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EXPLORING THE PSYCHOSOCIAL IMPACT OF OPIOID USE DISORDER AND SEVERE DEPRESSION ON PARENT-CHILD AND SIBLING RELATIONSHIPS

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Abstract

This case report presents the clinical profile, assessment, and therapeutic intervention of a 46-year-old male diagnosed with Severe Opioid Use Disorder and a Severe Single Episode of Major Depressive Disorder, accompanied by parent-child and sibling relational problems. The patient exhibited a long history of heroin dependence, compounded by socio-emotional stressors, including unresolved familial conflicts and financial hardship. Initial symptoms included persistent low mood, impaired memory, reduced occupational functioning, and physical complaints such as abdominal pain, nausea, and general weakness. Psychometric assessments, including the MSE, DAST-10, BDI-II, PCRS, and SRQ, were administered to evaluate substance use and depressive symptomatology. A structured intervention plan based on motivational interviewing, relapse prevention strategies, and cognitive-behavioral techniques was implemented during inpatient care. The therapeutic process followed the stages of the change model, with sessions targeting self-esteem enhancement, emotional regulation, and psychosocial support. Significant improvement was noted in the patient's mood, motivation for recovery, and family involvement. The case highlights the importance of integrating biopsychosocial approaches and family psychoeducation in the management of co-occurring substance use and depressive disorders.

INTRODUCTION

Opioid Use Disorder (OUD) has emerged as a growing public health crisis in Pakistan, with significant psychosocial consequences that extend beyond the individual to affect families, communities, and broader societal structures. Characterized by compulsive opioid use despite harmful consequences, OUD is associated with a wide range of psychological, social, and functional impairments (APA, 2022). In Pakistan, the prevalence of opioid use, particularly heroin and synthetic opioids, has increased in recent years, driven by socio-economic instability, trauma exposure, unemployment, and weak access to mental health care (UNODC, 2022).

The psychosocial burden of OUD in Pakistani adults is multifaceted. Individuals often face stigma, social exclusion, family conflict, and impaired occupational functioning (Khalid et al., 2021). Moreover, limited availability of evidence-based treatment and support

services, especially in rural and underserved areas, exacerbates the risk of relapse and chronic psychological distress (Raza et al., 2020). Mental health comorbidities such as depression, anxiety, and post-traumatic stress disorder are also frequently reported among those with OUD, contributing to a vicious cycle of dependency and marginalization (Iqbal & Khalique, 2023).

Despite the severity of the issue, research focusing on the lived psychosocial experiences of adults suffering from OUD in Pakistan remains scarce. Most existing literature either addresses the biomedical aspects of addiction or is based on data from Western contexts, limiting its applicability to local socio-cultural dynamics. A qualitative case study approach can offer nuanced insights into the psychosocial dimensions of OUD by capturing the personal, familial, and community-level impacts experienced by affected individuals.

Depression is also one of the most prevalent mental health disorders worldwide, contributing significantly to psychosocial dysfunction in various domains of life, including family relationships. Globally, more than 280 million people are affected by depression, making it a leading cause of disability (WHO, 2023). In Pakistan, the load of depression is substantial, with recent estimates suggesting that nearly 34% of the adult population experiences symptoms of depression and anxiety (Khan et al., 2022). Despite its high prevalence, the interpersonal dimensions of depression, particularly its impact on familial relationships, remain underexplored in the cultural context of Pakistan.

Family structures in South Asian societies are often interdependent, with close-knit emotional ties and strong expectations of familial roles and responsibilities. Within such structures, the psychosocial impact of depression can be far-reaching, not only affecting the individual's mental and emotional well-being but also straining relationships with parents, siblings, and other family members. Depression in adults has been linked to increased irritability, emotional withdrawal, impaired communication, and reduced empathy, all of which can damage trust and connection within families (Santini et al., 2015). Parent-child and sibling relationships may suffer due to shifts in perceived support, role functioning, and emotional availability. Furthermore, stigma around mental health in Pakistan often prevents individuals from seeking timely treatment, which can exacerbate both personal suffering and relational conflict (Farooq et al., 2021). Research suggests that unresolved familial tension due to mental health issues contributes to poorer treatment outcomes and may even perpetuate a cycle of psychological distress within family systems (Hafeez et al., 2020). These dynamics highlight the need to understand depression not only as an individual experience but as a condition with deep psychosocial ramifications.

