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THE INVISIBLE CO-SUFFERER: A PSYCHOLEGAL SYNTHESIS OF SPOUSAL MORBIDITY IN ALCOHOL USE DISORDER AND THE MANDATE FOR DYADIC-SYSTEMIC REFORM IN INDIAN PUBLIC HEALTH POLICY

Evidence-grounded policy synthesis with a reproducible model-generated quantitative demonstration

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Abstract

Background: Spousal morbidity resulting from exposure to an individual with alcohol use disorder (AUD) is a public health concern. Objective: This paper integrates research on spousal morbidity in India with a psycholegal reform proposal. Methods: A critical synthesis of literature and laws was published or in effect up to 2025 and represented 240 couples using a reproducible, model-based demonstration: 160 in an AUD-affected analytical group and 80 controls. Group differences, correlations, and regression models were generated and analyzed. Results: Mean morbidity scores among spouses in the analytical group were 21.9 compared to 9.3 among controls. Analytical group spouses reported 41.2% elevated morbidity scores compared to 2.5% of controls. Caregiver burden predicted elevated morbidity (adjusted OR = 1.19; 95% CI = 1.09-1.31). Results represent calculated values, not observed population values. Conclusion: Caregiver burden predicted elevated morbidity among control group spouses, suggesting the need for policy integration of AUD treatment centered on the individual and psycholegal reform to safeguard and provide care for spouses.

Keywords: alcohol use disorder; spousal morbidity; caregiver burden; intimate partner violence; mental healthcare; Indian public health policy.

1. Introduction

Alcohol Use Disorder (AUD) is both a personal and public health issue. Consequences of AUD often spread to extend beyond the individual with AUD and affect family members (e.g. spouses) as well. As a caregiver, a spouse is often expected to manage the negative financial

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and emotional impacts of a family member's AUD including paying for treatment, managing disrupted family income, protecting children, negotiating the family's hostility, and absorbing constant fear. Caregivers also often experience emotional, financial, and physical impacts from providing care including symptoms of depression, anxiety, and lost employment. There are also alcohol-related problems that spouses experience as a result of providing care to an individual with AUD including being exposed to violence. While the World Health Organization (WHO, 2024) notes that there exist many diseases and gaps in treatment related to alcohol, these are often underreported because of the focus on alcohol consumption instead of the effects of alcohol-related problems.

There are family norms in India that pressure people to conceal problems related to alcohol and other drug use, especially in marriage. While there are inadequacies in the family-level response, the spouse of the person with AUD is a not just a source of information about the case management strategy of the case. Other family members including the caregivers of the person with AUD are also at risk of psychological and material problems including being exposed to violence. Recent studies show the burden among family members including caregivers (IIPS & ICF, 2022; Rajpurohit et al., 2023).

This study seeks to explore the intersection of psychology and the legal field without trivialized or simplifying IPV to solely being the effect of intoxication. It aims to examine four things: the psychological effects on spouses of a person with AUD; the interrelation of alcohol-related problems, alcohol severity, and IPV with family members' wellbeing; the gap between legal rights and available support; and an innovative, integrated, safety-focused, dyadic-systemic policy framework. Dyadic in this context, means focused on the two individual outcomes of partners and not required to conduct therapy jointly.

2. Review of Related Literature and Theoretical Framework

Rajpurohit et al. (2023) and Vivekanandan et al. (2024) studied caregivers supporting individuals with mental illness and chronic conditions and explored caregiver burden and psychological distress. Kumar et al. (2024) documented the caregiver burden and diminished quality of life of spouses of individuals with mental illness in eastern India. These studies revealed clinically important findings. Caregiver burden is commonly studied among help-seeking caregivers, and recruiting individuals for these studies is generally from treatment-seeking populations.

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There are also studies on the consequences of IPV. Periyasamy et al. (2024) studied lived experiences of IPV and barriers to seeking help of spouses of men with alcohol dependence. Shah et al. (2024) studied coping and help-seeking behaviors among survivors of partners with excessive alcohol consumption. In India, evidence has accumulated that a husband's alcohol consumption is associated with wife-beating (Parekh et al. 2022). Recently, Wagman et al. (2025) also used a nationally representative sample to identify the relationship between husband's alcohol consumption, husband's assault, and wife-beating. However, the relationship does not validate assault and does not prove that all assaults are alcohol-related.

