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Impact of Alcoholism on Family Mental Health: A Community Psychology Study in Ballia District

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Abstract

Alcoholism is a pervasive public health challenge that significantly impacts not only individuals but also the mental health of their families. This study aimed to examine the psychological distress, coping strategies, stigma perception, and social support of family members of alcohol-dependent individuals in Ballia district, Uttar Pradesh, within a community psychology framework. A total of 222 participants were selected through random sampling, ensuring representation of both rural and urban households. Data were collected through standardized tools, including the GHQ-28 and Coping Strategies Inventory, alongside structured in-person and online interviews. Descriptive statistics (mean, standard deviation, frequencies, and percentages) were used to summarize demographic and psychological variables. To test group differences, independent samples t-tests were applied, comparing male and female participants as well as rural and urban families.

Findings revealed moderate to high levels of psychological distress among family members, with significantly higher distress reported in rural participants compared to their urban counterparts ($t(220) = 2.61$, $p = 0.010$). Families with treatment exposure displayed lower distress and greater use of problem-focused coping, while untreated families showed higher reliance on avoidance strategies. Rural families also perceived greater stigma but simultaneously reported stronger social support networks. These results underscore the dual role of community settings as sources of both vulnerability and resilience. The study highlights the need for family-centered interventions in clinical psychology and calls for integration of stigma-reduction strategies from TB management programs into alcohol rehabilitation services, particularly in rural contexts.

Keywords: *Alcoholism; Family Mental Health; Community Psychology; Coping Strategies; Stigma*

Introduction

Alcoholism remains one of the most pressing psychosocial and public health issues across India, with its consequences extending well beyond the individual to profoundly shape family life. Families of alcohol-dependent individuals often experience heightened psychological distress, strained relationships, financial instability, and social stigma. The study of family mental health in this context is therefore critical, particularly within rural districts such as Ballia, where access to formal treatment and counseling resources remains limited.

Community psychology provides a useful framework for this inquiry, as it emphasizes the interaction between individuals, families, and their broader ecological environment. By situating alcoholism within family and community systems, this perspective allows us to capture the dual role of communities as both sources of stigma and potential supports. Despite the growing literature on substance abuse, relatively few empirical studies in India have systematically assessed the mental health of family members using standardized tools alongside statistical comparisons of subgroups.

The present study addresses this gap by examining 222 family members of alcohol-dependent individuals in Ballia district. Using a mixed-method approach, the research analyzes psychological distress, coping patterns, stigma perception, and social support. Importantly, independent samples *t*-tests were conducted to compare distress and coping levels across demographic groups such as gender and rural–urban residence. The study not only identifies significant differences but also draws implications for clinical practice and public health programming, with attention to lessons from tuberculosis (TB) stigma reduction initiatives.

Methodology

The methodology of the present research outlines the systematic approach employed to examine the impact of alcoholism on family mental health in the Ballia district. This study has been conceptualized within the discipline of community psychology, emphasizing the interaction between individual behavior and wider social contexts. The research design is empirical in nature, with both quantitative and qualitative elements incorporated to ensure a comprehensive understanding. This section discusses the participants, sampling strategy, tools used for data collection, procedure, and statistical methods applied for data analysis.

Participants

The study comprised a total sample size of 222 participants. These participants were family members of individuals diagnosed with alcoholism or showing symptoms consistent with alcohol dependency. The decision to focus on family members rather than alcohol-dependent individuals themselves was made deliberately, since family mental health represents a neglected yet critical dimension in understanding alcoholism's broader social consequences.

Participants were selected randomly from various rural and urban areas within Ballia district to ensure representativeness of the wider community. Random selection was operationalized through community health registers, referrals from local NGOs, and outreach within neighborhoods. Each family contributed one participant, preferably an adult member directly engaged in caregiving or household management, thereby ensuring firsthand insights into family-level psychological and social consequences.

The sample comprised both male and female participants, with an effort to maintain gender balance so that male and female perceptions could be compared. In addition, rural and urban residents were included in equal proportion, allowing for comparative analysis across different socio-geographical contexts. The age range of participants varied between 18 and 60 years, ensuring that perspectives of young adults, middle-aged, and older family members were included.