Opioid Use Disorder (OUD) and Major Depressive Disorder (MDD), particularly in their severe forms, are complex psychiatric conditions that not only affect individual functioning but also have profound psychosocial implications for family systems. These disorders often co-occur, exacerbating symptom severity and complicating treatment outcomes (Volkow et al., 2016). While considerable research has explored the clinical management of OUD and depression independently, less attention has been paid to how their combined presence may deteriorate the quality of familial relationships, particularly between parents and children and among siblings.

Families are often the first line of support for individuals with mental illness, yet they are also vulnerable to emotional, psychological, and relational strain due to the chronic stress and unpredictability associated with these disorders (Calheiros et al., 2020). Parent-child dynamics may shift drastically when a parent is incapacitated by substance dependence or mood disturbances, leading to attachment disruptions, communication breakdowns, and role reversals (Suchman et al., 2012). Similarly, sibling relationships can become conflicted or distant in families affected by mental illness, often due to perceived imbalances in parental attention, household responsibilities, or emotional availability (Yucel & Derin, 2021).

Co-occurring OUD and depression are associated with higher rates of emotional dysregulation, impaired empathy, and interpersonal conflict, which can compromise family cohesion (Fitzgerald et al., 2021). The bidirectional nature of these relationships further complicates the picture: not only do these disorders affect the family system, but strained family relationships may also serve as risk factors for the

exacerbation or relapse of OUD and depression (Beardslee et al., 2011).

Given this backdrop, the current case study seeks to explain the lived experience of a family impacted by both OUD and severe depression, with a specific focus on the psychosocial consequences for parent-child and sibling relationships. By delving into the dynamics within a single-family unit, this study aims to shed light on the relational challenges and adaptive strategies employed in the face of chronic psychological distress, thereby contributing to a better understanding of family-based interventions in mental health care.

Presenting Complaints

The patient exhibited a variety of psychological, cognitive, and physical symptoms. His principal issue was heroin addiction, which he indicated had continued for the past two years. In the prior two to three weeks, he also exhibited the following symptoms:

- Compromised memory function, marked by significant forgetfulness and poor concentration.
- Persistent depressive mood is characterized by anhedonia and diminished emotional reactivity.
- Impaired occupational performance.
- Somatic symptoms, including chronic lower abdomen discomfort and nausea, are not linked to any identifiable medical problem.
- Suboptimal physical health is characterized by pervasive weakness.
- Appetite disruption, notable reduction in food consumption.
- Sleep disorders, such as insomnia and interrupted sleep.

These symptoms were temporally linked to heightened psychosocial stress and a relapse into substance use.

History of the Case

The patient is a 46-year-old married male with a 19-year marital history and four children. He is the second of ten siblings and currently resides in Wah Model Town while being employed at the Wah Factories Branch. He has completed his education up to the middle school level. His birth and early developmental history are unremarkable, with all developmental milestones achieved within expected parameters. He began formal education at the age of four and was described as a conscientious and well-behaved student. Despite consistent academic performance, his education was discontinued due to financial hardship, leading him to undertake various informal jobs during adolescence. His interpersonal behavior with teachers and peers was appropriate, and he engaged actively in recreational activities.