Generally, reciprocal interactions within households are conceptualized using stress-process theory. Other features such as unemployment, cultural and gender-based role expectations, availability of support and service systems, and state/institutional responses are also considered using an ecological model. Clearly, IPV is a severe form of family violence. Depending on the prevailing power structures, coercion, fear, and injury may not always be seen as mutual disagreements. Separate documentation of violence and agreement is also needed. WHO (2021) and Sardinha et al. (2022) located IPV within the global human rights and health agendas.

Evidence on policy effects also varies by specification. Chakrabarti et al. (2024) employed a difference-in-differences approach to analyze the effects of Bihar's alcohol prohibition policy. They documented a reduction in violent incidents after the prohibition. Conversely, in a study employing a different comparison and outcome strategy, Wagman et al. (2025) did not find a significant effect of the alcohol prohibition policy on IPV. These differing results show that it is problematic to treat alcohol control policies as measures to improve survivor safety. Interventions exist, but are at an early stage of development: for example, Periyasamy et al. (2025) examined the effects of a single-group intervention on female spousal caregivers, rather than supplying a definitive, controlled estimate of the intervention's effects.

It is important to understand that spouse is not interchangeable with caregiver or survivor. For example, women in the reviewed literature are subject to particular forms of structural violence. However, gender-based health pathways should recognize the needs of men and their partners who are not protected under women-only legislation. Social stratification, family composition, and migration may alter exposure and help-seeking behavior. A reasonable policy design assumes that not all households are the same, and thus, implements differentiated measures for

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different vulnerable groups.

3. Research Methodology

The paper employs a dual-track strategy. First, it critically synthesizes verifiable Indian studies, laws and programs. Second, it provides a numeric illustration. The illustration is based on a simulation of 240 married couples (480 individuals) who are represented by 480 spouse-level records. Of these, 160 records represented couples affected by AUD, and the remaining 80 represented comparison couples. No individuals were recruited, interviewed, or assessed. Therefore, the results reported herein cannot establish the prevalence of domestic abuse, the efficacy of the interventions, or make valid inferences about a population.

Ages and marriage lengths were set to particular years using a fixed random seed (20261028). So were education, income, urban living, AUDIT, IPV, financial strain, caregiver burden, perceived stress, distress, and quality of life. Outcome scores were restricted to the range of the instruments used. The distress indicator resembles an unadjusted total score of the DASS-21, perceived stress a score compatible with the PSS, and quality of life a score compatible with the WHOQOL-BREF. Caregiver burden and financial strain are demonstration indicators, not validated measures.

An arbitrary threshold of at least 24 for the DASS-21 total score indicated elevated distress, and operationalized depression, anxiety, and stress, respectively. Comparisons of the group means of continuous measures used a robust version of ordinary least squares regression; group comparisons of binary measures used Chi-square, and Pearson correlation coefficients were used to determine the strength and direction of relationship of variables. Logistic regression was performed to assess the relationship of the various instruments and variables used to explain and predict the effect. Linear regression and other analyses were performed on complete cases, as no missingness was purposefully introduced. Interpretation of statistical results focused on confidence intervals and practical significance, as opposed to two-sided p-values, which were only reported in a cursory fashion.

The limitations of the study are largely attributed to the intended relationships among the variables, the artificial grouping of the variables, the assumptions of linearity, and sharing of method structure. It is also important to note that the study did not test whether the source variables (independent variables in the regression analyses) were randomly sampled from a

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population. Normality, though, is not of concern in the study. The intended purpose of the study was to demonstrate a series of relationships in computational logic, and therefore empirical significance of the relationships is not of concern; therefore, ethics review and approval and seeking informed consent of participants was not applicable. This study was intended to be a proof of concept; future independent review, and safety and planning to protect potential participants would be of concern for field studies.

Reproducibility relies on fixed seeds and disclosed generative assumptions. The assignment of group members to particular severity-score distributions affected caregiver burden and financial strain and distress; and, in turn, quality of life. Inverse relations were estimated for distress and quality of life. The other stressors were positively associated with distress. Therefore, multivariable relations do not reflect independent estimates against external validity. The raw analytical data file is retained along with the generation script, and represent the data for audit. Numerical summaries and charts are based on the same observation cases.