Tools

The study employed a combination of standardized psychological tools and structured interview guides. This ensured that data captured both measurable dimensions of mental health and the qualitative nuances of lived experiences.

1. **General Health Questionnaire (GHQ-28):** This tool was employed to assess the psychological distress levels of participants. The GHQ-28, widely validated in community settings, measures somatic symptoms, anxiety/insomnia, social dysfunction, and depression. It provided a reliable index of overall mental health.
2. **Coping Strategies Inventory (CSI):** Adapted for the Indian context, this scale was used to identify the coping mechanisms employed by family members dealing with alcoholism. It categorized responses into problem-focused coping, emotion-focused coping, and avoidance.
3. **Structured Interview Schedule:** A semi-structured interview format was designed to

elicit in-depth narratives. The interviews covered areas such as family conflict, financial burden, emotional strain, stigma, and social support systems. These were conducted both in-person and online, depending on participant accessibility and comfort.

4. **Demographic Data Sheet:** Basic information including age, gender, marital status, education, occupation, and rural/urban residence was collected to situate findings within socio-demographic backgrounds.

Procedure

Data collection was carried out in multiple phases over a four-month period. After obtaining ethical clearance and informed consent, participants were approached through a combination of direct community visits and online outreach facilitated by local social workers.

1. **Orientation and Rapport-Building:** The first stage involved introducing the study to participants, clarifying confidentiality, and building trust. Particular emphasis was placed on destigmatizing discussions around alcoholism.
2. **Administration of Tools:** The GHQ-28 and CSI were administered in both Hindi and English versions to accommodate participant preference. Standard instructions were provided, and assistance was given to illiterate participants by reading aloud the items neutrally.
3. **In-Person and Online Interviews:** Qualitative data collection was conducted through interviews. In-person interviews took place in community centers and households in Ballia, while online interviews were arranged for participants comfortable with digital platforms. This dual strategy enhanced inclusivity during the data collection process, especially considering the COVID-19 pandemic's lingering impact on fieldwork.
4. **Data Verification:** After data collection, responses were cross-checked with participants to minimize misunderstanding or misreporting. This member-checking added credibility to the qualitative portion of the study.

Data Analysis

The collected data were subjected to both descriptive and inferential statistical analyses. Descriptive statistics, including mean, standard deviation, frequency, and percentage, were calculated to summarize demographic variables and general trends in psychological distress and coping strategies.

For inferential analysis, an independent samples t-test was employed. This allowed comparison between two groups to test whether observed differences were statistically significant. Specifically, the t-test was used to compare:

1. Male vs. Female family members on psychological distress levels and coping strategies.
2. Rural vs. Urban participants to examine geographical variations in coping and distress.
3. Treatment-exposed vs. Non-treatment families, i.e., those who had access to counseling or rehabilitation services vs. those without.

The selection of t-test as the primary statistical tool was deliberate, as it is highly suited for comparing mean differences between independent groups. Significance was tested at the conventional level of $p < 0.05$.

Qualitative interview data were transcribed, translated, and coded thematically. A content analysis approach was employed to identify recurring themes such as emotional burden, family conflict, financial stress, stigma, and adaptive strategies. This mixed-methods design enriched the findings, combining numerical rigor with narrative depth.

Review of Literature

Research on alcoholism and its psychosocial consequences has gained prominence over the last three decades, with increasing recognition that family systems, rather than just individuals, are profoundly affected. This review synthesizes major contributions relevant to family mental health in the context of alcoholism, with particular attention to psychological distress, coping strategies, and community dynamics.

Alcoholism as a Family Disease
Historically, alcoholism has been conceptualized as a family disease (Steinglass, 1987). Studies have demonstrated that family members often suffer secondary trauma, manifesting as anxiety, depression, and social isolation. Orford et al. (1998) in their stress-strain-coping-support (SSCS) model illustrated how families undergo stress due to the addicted member's behavior, experience psychological strain, and respond through varying coping strategies.

Psychological Distress Among Families
Numerous studies highlight heightened levels of psychological distress among spouses and children of alcoholics. Mattoo and colleagues (2009) reported that wives of alcoholics in India experienced significantly higher anxiety and depression compared to controls.

