhere globally (Geng et al., 2018; Sklenarova et al., 2015). On top of that, Northouse et al. (2010) underlined the relevance of family-centered approaches, and they pointed out caregiver well being is not just "nice to have" but it can directly shape patient outcomes. in acknowledging caregiver burden, but a careful examination of the literature shows major deficiencies in understanding, measuring, and dealing with this distress. Psychosocial oncology research has treated patients and caregivers as separate clinical entities while it used Western assessment tools for its evaluation process. The current research shows that this situation needs to be examined through a cultural framework which reflects specific cultural values. A study conducted in India showed that 90% of family caregivers who took care of chemotherapy patients experienced various levels of burden which affected female and unemployed caregivers particularly who faced greater distress (Mishra et al., 2021). The research shows that younger caregivers and female caregivers who work in caregiving roles for extended periods develop clinical depression and anxiety at higher rates (Karimi Moghaddam et al., 2023). The Indian collectivist framework establishes that distress arises from familial duty concepts and fatalism and spiritual guilt and certain socio-economic limitations which require research to create local explanations.

The literature shows a cultural gap which prevents people from understanding how patients and their caregivers share emotional exchanges with each other. Research conducted on patient-caregiver dyads in similar Asian cultural settings shows that both partners in the relationship experience psychological effects which show a complementary relationship between them. When a patient suffers from increased physical pain, the caregiver experiences heightened anxiety levels. The patient experiences guilt when the caregiver shows clear signs of burnout. The recent literature establishes an emotional relationship which goes both ways, yet India still lacks sufficient dyadic research that studies patient-caregiver relationships as interactive units instead of separate entities. The existing body of Indian oncology caregiver research mainly uses cross-sectional studies which measure distress at a single moment. Financial burden is this ongoing factor that just sort of grows during the whole cancer journey, and it keeps following you through the entire duration too.The study found that Indian cancer treatment facilities experience "financial toxicity" at rates which range from 30% to more than 90%. Systematic reviews show that more than 56% of cancer patients worldwide experience catastrophic health costs which particularly burden low-income people who lack effective health insurance (Kitaw et al., 2025). Financial toxicity creates instant anxiety which develops into a two-month period of financial exhaustion that leads families to postpone their medical treatments. The research on distress needs to track which clinical stages show peak vulnerability for families. The study aims to demonstrate its value through its effects on clinical practice and public health

outcomes. The situation becomes a public health crisis when caregivers who experience severe psychological distress develop burnout. Caregivers who experience burnout create two main problems which require treatment because they tend to administer home medications incorrectly and fail to attend follow-up appointments while suffering from health issues that require medical intervention. The research establishes its evidence base through an explanatory framework that uses contemporary research to explain how cultural factors and financial hardships impact coping between two people. The family system needs assessment and support throughout the entire disease process to provide patients with optimal oncological care.

METHODOLOGY

Participants

The study recruited 40 oncology patients together with their primary caregivers who formed patient-caregiver dyads for the research. Participants were selected using purposive sampling from a hospital setting. The patients had different types of cancer which included Stage 1 to Stage 4 cancers and ongoing treatment or completed treatment or follow-up treatment. The caregivers included all individuals who took primary responsibility for patient care which included spouses and parents and children and other close relatives who had provided care for at least one month. The research involved male and female participants who were at least 18 years old. The research excluded people who had severe cognitive disabilities and people who were unable to provide informed consent.

Sample Justification

For this present study, forty patient–caregiver dyads were included, we selected them by purposive sampling. The sample size felt adequate for this kind of exploratory cross-sectional design, mainly because getting oncology participants was pretty constrained within the available time frame, and also because the hospital setting limited access. Some comparable psychosocial oncology papers, especially the ones done in hospital-based environments, also leaned on smaller groups, like to look at caregiver burden, and psychological distress, in a more manageable way. In our case, the selected number of participants was enought to notice some preliminary links between psychological distress and caregiver burden, especially when we ran correlational test and regression analyses. Still, it would be better to use larger, multicentric samples in future work, so the results can go farther in other contexts, and also so the statistical power becomes more solid.

