



Quality of Life Impairment in Anxiety Disorders and Its Association with Caregiver Burden: A Narrative Review

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ABSTRACT:

Anxiety disorders are among the most common psychiatric illnesses, often starting in youth and following a chronic course. They substantially impair quality of life (QoL) across physical, psychological, social and environmental domains and place heavy demands on family caregivers. This narrative review synthesizes evidence on QoL impairment in anxiety disorders and its relationship with caregiver burden. Evidence indicates that QoL is markedly reduced in patients with anxiety disorders, particularly in mental health and social functioning. Greater anxiety symptom severity and comorbid depression predict worse QoL. Caregiver burden is substantial across anxiety disorders; high patient dependence, avoidance-related caregiving adaptations, persistent reassurance seeking and caregiver depressive symptoms increase burden. Cultural norms and lack of formal services further exacerbate caregiver strain. Routine assessment of QoL and caregiver burden, alongside caregiver-inclusive interventions, is essential for improving outcomes.

Introduction

1. Introduction

Anxiety disorders (ADs), including generalized anxiety disorder, panic disorder, social anxiety disorder and obsessive-compulsive disorder (OCD), affect roughly 3.6 % of the world's population and rank among the leading causes of disability [1,2]. These conditions are characterized by persistent and excessive fears or worries that cause distress, avoidance and functional impairment. Traditional outcome studies have focused on symptom reduction, yet improvements in symptoms are not always accompanied by parallel improvements in quality of life (QoL). QoL refers to a person's subjective evaluation of their physical health, psychological state, social relationships and environmental circumstances. Many

patients continue to report poor QoL despite symptom improvement [3].

Family members often assume the role of informal caregivers, providing practical and emotional support. Caregiving responsibilities include supervising medication, accompanying patients to appointments, managing financial matters and offering constant reassurance. This role is physically and emotionally taxing, leading to high levels of stress, depression and anxiety among caregivers. A national survey from China reported that over 70 % of informal caregivers of people with mental illness experienced high caregiving burden and more than half suffered moderate to severe depression and anxiety [3]. Available evidence from anxiety-related caregiving research suggests that caregiver burden may be substantial and comparable to



that observed in other chronic psychiatric conditions, exceeding that reported in depressive disorders in some contexts [4,5]. This review synthesizes research on QoL impairment in anxiety disorders and examines how these impairments relate to caregiver burden.

2. Quality of Life Impairment in Anxiety Disorders

2.1. Measurement and conceptualization

QoL is a multidimensional construct encompassing subjective perceptions of physical health, mental well-being, social relationships and environment. Instruments such as the WHOQOL-BREF, Quality of Life Inventory and Quality of Life Enjoyment and Satisfaction Questionnaire assess these domains. Subjective measures of QoL provide unique information not captured by symptom scales; for example, Barrera and Norton found that diagnostic symptom severity did not predict QoL, whereas comorbid depression did [6].

2.2. Evidence of impairment

Meta-analytic evidence confirms that patients with anxiety disorders have significantly poorer QoL than non-clinical controls, with large effect sizes across all anxiety disorders. Mental health and social functioning domains are particularly affected. In a cross-sectional study of individuals with generalized anxiety disorder, social phobia and panic disorder, patients reported less satisfaction across life domains than non-anxious adults; comorbid depression but not anxiety severity predicted poorer QoL [7]. Recent longitudinal work shows that cognitive behavioural therapy (CBT) leads to moderate improvements in QoL, but gains in QoL often lag behind symptom reductions [1].

2.3. Determinants of QoL

QoL impairment is influenced by multiple factors. Greater anxiety symptom severity correlates with poorer QoL. Comorbid depression exerts a strong additive effect. Chronicity of illness, early onset, low socioeconomic status, unemployment and lack of social support further reduce QoL. Subjective constructs such as anxiety sensitivity, avoidant coping and emotion regulation difficulties also mediate the relationship between symptoms and QoL [8,9]. Conversely, strong social support, adaptive coping skills and effective treatment engagement predict better QoL.