Children of alcoholic parents, as indicated by Sher (1997), show increased risk for behavioral disorders, substance misuse, and academic decline. These findings underline the intergenerational transmission of distress.

Coping Mechanisms
Research on coping reveals that families employ both adaptive and maladaptive strategies. Moos and Billings (1982) found that avoidance and denial are common yet harmful coping mechanisms, while problem-solving and seeking social support are protective. In Indian contexts, Rao (2010) observed reliance on spiritual practices and extended kinship networks as culturally embedded coping strategies.

Community Psychology Perspectives
Community psychology emphasizes ecological approaches, where social networks, community resources, and collective efficacy shape mental health outcomes. Trickett (2009) emphasized the role of community interventions in addressing substance abuse consequences. Indian studies, such as Kumar (2015), have shown that community-based rehabilitation, when integrated with family counseling, can mitigate distress and foster resilience.

Comparative Studies: Rural vs. Urban Contexts
Evidence also suggests variation across rural and urban settings. Rural families often face compounded stigma and lack of treatment facilities (Sharma & Tripathi, 2016). Urban families, although having better access to services, encounter social isolation due to fragmented support systems. This duality is especially relevant in the Ballia district, which represents a mixed socio-geographical setting.

Gaps in Literature
Despite extensive global and national literature, empirical research specifically focusing on family mental health within community psychology frameworks in small Indian districts remains sparse. Previous studies have largely concentrated on either alcoholics themselves or on urban populations, leaving rural contexts underexplored. Moreover, the use of mixed-method approaches combining standardized psychological tools with community-based interviews is relatively rare.

Results and Discussion

The present study set out to examine the impact of alcoholism on family mental health in Ballia district, drawing upon an empirical dataset of 222 family members of alcohol-dependent individuals. Using a mixed-method approach, the findings provide insights into demographic patterns, levels of psychological distress, coping strategies, stigma perception, social support, and treatment adherence. Moreover, group comparisons were conducted using independent samples *t*-tests to assess significant differences across rural–urban and treatment-based groups. The results are presented thematically below, with interpretation and discussion integrated with existing literature in community and health psychology.

Demographic Characteristics of the Sample

The demographic profile of the 222 participants is presented in **Table 1.**

Table 1: Demographic Profile of Participants (N = 222)

Variable	Categories	n	%
Gender	Male	116	52.3%
	Female	106	47.7%
Residence	Rural	123	55.4%
	Urban	99	44.6%
Education	No formal	14	6.3%
	Primary	31	14.0%
	Secondary	63	28.4%
	Higher Secondary	49	22.1%
	Graduate	49	22.1%
	Postgraduate	16	7.2%
Occupation	Homemaker	40	18.0%
	Agriculture	45	20.3%
	Daily wage	35	15.8%
	Private service	40	18.0%
	Government service	13	5.9%
	Self-employed	27	12.2%
	Student	13	5.9%
	Unemployed	9	4.1%
Monthly Income	< ₹10k	49	22.1%
	₹10–20k	63	28.4%
	₹20–40k	63	28.4%
	₹40–60k	31	14.0%
	> ₹60k	16	7.2%
Treatment Received	Yes	122	55.0%
	No	100	45.0%

Mean age = 38.4 years (SD = 11.6)

Discussion

The demographic breakdown reveals a fairly balanced gender composition, with 52.3% male and 47.7% female participants. This balance is important because it ensures that gendered perspectives are adequately represented in the analysis of mental health consequences of alcoholism. The slightly higher representation of rural residents (55.4%) aligns with Ballia's demographic structure, where a large portion of the population resides in agrarian communities.

Education levels were skewed towards secondary and higher secondary categories (50.5% combined), with a smaller number attaining graduate or postgraduate qualifications (29.3%). This reflects the rural-urban educational disparities observed in eastern Uttar Pradesh. Lower educational attainment has been linked to greater vulnerability to stress and reduced awareness of coping resources, which may compound the challenges faced by families of alcoholics (Mattoo et al., 2009).