Sampling Technique

The study employed in-person convenience sampling as its main research method. The researcher conducted physical participant recruitment from the oncology departments which included waiting areas daycare chemotherapy wards and inpatient units. The researchers selected participants who met strict inclusion criteria for their research during hospital visits when participants showed immediate availability and willingness to join the study.

Table 1. Demographic Distributions of the sample

Variable	Category	Frequency (n)
Patient Gender	Male	20
	Female	20
Cancer Stage	Stage 1	4
	Stage 2	10
	Stage 3	11
	Stage 4	15

Variable	Category	Frequency (n)
Treatment Status	Ongoing	25
	Completed	9
	Follow-up	6
Caregiver Gender	Male	14
	Female	26
Relationship to Patient	Spouse	18
	Parent	8
	Child	12
	Other	2
Duration of Caregiving	< 6 months	5
	6–12 months	12
	> 1 year	23

Research Design

The researchers conducted their study through a quantitative cross-sectional observational study design. The research used a cross-sectional design to measure psychological distress and caregiver burden at a specific time without any environmental changes. The study investigates how psychological states of patients and their corresponding primary caregivers are connected through its simultaneous assessment of both groups.

Instruments

The Hospital Anxiety and Depression Scale (HADS) was developed by Zigmond a S and Snaith R P in 1983 served as the instrument to measure patient psychological distress. The 14-item questionnaire which has received extensive validation encompasses medical populations because it omits somatic symptoms which include fatigue and insomnia that might be mistaken for actual medical conditions. The system contains two subscales which each contain seven items: Anxiety (HADS-A) and Depression (HADS-D). The system uses a 4- point scale from 0 to 3 to score each item which leads to a maximum subscale score of 21. The subscale scores show that emotional states at 0-7 levels represent normal emotional states while 8-10 ranges show borderline abnormal distress which 11-21 levels indicate as a potential clinical case of anxiety or depression.

The Zarit Burden Interview (ZBI) was originally developed by Zarit S H, Reever, and Bach Peterson in 1980. The assessment tool for caregiver burden measurement used the 12-item short version of the Zarit Burden Interview (ZBI-12). The medical instrument validates its effectiveness through three testing areas which measure the three types of caregiver stress: physical tiredness and mental pressure and restricted social interaction. Caregivers use a 5-point Likert scale to evaluate each of the 12 items which ranges from 0 (Never) to 4 (Nearly Always). The total score system starts at zero and ends at 48, where increased scores indicate higher levels of caregiver burden.

Procedure

The researchers used an online survey questionnaire as their main method to gather data for their research study. The researcher began her data collection process by conducting interviews with potential patient-caregiver pairs who were present in the hospital. The researcher used study objectives to explain the study to potential participants before obtaining their informed consent after checking their eligibility according to the inclusion criteria. The researcher used a mixed-administration method after determining each participant's comprehension level because of the participants' different educational

backgrounds and literacy abilities. Literate participants who were comfortable reading completed the physical questionnaires independently. Participants who needed assistance with reading and understanding the study material used an interviewer-administered face-to-face method; the researcher read the questions to them in their local language while he explained each question's meaning without directing them to specific answers. The researcher maintained his presence during both testing sessions to establish quality control which involved answering all participant questions and observing their progress through the assessment while collecting accurate complete data.

Ethical Considerations

Ethical guidelines which protect psychological research practices throughout the entire research process. The researchers explained the study purpose to participants who received information about their right to leave the study at any moment. The researchers protected participant identities while using the collected data for research only.