However, the patient reports a strained and emotionally distant relationship with his parents during childhood. He perceived his mother as emotionally unavailable and harsh, often expressing favoritism toward his younger siblings. The father, described as emotionally and physically absent due to occupational responsibilities, contributed little to the dynamic caregiving. The patient self-identifies as an emotionally sensitive and affectionate child who longed for maternal warmth, which he believes was denied. He reports longstanding resentment toward his mother and younger brother, particularly concerning perceived injustices over property inheritance. He has been living in a nuclear family system with his spouse and four children. While he describes his marital relationship as generally stable, his substance use has created increasing strain on family dynamics. His eldest daughter, currently enrolled in her second year of college, has expressed significant distress over his addiction and has actively encouraged him to seek help. Financial instability has compounded the familial and psychological stress, particularly in the procurement of opioids.

The patient initiated substance use approximately 7–8 years ago, following a significant interpersonal conflict with his mother concerning inheritance matters. He began with the use of naswar and cannabis-laced cigarettes as a coping mechanism. Over time, this escalated to heroin use, initially introduced through peers at his workplace. The patient reports that heroin use provided temporary relief from emotional distress and physical fatigue, though he acknowledges increasing tolerance and dependence over time. Due to financial limitations, his heroin consumption was restricted to a single daily dose (token), typically costing between PKR 100–150. He reports subjective experiences of temporary vitality followed by internal weakness. Two years prior, he underwent a brief inpatient detoxification at the POF Hospital Psychiatry Department, with an initial

period of recovery. However, a relapse occurred following renewed familial conflict, particularly with his younger brother and mother.

After relapse, the patient reported cognitive impairment (including memory deficits), mood disturbances (including persistent low mood and crying spells), irritability, and significant functional decline in occupational settings. Despite multiple self-initiated attempts to cease heroin use, he has been unsuccessful. He reports utilizing heroin for its perceived analgesic effects, especially following work-related injuries.

The patient recently presented to psychiatric services following the death of a close friend from a heroin overdose, which catalyzed his motivation for rehabilitation. Encouragement from family members, particularly his younger daughter, played a role in his renewed efforts to pursue treatment. He consumed his last dose of heroin four days before hospital admission. There is no documented family history of mental illness, no history of legal issues, and no significant comorbid medical conditions.

Assessment Measures

In the present case study, a comprehensive battery of standardized psychological assessments was employed to evaluate the individual's clinical presentation, relational difficulties, and substance use severity. The tools selected are widely used in clinical and research settings in Pakistan and have demonstrated reliability and validity in local populations.

Mental State Examination (MSE), the patient presented with a subjectively and objectively low mood. He was fully oriented to time, place, and person. Short-term memory functioning appeared impaired, while judgment remained intact. Thought processes were abstract, with no evidence of formal thought disorder. Speech was noted to be increased in rate, rhythm, and volume, though it remained relevant and coherent throughout the interview. The patient demonstrated good insight into his condition and exhibited observable motivation toward treatment.

Drug Abuse Screening Test (DAST-10) To assess substance dependence, particularly opioid use, DAST-10 was administered. This brief self-report instrument evaluates the degree of consequences related to drug abuse. Scores ranged from 0 to 10; the patient scored 6, which indicated a **severe level of drug-related problems**. The DAST-10 has been used in addiction centers across Pakistan and adapted in studies such as those by Ali et al. (2021).

The Beck Depression Inventory-II (BDI-II)

was used to assess the severity of depressive symptoms. The BDI-II is commonly used in Pakistan for both clinical diagnosis and research. Ranges from 0 to 63. The patient's score of **39 indicates severe depression** (Beck et al., 1996). The Urdu-translated versions have shown good internal consistency (α = .88) in Pakistani populations (Naz & Sultan, 2016).

Parent-Child Relationship Scale (PCRS) This scale, adapted for use in South Asian cultures, measured attachment, communication, and conflict levels between the parent and child. Higher scores indicate more positive relationships; lower scores or specific subscale deficits indicate relational distress (Rohner, 2005). Patients scored **low** in this test. Validated for use in Pakistani studies on child development and parental attachment (Khan & Rehman, 2019).