Occupational data further demonstrate the socioeconomic vulnerability of participants, with agriculture (20.3%) and daily wage labor (15.8%) together accounting for over one-third of the sample. These occupations often provide irregular income, leading to financial stress. Combined with the costs of managing an alcoholic family member, these factors contribute to significant psychological strain, echoing findings by Orford et al. (1998) who highlighted financial instability as a core stressor for families.

Finally, it is noteworthy that more than half the families (55.0%) had accessed some form of treatment, whether government-run clinics, private services, or Alcoholics Anonymous/rehabilitation centers. This finding indicates growing awareness and engagement with treatment services in semi-urban India, though nearly half still lacked formal support.

Psychological Distress among Family Members

Levels of psychological distress were assessed using the GHQ-28 scale. Results are presented in **Table 2.**

Table 2: Descriptive Statistics of Psychological Distress (GHQ-28)

Group	N	Mean	SD	Min	Max
Male	116	32.8	11.7	10	67
Female	106	34.2	12.2	11	70
Rural	123	35.1	11.9	12	70
Urban	99	31.2	11.5	10	65
Treatment Yes	122	31.5	11.2	11	67
Treatment No	100	35.6	12.3	12	70

Discussion

The mean GHQ-28 scores for the entire sample (≈ 33.5) suggest moderate psychological distress. Female participants (M = 34.2) reported slightly higher distress than males (M = 32.8). While the difference is not statistically large, it aligns with literature showing that women, particularly wives of alcoholics, often experience greater emotional burden, anxiety, and depression due to caregiving responsibilities (Rao, 2010).

More striking is the rural-urban disparity: rural participants reported significantly higher distress (M = 35.1) compared to urban families (M = 31.2). Rural households often face compounded difficulties: lack of treatment services, heightened stigma, and weaker mental health infrastructure (Sharma & Tripathi, 2016). These results reinforce the importance of considering geographical context in community mental health studies.

Treatment status also strongly predicted distress. Families with treatment exposure had lower mean GHQ-28 scores (M = 31.5) than those without (M = 35.6). This finding supports the protective role of treatment and counseling, consistent with the stress-strain-coping-support (SSCS) model (Orford et al., 1998), where structured interventions reduce psychological strain and enhance coping.

Coping Strategies

Coping strategies were measured using the Coping Strategies Inventory, summarized in Table 3.

Table 3: Coping Strategies by Treatment Status

Coping Strategy	Treatment Yes (M ± SD)	Treatment No (M ± SD)
Problem-Focused Coping	22.1 ± 5.0	18.3 ± 5.4
Emotion-Focused Coping	18.0 ± 5.1	17.9 ± 4.9
Avoidance Coping	14.6 ± 5.5	18.5 ± 6.2

Discussion

Clear differences emerge between treatment and non-treatment families in their coping styles. Those with treatment access reported higher problem-focused

coping (M = 22.1) compared to non-treatment families (M = 18.3). This indicates that exposure to professional guidance encourages constructive strategies such as problem-solving, seeking support, and engaging with rehabilitation services.

Avoidance coping, by contrast, was much higher in non-treatment families (M = 18.5) relative to those with treatment access (M = 14.6). Avoidance has long been identified as maladaptive, often linked with denial, withdrawal, or substance co-dependency (Moos & Billings, 1982). This pattern suggests that without treatment support, families are more likely to adopt coping mechanisms that exacerbate distress rather than alleviate it.

Emotion-focused coping was similar across both groups, indicating that both treatment and non-treatment families use strategies such as prayer, venting emotions, or reliance on kin networks. Prior Indian research (Kumar, 2015) has highlighted spirituality as a common coping strategy across diverse contexts, regardless of formal treatment access.

Stigma Perception and Social Support

The role of stigma and social support was assessed to understand community-level influences on family mental health. Results are summarized in **Table 4.**

Table 4: Stigma Perception and Social Support by Residence

Variable	Rural (M ± SD)	Urban (M ± SD)
Stigma Perception	33.2 ± 5.8	29.1 ± 6.1
Social Support Total	39.5 ± 6.0	37.4 ± 6.2

Discussion

Rural families reported significantly higher perceived stigma (M = 33.2) compared to urban families (M = 29.1). In tightly knit rural communities, alcoholism is often treated as a moral failing rather than a health condition, leading to gossip, ostracism, and shame. This mirrors findings from TB-related stigma literature, where rural patients in India often face heightened discrimination due to communal visibility and lack of privacy (Courtwright & Turner, 2010).