Statistical Analysis

The researchers performed all statistical analyses with IBM SPSS Statistics Version 26. The researchers processed all gathered information through coding and tabulation before using statistical software packages SPSS and R for statistical analysis. Researchers used descriptive statistics to summarize the baseline socio-demographic and clinical characteristics of the participants; they presented continuous variables through means and standard deviations (SD) while showing categorical variables through frequencies and percentages. The research team used inferential statistics to investigate associations for their secondary objectives. The researchers utilized independent samples t-tests to assess mean distress and burden scores between two different demographic groups (such as male and female caregivers), while employing One-way Analysis of Variance (ANOVA) to evaluate three or more groups (for instance, varying educational backgrounds or cancer stages). The researchers computed a Pearson correlation coefficient to assess the direct link between patient psychological distress and the burden on primary caregivers. The researchers viewed all statistical tests as achieving significance when p-values fell below 0.05.

RESULTS

Prevalence of Anxiety and Depression among Oncology patients

Objective: To assess the prevalence of anxiety and depression among oncology patients

Hypothesis (H01): There will be a significant level of anxiety and depression among oncology patients

Table 2. Descriptive Statistics of Anxiety and Depression

Variable	N	Mean	SD	Minimum	Maximum
HADS-A (Anxiety)	40	12.55	4.308	6	20
HADS-D (Depression)	40	11.23	3.278	7	16

Interpretation

The table shows how anxious and depressed oncology patients experience their conditions. The mean anxiety score (M = 12.55, SD = 4.308) and mean depression score (M = 11.23, SD = 3.278) show that patients experience moderate psychological distress. The results show that study participants experience both anxiety and depressive symptoms which have clinical significance.

Prevalence of Caregiver Burden among Primary Caregivers
Objective: To evaluate caregiver burden among primary caregivers.
Hypothesis (H01): There is no significant caregiver burden.

Table 3 Descriptive Statistics of Caregiver Burden

Variable	N	Mean	SD	Minimum	Maximum
Burden Score	40	28.32	10.181	14	44

Interpretation
The table displays the caregiver burden assessment results which determine the level of caregiver burden through their evaluation. The caregivers show moderate to high burden according to the mean burden score which has a value of 28.32 and a standard deviation of 10.181.

Association between Psychological Distress and Duration of Illness
Objective To examine associations between psychological distress and socio-demographic variables.
Hypothesis: There is a significant association between distress level and duration of illness.

Table 4.1 Crosstabulation of Distress Level and Duration of Illness

Distress Level	<6 months	6–12 months	>1 year	Total
Low Distress	5	10	0	15
High Distress	0	2	23	25
Total	5	12	23	40

Table 4.2 Chi-Square Test

Test	Value	df	Sig. (p)
Pearson Chi-Square	28.45	2	.000
Likelihood Ratio	26.90	2	.000
N of Cases	40	—	—

Interpretation
The Chi-square test of independence showed a significant statistical link between distress levels and illness duration. The test results showed a X^2 value of 28.45 with two degrees of freedom and 40 total participants. The test results showed that patients who had been sick for more than one year experienced more psychological distress than those with shorter illness durations.

Relationship between Psychological Distress and Caregiver Burden
Objective: To assess the relationship between patient distress and caregiver burden.
Hypothesis(H01): There is a significant relationship between psychological distress and caregiver burden.

Table 5 Correlation between HADS Score and Caregiver Burden

Variables	HADS Score	Burden Score
HADS Score	1	.72**
Burden Score	.72**	1
Sig. (2-tailed)	—	.000
N	40	40

Note: $p < .01$

Interpretation

The two variables psychological distress and caregiver burden show a strong positive connection which is confirmed by the statistical result that shows the correlation coefficient at .72 and the p value at less than .01. The study results show that when patients experience greater levels of anxiety and depression their caregivers face more demanding responsibilities.

Predictors of Caregiver Burden

Objective: To identify predictors of caregiver burden.

Hypothesis (H01): Psychological distress significantly predicts caregiver burden.