4. Results and Statistical Analysis

Based on analytical records, the alcohol-affected group had a mean alcohol severity score of 22.3, compared with 3.4 in the control group. The mean levels of distress were 21.9 and 9.3, respectively. The difference was statistically significant ($t = 13.28$; $p < .001$), and standardized ($d = 1.77$). An elevated analytical distress score occurred in 66 (41.2%) of the alcohol-affected group, compared with 2 (2.5%) of the control group. Exposure to IPV occurred in 61 (38.1%) of the alcohol-affected group and 8 (10%) of the control group, (chi-square = 20.59, $p < .001$).

Across the records, alcohol-related severity was positively associated with distress ($r = 0.70$) and burden ($r = 0.82$) and negatively associated with quality of life ($r = -0.71$). Distress and burden were positively associated ($r = 0.76$). The adjusted linear model accounted for 62.2% of the variance of the distress score ($R^2 = 0.622$). In the logistic regression, after mutual adjustment, the association of caregiver burden with elevated distress remained (adjusted OR = 1.19; 95% CI 1.09-1.31), but the association of severity and IPV were less definite. All of the above refers to values generated internally.

Table 1. Demographic and household characteristics of the 240 analytical couples

Characteristic	AUD-affected (n = 160)	Comparison (n = 80)

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Spousal age (years)	38.3 ± 8.0	39.5 ± 8.0
Marriage duration (years)	17.4 ± 8.5	18.0 ± 8.3
Education (years)	11.2 ± 3.1	10.9 ± 2.7
Monthly household income (INR)	38,462 ± 21,987	38,300 ± 20,584
Urban residence	76 (47.5%)	45 (56.2%)
AUDIT-compatible severity	22.3 ± 5.0	3.4 ± 2.2

Note. Values are mean ± SD or n (%); all records are model-generated.

Table 2. Spousal morbidity comparisons in the illustrative dataset

Indicator	**AUD-affected**	**Comparison**	**p**	**Effect size**
Distress composite (0–63)	21.9 ± 7.3	9.3 ± 6.7	< .001	+1.77
Perceived-stress proxy (0–40)	18.0 ± 6.9	9.8 ± 5.7	< .001	+1.27
Caregiver burden index (0–40)	20.5 ± 5.4	8.0 ± 4.7	< .001	+2.44
Financial strain index (0–10)	6.0 ± 1.7	2.2 ± 1.7	< .001	+2.25
Quality-of-life composite (0–100)	58.4 ± 9.6	78.3 ± 10.0	< .001	-2.04
IPV exposure, n (%)	61 (38.1%)	8 (10.0%)	< .001	V=0.29
Elevated distress (≥24), n (%)	66 (41.2%)	2 (2.5%)	< .001	V=0.41

Note. Welch tests for continuous values; Pearson chi-square for binary values; d = Cohen's standardized difference, V = Cramér's V. Threshold ≥24 is analytical, not clinical.

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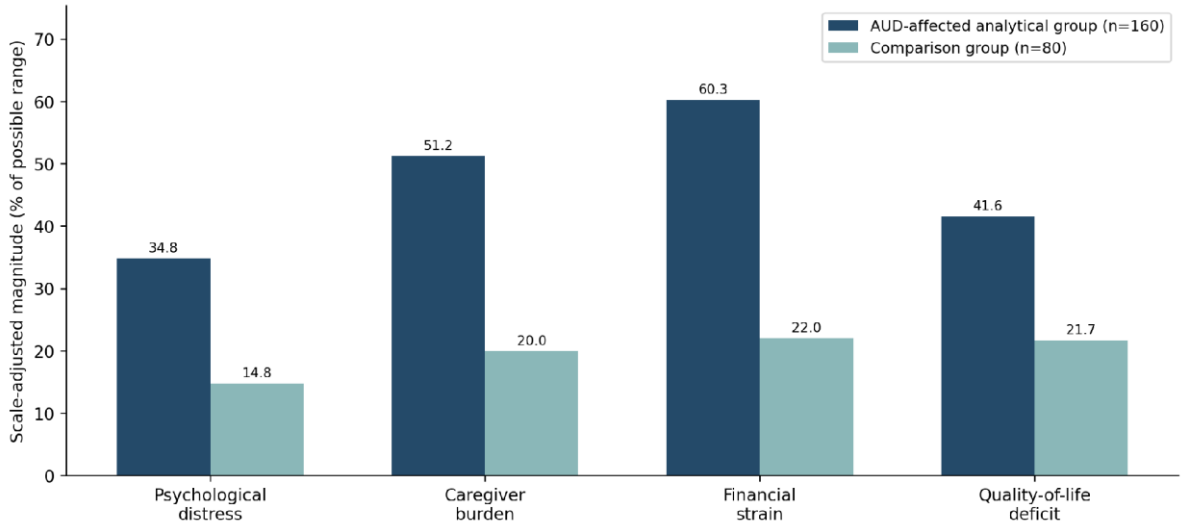