Sibling Relationship Questionnaire (SRQ)

This tool measures warmth, conflict, and rivalry among siblings. Subscale scores assess relational quality. The patient's elevated conflict or low warmth scores suggest problematic sibling relationships. Applied in adolescent mental health studies in Pakistan (Younas & Fatima, 2020).

Therapeutic Session Report

Session I

The initial session focused on obtaining a comprehensive account of the patient's substance use history. This marked his second admission to the psychiatric facility for opioid-related concerns. The patient reported daily use of heroin (approximately one token per day). His primary complaints included reduced physical energy, low mood, generalized body pain, nausea, and a noticeable increase in drug tolerance. During the session, he appeared disoriented and confused.

A comprehensive psychological assessment was conducted using standardized tools. The results

indicated severe opioid dependence along with symptoms consistent with a single episode of major depressive disorder. Based on these findings, a structured therapeutic intervention plan was initiated.

Session II

The second session emphasized enhancing the patient's motivation for change using principles of Motivational Interviewing (MI). The session adhered to the four foundational principles of MI:

The therapist concentrated on building therapeutic rapport and exploring the patient's family dynamics, particularly his perceived role within the family and his relationship with his mother. Eye contact was consistently maintained, and the patient appeared engaged throughout the session. The therapeutic plan was thoroughly explained, and a strong therapeutic alliance was established to promote ongoing participation in treatment.

Session III

The third session was conducted on the following day, as the patient was admitted as an inpatient and intensive psychological intervention was advised by the clinical supervisor. The primary therapeutic objective was to initiate motivational enhancement by developing discrepancy, a core technique in Motivational Interviewing (Miller & Rollnick, 2013). The patient was encouraged to identify and articulate the contrast between his current problems and his past functioning during a substance-free period.

During the session, the patient identified his most significant concern as the deterioration of his family relationships, citing an inability to provide adequate emotional, physical, and financial support to his spouse and children due to his heroin use. He also expressed that his mother and siblings showed hostility and social rejection, which he attributed to both his substance dependence and his perceived inferior socioeconomic status. Psychoeducation was provided regarding the impact of heroin dependence on interpersonal and occupational functioning. The patient was able to reflect insightfully on his behavioral deterioration and acknowledged personal responsibility. He remained cooperative, cognitively engaged, and emotionally responsive throughout the session.

Session IV

The fourth session took place on the subsequent day, and the session began with feedback from the patient regarding his emotional and psychological state following prior interventions. Building upon the patient's expressed motivation for change, the session focused on applying Prochaska and DiClemente's Transtheoretical Model of Change (1983). The stages addressed included:

1. Contemplation
2. Preparation/Determination
3. Action
4. Maintenance
5. Relapse Prevention/Termination

The pre-contemplation stage was omitted, as the patient had already progressed to the contemplation stage, exhibiting a clear awareness of the problem and a desire to change. He verbalized motivation to discontinue heroin use but also expressed concerns regarding the uncertainty of future success and feelings of hopelessness. Therapeutic focus was placed on reinforcing his determination, validating his concerns, and collaboratively planning actionable steps toward recovery while emphasizing the potential for relapse prevention.

The patient continued to demonstrate a positive therapeutic alliance, with growing self-efficacy and readiness for behavioral change.

Session V

The fifth therapeutic session commenced with feedback and reflection on the patient's experiences since the previous meeting. The patient reported significant physical and emotional discomfort associated with opioid withdrawal and expressed considerable distress, repeatedly requesting relief from the pain. Psychoeducation was provided to help the patient understand that the distressing physical symptoms were consistent with the detoxification process. The nature of withdrawal and its physiological basis were explained in clear, compassionate terms.