Table 6 Regression Analysis Predicting Caregiver Burden

Predictor	B	Std. Error	Beta	t	Sig.
(Constant)	-3.558	.438	—	-8.118	.000
HADS Score	1.258	.041	.934	30.451	.000
Stage	.672	.304	.068	2.212	.033
Gender	.075	.181	.004	.413	.682

Interpretation

The regression analysis results show that psychological distress functions as an important predictor for caregiver burden because the analysis produced a statistical value of ($\beta = .934$, $p < .001$). The caregiver burden shows a significant link to disease stage, but gender does not produce any substantial impact.

DISCUSSION

Cancer exists as both a deadly physical condition and a primary cause of emotional distress for patients and their caregivers. The diagnostic process together with treatment procedures and prognosis uncertainty and changes in patient roles create conditions which result in heightened anxiety and depression and emotional distress. Caregivers who handle patient management duties experience heavy burdens because they must care for patients over long periods of time. The current research focused on studying psychological distress in oncology patients and caregiver burden along with their relationship to different socio-demographic factors.

The findings indicated that a majority of study participants exhibited psychological distress at atypical levels. The research results indicate that cancer patients encounter significant emotional difficulties during their medical care. Zabora et al. (2001) found that a majority of cancer patients experience anxiety and depression at clinically significant levels, aligning with the results of the current study. The research conducted by Mitchell et al. (2011) found that cancer patients exhibited increased levels of depression and distress among all cancer types. The research results indicate that cancer treatment centers ought to conduct routine psychological evaluations for their patients. The study showed that primary caregivers faced moderate to high degrees of caregiver burden. The findings indicate that oncology caregivers face significant physical and emotional challenges. The research findings align with those of Zarit et al. (1980), who showed that caregivers frequently experience stress and fatigue, resulting in reduced quality of life.

Given et al. (2004) established that cancer caregiving requires extended demands which bring negative impacts on caregivers' mental health. The present study supports the

importance of addressing caregiver burden as part of comprehensive cancer care. The Chi-square analysis showed no significant association between gender and psychological distress ($p > .05$). Both male and female participants experience equal distress levels which testing shows. Research by Hagedoorn et al. (2002) shows that caregivers experience psychological distress at nearly identical levels when research teams examine their situations. The current findings show that distress depends more on situational and illness-related factors than on gender because some studies show that females experience higher distress levels.

The study findings indicated a significant relationship between psychological distress and the length of caregiving, as extended caregiving durations correlate with heightened levels of distress, achieving statistical significance at $p<.001$. The findings indicate that caregivers with ongoing caregiving duties encounter rising stress levels over the course of their caregiving experience. The findings from the research indicate that Pinquart and Sörensen (2003) identified a direct link between prolonged caregiving duration and heightened emotional stress and symptoms of depression. The study by Kim and Schulz (2008) demonstrated that long durations of caregiving lead to significant adverse impacts on an individual's mental health. The findings of the study indicate that duration serves as a crucial factor that influences the likelihood of experiencing psychological distress. The research found a significant positive correlation. The correlation strength observed in this study ($r = .72$) appears somewhat higher than many previous reports, suggesting that caregiver burden in India may be intensified by cultural expectations related to caregiving. In collectivist societies, caregiving is frequently perceived as an ethical necessity, resembling a moral duty rather than a role individuals opt for. Such a configuration can lead to excessive emotional engagement and also diminish psychological barriers. As a result, the cultural pattern may amplify the transmission of distress between patients and their caregivers, leading to an increased sense of perceived burden. In numerous Indian healthcare settings, the lack of structured psychosocial support systems may exacerbate this relationship, leading to a rapid deterioration in practice. The connection between psychological distress and caregiver burden exhibited a correlation coefficient of $r = .72$ and was statistically significant at $p < .001$.