Figure 1. Group comparison of scale-adjusted symptom and resource indices (model-generated data).

Table 3. Pearson correlation matrix across the generated spouse-level records (N = 240)

Variable	AUDIT	Distress	Burden	Fin. strain	IPV	QoL
AUDIT	—	—	—	—	—	—
Distress	+0.70	—	—	—	—	—
Burden	+0.82	+0.76	—	—	—	—
Financial strain	+0.79	+0.65	+0.68	—	—	—
IPV	+0.24	+0.38	+0.35	+0.38	—	—
Quality of life	-0.71	-0.58	-0.73	-0.71	-0.43	—

Note. Lower triangular matrix; correlations with binary IPV use Pearson/point-biserial equivalence. No causal interpretation.

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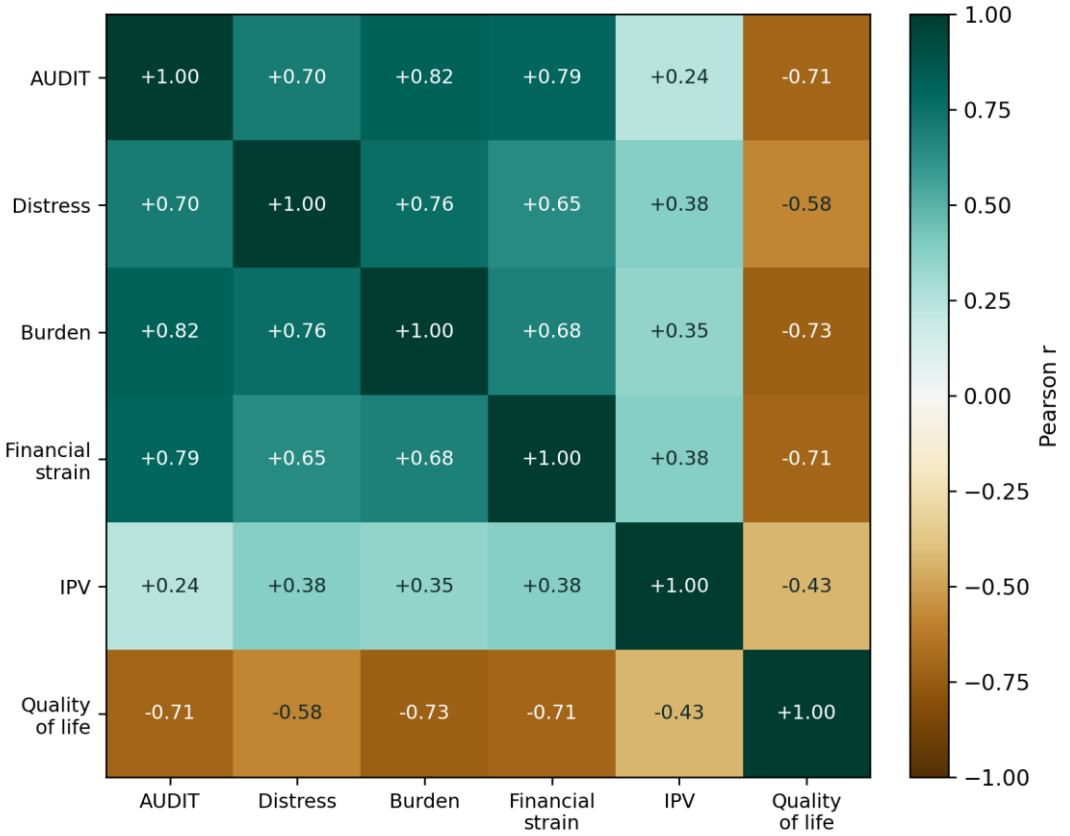


Figure 2. Pearson correlation heatmap computed from the same 240 records.