3. Caregiver Burden in Mental Health

Caregiver burden refers to the objective and subjective strains experienced by those who care for individuals with chronic illnesses. It encompasses emotional distress, physical exhaustion, social isolation and financial strain. Instruments like the Zarit Burden Interview (ZBI) quantify burden, with scores above 40 often indicating severe burden. High burden is associated with increased caregiver depression and anxiety, poor physical health and reduced quality of care. In a cross-sectional Ethiopian study, mean ZBI scores approached 48, and over 70 % of caregivers reported moderate-to-severe burden [10]. Studies across mental disorders estimate the prevalence of high burden at around 30 %. Burden is influenced by patient factors (symptom severity, functional impairment), caregiver factors (mental health, coping skills) and contextual factors (social support, cultural norms). Cultural expectations often require family members to provide extensive care; in China, traditional familism and limited formal mental health services contribute to prolonged caregiving [11,12].

4. Caregiver Burden in Anxiety Disorders

4.1. Generalized anxiety, panic and social anxiety disorders

Research on caregiver burden in other anxiety disorders is limited. Anecdotal reports suggest that caregivers of patients with panic disorder or agoraphobia often curtail their own activities to accompany patients, while caregivers of individuals with social anxiety disorder may take on social roles for them. Cross-diagnostic studies indicate that caregiver burden does not differ significantly by patient diagnosis, implying that caregivers of anxiety disorder patients may experience burdens similar to those of caregivers of other psychiatric conditions [13]. Factors such as patient dependence, avoidance behaviour and comorbid depression likely contribute to burden, but empirical evidence is needed.

4.2. Determinants of burden and QoL among caregivers

Determinants of caregiver burden include patient symptom severity, illness chronicity, comorbid depression and functional impairment. Caregiver factors such as depressive symptoms, coping style and perceived



social support play significant roles. Evidence from pediatric anxiety-spectrum caregiving research suggests that caregiver depressive symptoms and child externalising behaviours are stronger predictors of caregiver burden than anxiety symptom severity alone [14]. Socioeconomic strain, stigma and lack of respite services exacerbate burden. Protective factors include strong social networks, psychoeducation and involvement in treatment planning.

5. Relationship Between Anxiety Severity, Quality of Life and Caregiver Burden

Contemporary research portrays the relationship among anxiety symptom severity, patient quality of life and caregiver burden as dynamic and reciprocal. One conceptual framework positions these variables at the vertices of a triangle: higher anxiety severity diminishes patients' ability to function autonomously, thereby reducing quality of life and amplifying caregiver burden [15,16]. Severe worry, panic attacks or intrusive obsessions can impede work, schooling and social interactions; patients may depend on others to manage everyday tasks or to avoid feared situations. Such dependence not only lowers the patient's sense of autonomy and satisfaction but also compels relatives to reorganize their own activities, increasing objective and subjective burden [17]. For example, in panic disorder and agoraphobia, relatives may accompany patients on every outing; in social anxiety disorder, caregivers may speak on the patient's behalf or handle social obligations. These accommodations, while intended to alleviate distress, often perpetuate avoidance and maintain functional impairment.

Findings from broader anxiety-related caregiving literature highlight the role of sustained caregiving adaptations, such as reassurance provision and avoidance enabling behaviours, in contributing to caregiver burden and reduced personal well being [18]. Accommodation fosters a cycle in which patient anxiety is temporarily alleviated but compulsions intensify over time. Similar patterns likely occur in other anxiety disorders, though data are sparse [19]. The presence of comorbid depression in the patient or caregiver further exacerbates this cycle [20]. Cultural norms emphasizing filial duty can intensify burden by discouraging the delegation of care to external services and by increasing guilt when caregivers feel overwhelmed. Conversely, caregivers

with strong social support networks and adaptive coping strategies experience lower burden, suggesting that psychosocial resources moderate the relationship between patient symptoms and caregiver outcomes [21,22].