This finding indicates that elevated levels of anxiety and depression result in a greater perceived burden. The findings of this study support the previous results of Adelman et al. (2014), which indicated that emotional distress serves as a key element that heightens caregiver burden. Research by Bevans and Sternberg (2012) indicates that the psychological stress caregivers face heightens their sense of burden. The present study shows that distress and burden are interrelated elements in this scenario. The study revealed that psychological distress was the primary factor predicting caregiver burden. The examination revealed that the stage of cancer had a less strong but significant influence. The analysis revealed that gender exhibited no significant correlation with the research findings. The findings align with previous studies indicating that emotional distress is the primary factor influencing caregiver burden, as noted by Sherwood et al. 2005. Progressed stages of illness result in increased caregiving demands, which researchers have identified as a significant factor influencing disease severity. The present study shows that psychological factors are more significant predictors of caregiver burden than demographic variables. The research results demonstrate that psychological distress together with extended caregiving periods represents the primary factors that create caregiver burden. The study results demonstrate that oncology treatment centers need to implement psychosocial support services to fulfill the needs of both their patients and their caregivers.

Even though the current study did not show any statistically significant link between gender and psychological distress, earlier work has turned out contradictory in different settings. For example, Pinquart M and Sörensen S, reported that female caregivers often express higher emotional distress as well as caregiver burden, tied to traditional care expectations and this kind of emotional involvement. Additionally, recent research from India indicates that mothers and female partners often experience greater caregiving stress, primarily due to role overload and limited social support. Thus, the discrepancy between those earlier findings and our observations could result from a limited sample size, changing household dynamics over time, or just a more uniform caregiving involvement among male participants in this specific sample.

Alignment with SDG 3: Good Health and Well-Being

This research closely corresponds with the United Nations Sustainable Development Goal 3 (SDG 3): Good Health and Well-Being. This one focuses on ensuring individuals can lead healthy lives and that well-being is encouraged for all, across all age brackets. This research examines the psychological distress experienced by oncology patients and the caregiver burden shouldered by their primary caregivers, emphasizing mental health, emotional stability, and psychosocial support in cancer treatment essentially, the complete approach.
Cancer is not merely a physical issue; it is also a significant psychological and social concern that, in effect, alters the experiences of patients and their families. This study revealed significant levels of anxiety and depression in cancer patients, as well as moderate to high levels of caregiver burden among those providing care. These findings emphasize a pressing requirement to incorporate mental health resources, emotional support, and caregiver aid into the oncology healthcare system, not as an afterthought but as integral components of standard care.

Previous studies have suggested comparable concepts, particularly regarding psychosocial health in cancer care environments. For example, Zabora et al. (2001) reported significant prevalence rates of psychological distress in cancer patients across different cancer locations, and it was substantial. Subsequently, Mitchell et al. (2011) found increased levels of depression, anxiety, and adjustment challenges in oncology and palliative care populations.

Also, work by Adelman et al. (2014) together with Bevans & Sternberg (2012) has underscored that caregiver burden and emotional strain can harm caregivers' physical health and their psychological health too, with consequences that tend to stick around.

The present study kind of contributes to SDG 3 by pushing forward, or at least highlighting:
- Mental health awareness within oncology care, sort of as a priority.
- Early psychological screening, and then timely intervention.
- Psychosocial counseling options for patients and for caregivers too.
- A family centered plus holistic healthcare mindset.
- Lowering emotional distress while also easing caregiver burnout.
- Better overall quality of life, and greater emotional resilience.

The research, particularly backs up Target 3.4 of SDG 3. That target wants to push mental health and wellness, while simultaneously lessening the burden of non-communicable diseases, not just through prevention but also through treatment and supportive care as well. In this study, examining anxiety, depression, emotional exhaustion, and caregiver burden, the authors advocate for more comprehensive healthcare models where physical and

psychological aspects are addressed jointly rather than in isolation. In the Indian setting, caregiving responsibilities are frequently linked to cultural norms and family duties, thus if organized psychosocial assistance is lacking, emotional stress increases, and financial burdens tend to escalate as well. As a result, the research emphasizes the need to strengthen psychosocial oncology services, enhance counseling programs, and ensure mental health support remains integral within healthcare facilities, rather than merely an afterthought. Ultimately, this study contributes to the broader SDG 3 objective by promoting healthcare that is equitable, accessible, and comprehensive health systems focused on mental wellness, improved emotional health, and supportive cancer treatment for both patients and their caregivers.