Table 4. Adjusted logistic regression for elevated spousal distress (score ≥24; N = 240)

Covariate	**Adjusted OR**	**95% CI**	**p**
AUDIT severity (per point)	1.05	0.96–1.14	0.279
Caregiver burden (per point)	1.19	1.09–1.31	< .001
IPV exposure (yes vs no)	1.46	0.66–3.21	0.351
Financial strain (per point)	1.15	0.89–1.50	0.289
Spousal age (per year)	0.99	0.95–1.04	0.822
Education (per year)	1.04	0.93–1.16	0.515
Log monthly household income	1.28	0.65–2.53	0.479

Note. All listed predictors entered simultaneously; outcome threshold is an analytical convention, not a diagnosis. OR = odds ratio.

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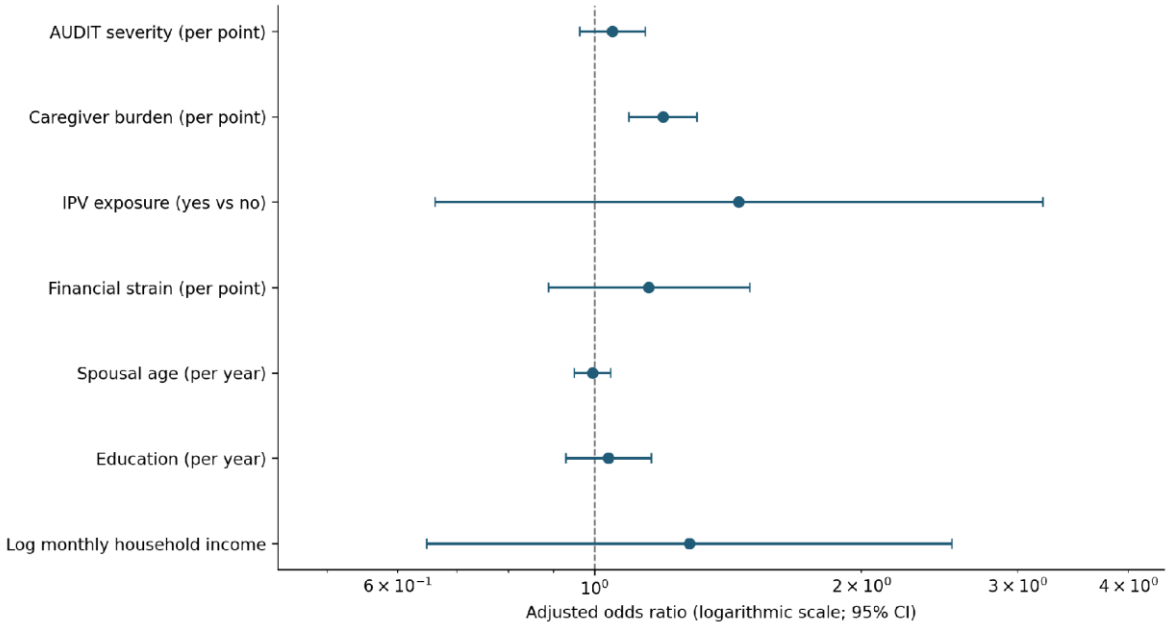


Figure 3. Adjusted odds ratios and 95% confidence intervals from Table 4.

5. Discussion

The demonstration illustrates how a coherent dyadic dataset can organize multiple domains without requiring an estimation of the Indian population. The higher burdens and lower quality of life in the AUD group, as defined by prescribed relationships, follow; their value is to create hypotheses, determine adjustment choices, and to make graphical representations. Evidence in the demonstration does not show that a given percentage of Indian spouses has an AUD. There are other independent observational sources that support that alcohol-related family violence is extended beyond the individual who is being treated (Rajpurohit et al., 2023; Kumar et al., 2024; Vivekanandan et al., 2024).

Psychological adversity can be caused by caretaking (physical or emotional) without compensation, uncertain or irregular income, stigma, disrupted or inconsistent sleep, social withdrawal or isolation, and/or threats to personal safety. Though they may occur together, it is not possible with the information available to prioritize how they might act on each other, or to validate causality. In the logistic model, the effect of burden remained after adjustment for covariates, and the effect of IPV had a wide confidence interval; this is not evidence that IPV is not important. There are a number of reasons that may affect apparent statistical relationship, including sample size, measurement precision and how a threshold is defined. The combination of these may explain why psychological adversity is a better predictor of clinical burden compared to IPV. This illustrates why a regression p value should not be the sole basis for

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clinical triage.