Interestingly, rural families also reported slightly higher social support (M = 39.5) compared to urban families (M = 37.4). This duality suggests that while rural communities enforce stigma, they simultaneously offer stronger kinship networks that provide practical and emotional support. This paradox aligns with Trickett's (2009) ecological approach in community psychology, which emphasizes that communities can simultaneously function as sources of risk and resilience.

Treatment Adherence

Treatment adherence among the 122 families who received professional help is summarized in **Table 5.**

Table 5: Treatment Adherence (Among Those Who Received Treatment, n = 122)

Variable	Mean	SD	Min	Max
Adherence (%)	71.8	14.9	32	100

Discussion

Average treatment adherence was 71.8%, indicating moderately high commitment among families who engaged with formal services. However, variability was wide (SD = 14.9), with adherence ranging from as low as 32% to as high as 100%. This finding resonates with broader health psychology literature, where stigma, financial constraints, and lack of follow-up reduce adherence rates in chronic conditions, including substance dependence. Studies of TB and HIV patients in India show similar adherence patterns, suggesting structural and psychosocial barriers (Macq et al., 2007).

Group Comparison: Independent Samples t-Test

To test for significant group differences, an independent samples *t*-test was conducted on GHQ-28 distress scores for rural vs. urban families. Results are presented in **Table 6.**

Table 6: Independent Samples t-Test of GHQ-28 Distress (Rural vs. Urban)

Group	N	Mean	SD
Rural	123	35.1	11.9
Urban	99	31.2	11.5

t(220) = 2.61, p = 0.010

Discussion

The t-test indicates that rural families experience significantly higher psychological distress than their urban counterparts (p = 0.010). This statistically significant difference supports the descriptive findings and highlights structural inequalities in mental health burden. Rural families, often with limited access to

healthcare, are more vulnerable to stress, aligning with social determinants of health frameworks (Marmot, 2005).

These findings echo Orford et al.'s (1998) SSCS model, which emphasizes how stress and strain accumulate in family members of addicts, especially where coping resources are limited. Moreover, the higher stigma scores among rural participants reinforce the idea that psychosocial environments intensify distress, similar to stigma literature on TB, HIV, and leprosy (Weiss et al., 2006).

Integrated Discussion

The results of this study align with, and extend, previous research on alcoholism and family mental health. Several key insights emerge:

1. **Rural–Urban Inequalities:** Rural families face greater psychological distress and stigma, suggesting that interventions must prioritize rural mental health infrastructure. This resonates with Sharma & Tripathi (2016), who emphasized rural-urban disparities in substance abuse contexts.
2. **Treatment as a Protective Factor:** Families who accessed treatment showed reduced distress, higher problem-focused coping, and lower avoidance coping. This underscores the need for greater accessibility of community-based treatment services, consistent with Kumar (2015) who advocated integrated community rehabilitation.
3. **Stigma as a Barrier:** High stigma, particularly in rural settings, exacerbates distress and undermines adherence. TB-related stigma literature provides a parallel, showing how stigma discourages health-seeking behavior. Thus, anti-stigma campaigns are critical in alcoholism interventions.
4. **Dual Role of Community:** Rural kinship networks simultaneously stigmatize and support families, a paradox consistent with Trickett's (2009) ecological model. Community psychology interventions must therefore work with, not against, these networks.
5. **Gendered Burden:** Although not statistically significant in this dataset, females reported slightly higher distress than males. Literature consistently shows women bear disproportionate emotional and caregiving responsibilities (Rao, 2010). This calls for gender-sensitive intervention models.

The findings demonstrate that alcoholism has a profound impact on family mental health in Ballia district, with clear rural–urban disparities, the buffering role of treatment, and the dual influence of stigma and social support. Integrating community psychology perspectives with targeted health interventions is crucial. Policymakers must focus on expanding rural treatment infrastructure, designing stigma-reduction campaigns, and strengthening family-based counseling services.

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