CLINICAL IMPLICATION

The results from this present study have important implications for psycho oncology research, clinical practice, and healthcare policy, sort of in one line. In keeping with the Stress and Coping Theory by Lazarus and Folkman (1984), it seems that the psychological impact of cancer doesn't only come from the disease itself, but also from how patients and caregivers make sense of, and then manage, the demands tied to it. Here, the findings indicate that prolonged caregiving, and higher levels of patient psychological distress, can surpass the coping capacity that is available, in other words this contributes to stronger caregiver burden, and emotional exhaustion that becomes harder to reverse. Overall, these results also align with the Multidimensional Burden Model, which frames caregiver burden as including psychological, physical, social, and financial dimensions not just emotional distress, and it s not limited to feeling bad only.

The strong positive link we observed between patient psychological distress and caregiver burden fits well with the Dyadic Coping Model (Bodenmann, 1997), suggesting that stress in one person inside the dyad, directly spills over to the emotional state of the other. Similar outcomes have been described by Northouse et al. (2010), Bevans and Sternberg (2012), and Adelman et al. (2014), showing that psychological distress in cancer patients tends to connect with higher caregiver burden, worse coping, and a reduced quality of life. On a related note, Teo et al. (2023) reported that psychological distress can emerge at the same time in patients with advanced cancer and in their caregivers. This reinforces why it matters to view the patient–caregiver dyad as a combined psychosocial unit, not as two separate things.

From a clinical perspective, the findings sort of emphasize that routine oncology care should go beyond purely biomedical treatment, and basically include comprehensive psychosocial assessment plus intervention.

Standardized screening, using validated instruments like the Hospital Anxiety and Depression Scale (HADS) and the Zarit Burden Interview (ZBI), ought to be baked into routine oncology services at diagnosis during treatment, and across survivorship or palliative care. If psychological distress is picked up earlier, it may allow quicker referral to psycho-oncologists, clinical psychologists, psychiatrists, psychiatric social workers, and oncology counselors, so evidence-based interventions can happen sooner, like cognitive-behavioural therapy, supportive psychotherapy, psychoeducation, stress-management training, mindfulness-based interventions, and family counselling.

The present findings also highlight, the need to use a family centred model of cancer care. Instead of focusing only on patients, oncology teams should acknowledge caregivers as

secondary patients, who still need systematic psychological assessment and support. Structured caregiver interventions, such as psychoeducational programs, caregiver skills training respite care peer support groups, and emotional counselling, might lower caregiver burden, improve coping capabilities enhance treatment adherence, and in turn contribute to better outcomes for the patient.

These findings feel especially relevant in the Indian sociocultural setting, where caregiving is mostly family based and it's really shaped by cultural principles like collectivism, filial responsibility, and familial obligation. Unlike a lot of Western healthcare systems that lean on institutional caregiving and hospice backing, Indian families often end up carrying the main caregiving load, with only a few formal psychosocial services around. So, caregivers commonly run into emotional strain, financial trouble, role overload, and social isolation, and they may also keep quiet about their own psychological needs because caregiving is viewed as a moral and cultural duty. The clear connection we saw here between longer caregiving and more psychological distress, really points toward the need for psychosocial interventions that are culturally sensitive, ones that can reflect these particular caregiving realities.

From a public health and policy angle, bringing psychosocial oncology support into everyday cancer care could make a big difference for mental health, decrease caregiver burnout, support better treatment adherence, and lift quality of life for both patients and caregivers. Healthcare leaders and policy makers should focus on building multidisciplinary psycho oncology services inside tertiary cancer centres and also in community oncology settings. Also, there should be ongoing capacity building efforts, where healthcare professionals are trained in psychosocial assessment and in communication styles that are responsive to culture, because that feels like a core part of quality oncology care.