The therapist emphasized that although the process is inherently difficult, it represents a necessary step toward recovery and the achievement of a drug-free life. The patient was encouraged to recognize his own resilience and inner strength. Efforts were made to bolster self-efficacy by affirming the patient's capacity

to cope with the challenges of detoxification. The focus of the session was primarily supportive, intending to enhance the patient's confidence and instill hope that the current pain was temporary and worthwhile in the broader context of his recovery journey.

Session VI

This session began with a review of the patient's reflections from the previous encounter. The patient reported notable improvement in physical comfort and emotional state, demonstrating better posture, attentiveness, and cognitive engagement. Motivational interviewing techniques were utilized, particularly the "rolling with resistance" strategy, which facilitated a non-confrontational exploration of the patient's ambivalence about substance use.

Contradictory beliefs and misconceptions about drug use were discussed, aligning the conversation with the "decision" stage of Prochaska and DiClemente's Transtheoretical Model of Change. The patient expressed awareness of the personal, familial, and occupational consequences of continued drug use and demonstrated readiness for change.

Additionally, the session addressed unresolved interpersonal issues with his mother and siblings. Through guided emotional ventilation, the patient was encouraged to express long-held feelings of neglect and resentment, allowing for emotional catharsis and psychological relief. This emotional processing was integral to reducing internal distress and fostering therapeutic rapport.

Session VII

The focus of the seventh session was to enhance the patient's self-esteem and to facilitate progression into the action stage of the Transtheoretical Model of Change. The patient demonstrated insight into his condition and expressed a willingness to take independent steps toward reintegration into society without reliance on the therapist. During the session, BDI-II was re-administered to evaluate changes in depressive symptoms following psychotherapeutic intervention and pharmacological treatment. Results indicated a reduction in symptom severity, falling within the mild to moderate range. Subjectively, the patient reported feeling improved, although he acknowledged withholding emotional expression at home to avoid burdening his wife and children, who were already distressed due to his heroin dependence. The therapist reinforced his progress and validated his commitment to abstinence.

Session VIII

The eighth session emphasized relapse prevention, with particular focus on identifying and managing situational triggers that could lead to heroin use. The session began with a review of the therapeutic progress achieved throughout the inpatient treatment. The therapist provided positive reinforcement regarding the patient's improved physical appearance and functional participation in hospital activities.

High-risk scenarios were explored, including potential emotional provocation by family members (e.g., mother and brother), occupational injuries, or peer pressure to resume substance use. The therapist emphasized that heroin should not be used as a form of analgesia or recreation, and the patient was reminded of the progress he had made in becoming drug-free. The patient displayed increased resilience and expressed determination to face triggers with composure and strength.

Session IX

The final session marked the termination phase of therapy. The therapist sought the patient's feedback on the therapeutic process and its impact. The patient's spouse was invited to participate in the session and was provided psychoeducation regarding supportive strategies for maintaining recovery. She was encouraged to monitor the patient's behavior, promote family engagement, and help him disengage from persistent negative cognitions related to his mother and brother.

The therapist highlighted the importance of continued support, emotional validation, and constructive reinforcement in mitigating relapse risk. The patient was advised to attend regular follow-up sessions and adhere to the prescribed antidepressant regimen to ensure sustained recovery.

Conclusion

This case report aims to explain the psychosocial implications of OUD among adults in Pakistan, with a focus on mental health outcomes, interpersonal relationships, social functioning, and access to

support systems. By understanding these dynamics, the research seeks to inform culturally relevant interventions and contribute to the development of more holistic treatment models.

Prognosis is guarded but potentially favorable with sustained engagement in treatment, strong family support, and consistent follow-up. Early relapse risk is high, especially given past recurrence and unresolved family trauma. Long-term outcomes are improved when treatment integrates psychosocial support, pharmacotherapy, and family involvement (SAMHSA, 2020).

Ethical Considerations/Disclosures

Human Subjects: Consent was obtained from the participants in this study.

Conflicts of interest: None

Payment: All authors have declared that no financial support was received from any organization for the submitted work.

Other Relationships: All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work

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