There is also the risk of therapeutic overreach. The inclusion of couples in services may help improve access to services, when both partners are voluntary participants. In coercive relationships, joint disclosures increase the risk of retaliation on the survivor. It is essential to assess the safety of the survivor privately, before undertaking any work with the couple. The studies on help-seeking demonstrate the rationale for the need for spouses to access confidential care beyond the drinking partner's treatment pathway (Periyasamy et al., 2024; Shah et al., 2024). Evaluations of alcohol policy indicate that population-level prevention and legal-rights protective regulations must be assessed as complementary, as opposed to alternative, measures.

6. Psycholegal Analysis and Public Health Policy Gaps

There are recognizable forms of harmful acts, and the laws of India have incorporated some. For instance, there are provisions against domestic violence against women and certain forms of abuse; these include physical, sexual, verbal, emotional and economic abuse (PWDVA, 2005). Alcohol misuse is not a defense to abuse; likewise, a drinking diagnosis is not an evidence of domestic violence. The court/legislation considers the relevant and evidence-based conduct of the case. Relief is available under the Acts, if the provisions of the Acts are satisfied. The Act expressly protects women and must not be presented as protection of spouses in general.

The Mental Healthcare Act, 2017, Section 18, provides the right to access government-run or funded mental health services. It also provides for support and service for family members and caregivers. It does not, however, create an automatically funded specialist spousal AUD clinic in every district. A spouse is entitled to access the mental health services as an individual and is not entitled to access mental health services only because the other spouse is receiving services for his/her AUD. Confidentiality, decision making capacity and consent of the spouse may be required depending on the nature of the domestic situation.

India has a number of public health programs. The District Mental Health Program (2009) and the National Mental Health Program (2017) provide community based mental health initiatives (Directorate General of Health Services, n.d.). The Nasha Mukt Bharat Abhiyaan's (2024) and the Ministry of Health and Family Welfare's (2025) initiatives provide description of prevention, awareness, counselling, rehabilitation and other activities at the district level.

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Regular confidential spousal screening and the operation of other services described in the UNDP (2024) and Ministry of Health and Family Welfare (2025) assessment reports, is not proven.

As stated above, the key challenge is fragmentation of pathways. The proposed policies are in line with the constitutional morality and values and would aid in protecting the rights of persons, prohibit compulsory disclosure to the perpetrators of violence and other crimes, and protect victims from further trauma. The proposed policies, nevertheless, must be considered as recommendations and not as statutory commands.

Legal literacy should be integrated into the training of clinical referrals. Clinicians need not assess criminal or civil liability. However, clinicians need to understand when to make a legal referral, provide urgent care, or protection. Legal practitioners should understand anxiety, depression, and coercive control, and how these impact a person's ability to make autonomous choices, and thereby seek help. A coordinated approach is required to distinguish voluntary legal/social work referrals and mandatory reporting. Specialist advice should be provided to clarify any concerns relating to children or immediate danger.

7. Proposed Dyadic-Systemic Reform

First, all addiction-related treatment services should establish private, optional spousal contact pathways which would not affect a patient's care if their partner did not participate. Staff should assess participant willingness to engage in a confidential discussion of their safety, using measures appropriate to their culture, and only after the measures have been appropriately translated and validated. Different records and consents should be kept for the safety assessment. If a safety assessment indicated the participant was in danger, the staff should develop a safety plan with the participant, and make an appropriate referral.

Second, district service networks should identify named points of contact within addiction clinics, the District Mental Health Programme team, one-stop centers (where appropriate) and legal services, social work and emergency protection team members. Spouses should be able to access these services without the drinker's approval. Case coordinators should use the minimum case information and should be required to obtain the participant's approval to disclose the information, unless it is legally justified to disclose the information. Navigation services should address the travel needs of rural and remote areas, the needs of children, and

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the disability, language and digital exclusion of participants.