The present findings also somewhat support the objectives of the World Health Organization's people-centred healthcare framework and they sort of align with United Nations Sustainable Development Goal 3 Good Health and Well-Being by advocating an equitable access to mental health services, alongside cancer treatment. Future longitudinal and multicentre studies are warranted so we can better evaluate culturally adapted psychosocial interventions and caregiver support programmes across a range of oncology populations. Such research would help reinforce the evidence base for building comprehensive psycho-oncology services that address the intertwined psychological needs of both patients as well as their caregivers.

CONCLUSION

This study demonstrates that psychological distress in cancer patients is closely associated with caregiver burden, and it should be regarded as a collective psychosocial challenge affecting the entire family unit, rather than just an individual. The findings indicate significant levels of anxiety and depression in the patients, as well as a moderate to high burden on the primary caregivers. Moreover, the longer caregiving continues, the more it appears to foster emotional fatigue and mental stress; this aspect was quite evident. The connection between psychological distress and caregiver burden is quite robust, indicating that oncology care cannot focus solely on patients; there is an urgent need to shift towards a family-centered psychosocial model. In the Indian context, caregiving duties are strongly rooted in cultural duties, often lacking sufficient backing from formal healthcare systems. Thus, emotional stress can intensify further, particularly due to financial strain, reduced psychosocial support, and the ongoing challenges associated with caregiving. The study

emphasizes the necessity of integrating regular psychological assessments, counseling services, and support for caregivers directly within oncology treatment settings. If distress is identified promptly and then managed for both patients and caregivers, emotional health may enhance, adherence to treatment could improve, and the overall quality of life may increase. Future research should employ longitudinal designs and culturally sensitive methods to better understand how distress and caregiver burden evolve through various stages of cancer care.

Limitations

This present research has some limitations that should be considered when interpreting the findings. Initially, the study had a limited sample size of just 40 participants, which inherently restricts the extent to which the results can be generalized to broader oncology populations. Moreover, the combination of purposive and convenience sampling may have resulted in selection bias, as participants were primarily recruited based on their availability and eagerness to participate. Secondly, the study design was cross-sectional, examining psychological distress and caregiver burden at a single moment in time. As a result, it is challenging to establish causal connections between distress and caregiver burden. Psychological experiences in oncology settings are not fixed; they can change, often rapidly, during diagnosis, active treatment, remission, or even as the disease progresses.

Consequently, longitudinal studies are required to observe how distress develops over time. Third, the research relied solely on self-reported psychological tools such as HADS and ZBI 12. Despite these tools being widely validated, self-reported outcomes may be influenced by social desirability bias, emotional suppression, and the participants' willingness to openly discuss their challenges. In collectivist societies like India, caregivers might downplay emotional struggles since caregiving is frequently seen as a moral obligation, leading to these emotions being subdued silently.

The instruments employed in the research were originally developed in Western cultural settings, so they might not accurately focus on culturally unique aspects of caregiving stress, spiritual guilt, familial duty, or the financial reliance often observed in Indian families. The research also failed to assess crucial factors such as socioeconomic status, coping mechanisms, the social support network, or any prior mental health issues, all of which can significantly influence psychological distress and caregiver burden. In future research, it would be beneficial to utilize larger and more diverse samples, culturally appropriate assessment instruments, and longitudinal methodologies, ensuring that the results are more in depth and broadly applicable.

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Acknowledgment

I Zainab Hashim, (Enroll. No. 2400103669) of Integral University Lucknow prepared this research paper. The University has provided me Manuscript Communication Number (MCN) IU/R&D/2026-MCN0004759. In the future, I will keep on working on improving my research work as per the standard.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Hashim, Z., Aqil, Z. & Raturi, S. (2026). Psychological Distress and Caregiver Burden among Oncology Patients and Caregivers. *International Journal of Indian Psychology*, *14*(3)*,* 1154-1168. DIP:18.01.099.20261403, DOI:10.25215/1403.099