Emerging evidence also indicates that patient quality of life may mediate the impact of anxiety severity on caregiver burden. Studies in youth with anxiety-related functional impairment show that caregiver psychological distress and disruptive behaviours, rather than anxiety symptom intensity alone, predict caregiver burden [23]. These findings suggest that behaviours that visibly disrupt family routines – such as aggression or school refusal – contribute more to caregiver strain than internal distress. Similar trends are observed in generalized anxiety disorder, where high levels of fatigue, muscle tension and avoidance impose practical challenges on families. Longitudinal studies are needed to determine causality, but the current literature underscores the importance of addressing functional impairments and quality of life alongside symptom reduction when aiming to ease caregiver burden [24,25].

6. Measurement Instruments

Reliable measurement tools are indispensable for evaluating anxiety severity, quality of life and caregiver burden in both research and clinical settings. Among symptom measures, the Hamilton Anxiety Rating Scale (HAM-A) is a clinician-administered instrument covering 14 items related to psychic and somatic anxiety; it remains a standard in clinical trials [26]. The Beck Anxiety Inventory (BAI) complements the HAM-A by providing a self-reported assessment of somatic and cognitive anxiety symptoms that may not surface during clinical interviews [27,28].

Quality of life is most commonly assessed using multidimensional instruments. The WHOQOL-BREF, developed by the World Health Organization, evaluates four domains—physical, psychological, social and environmental—and has been translated and validated across diverse cultures. Scores are standardized, facilitating comparisons across studies and populations. The Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) and the Quality of Life Inventory (QOLI) are additional tools that incorporate patient ratings of the importance of each life domain,



enabling tailored interventions. Studies repeatedly demonstrate that QoL improvements lag behind symptom reductions, particularly following pharmacotherapy or cognitive behavioral therapy; thus, clinicians should employ these instruments to monitor progress beyond symptom remission [29,30].

Several instruments quantify caregiver burden. The Zarit Burden Interview (ZBI) is the most widely used; it consists of 22 items addressing emotional strain, financial difficulties, social restrictions and health impacts, with scores above 40 indicating high burden. Short forms (e.g., ZBI 12) provide briefer screening options without sacrificing reliability. The Caregiver Strain Index (CSI) offers a 13 item measure encompassing employment, financial, physical and social strain. Measures assessing caregiving-related behavioural adaptations and caregiver psychological distress provide additional insight into mechanisms contributing to caregiver burden across anxiety disorders. Measures such as the General Health Questionnaire (GHQ 12) and the Patient Health Questionnaire (PHQ 9) allow the identification of depression and anxiety in caregivers themselves, ensuring that caregiver mental health needs are addressed [31–35]. Incorporating these assessments into routine care enables clinicians to identify at-risk families, monitor changes over time and tailor interventions that simultaneously target symptom reduction, functional recovery and caregiver well-being.

7. Clinical and Public Health Implications

Routine QoL assessment should accompany symptom measurement in anxiety disorder treatment. Clinicians should evaluate caregiver burden and incorporate caregivers into treatment planning. Psychoeducation programs that teach caregivers about anxiety disorders, coping strategies and communication skills can reduce burden and improve caregiver QoL. Respite services and support groups provide caregivers with emotional support and opportunities for self-care. In low- and middle-income countries, culturally sensitive interventions, community mental health services and financial assistance are needed to alleviate caregiver burden [36].

8. Research Gaps and Future Directions

Longitudinal studies are needed to track changes in caregiver burden over time and to test whether QoL mediates the relationship between anxiety severity and caregiver burden. Studies should examine cultural and socioeconomic influences on caregiving and explore protective factors such as social support and adaptive coping. Intervention trials targeting caregivers—through psychoeducation, peer support and digital tools—are required to evaluate efficacy. Economic evaluations of caregiving in anxiety disorders would inform policy on resource allocation.

9. Conclusion

Anxiety disorders significantly impair quality of life and impose considerable burden on family caregivers. Despite improvements in symptomatology through treatments like CBT, QoL often remains poor. Greater anxiety severity, comorbid depression and longer illness duration predict worse QoL and higher caregiver burden. Informal caregivers frequently experience substantial stress, depression and anxiety, particularly in cultures with strong familistic values. Integrating QoL assessment and caregiver support into treatment, delivering culturally tailored interventions and expanding research on caregiver burden across anxiety disorders are essential steps toward improving outcomes for patients and their families.

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