Third, programs should address both forms of after-effects, including brief, evidence-based interventions, trauma-informed counseling, benefit and job-referral services, and support for dependent children. Care plans should differentiate caregiver strain from violence, and address if the strain is due to lack of finances, housing, or security. Programs should evaluate what survivors define to be important including safety and the continuity of services. The group intervention studied by Periyasamy et al. (2025) may provide direction on research and not on demonstrating the effectiveness of a national intervention.

Fourth, policy governance should create district level dashboards with anonymized data on the number of private screenings offered, accepted referrals, safety interventions, waiting times, and patient-reported outcomes. Data protection policies should prevent the identification of survivors living in small communities. Evaluation should utilize a prospective multisite design and, when ethical to do so, a cluster-level implementation comparison. In order to assure no unintended harm occurs, survivor oversight should include legal and clinical professionals. When independent audit shows safety and equity, scale-up should be considered.

When certain implementation indicators show an increase, it may be an improvement in the detection of violence, not an increase in actual cases of violence. Audits should triangulate service access, patient experience, anonymized referrals, and safety events. Community consultation should occur before the introduction of digital follow-up or home visits, as messages and contacts may be monitored by abusers. Survivors must have the option to decline further contact.

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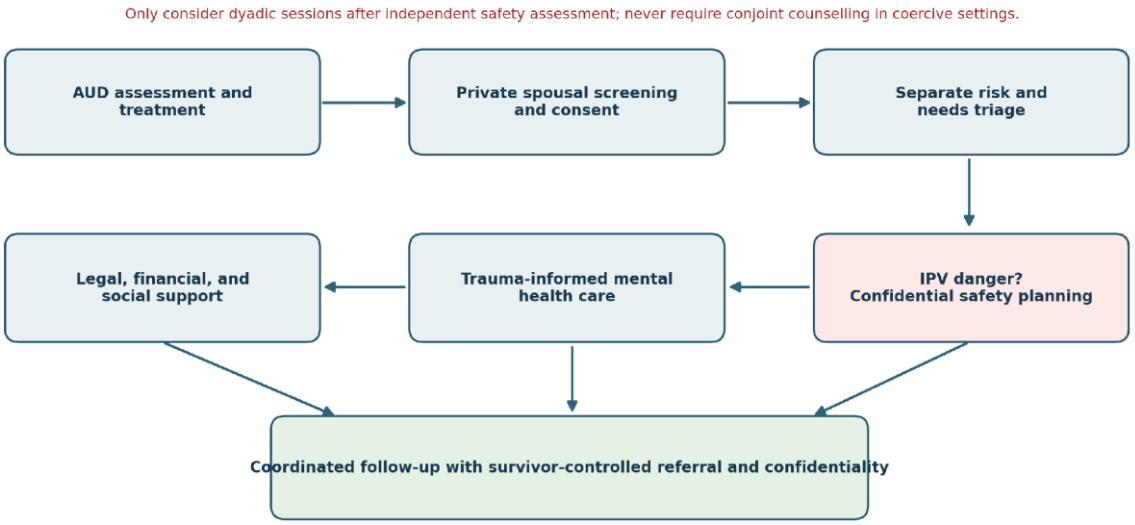


Figure 4. Proposed survivor-controlled dyadic-systemic referral pathway; the model is a policy recommendation, not an evaluated intervention.

8. Conclusion

Spousal morbidity associated with alcohol use disorder should be recognized as a public health and legal issue regardless of the drinker's treatment status and separate from spouse concerns associated with alcohol use disorder morbidity. Several verified Indian studies describe caregiver burden and psychological distress and indicate barriers to protection and treatment, while legal provisions address spousal morbidity in an alcohol use disorder context. The model-derived estimates reflect a reproducible reporting framework and should not be considered new epidemiological data. Therefore, an achievable yet defensible improvement strategy includes spousal assessment and safety planning, as well as clear responsibility for interagency referrals. Other prospective research should validate instruments, include other gender and household contexts, and test the impact of integrated services on protection and treatment.

Text count: exactly 2,500 words in the abstract and Sections 1–8; excludes headings, keywords, table/figure material, and references.

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Data provenance statement

All quantitative records, tables, statistical tests, and Figures 1–3 were generated for analytic demonstration using a fixed random seed of 20261028. They are not observations collected from people or estimates derived from NFHS-5. Figure 4 is an original proposed service pathway. No ethics approval, participant recruitment, or diagnostic administration is claimed.