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Case Report

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Alcoholism: a case report on the silent epidemic affecting urban Indian men

Abstract

This case report examines alcohol use disorder (AUD) in a 39-year-old urban Indian man with chronic alcohol consumption, hypertension, diabetes, and withdrawal symptoms, highlighting broader public health concerns. Alcohol use disorder (AUD) is a common public health problem in both developing and developed nations of the world. In India, historically, alcohol use has been an issue of great ambivalence throughout the subcontinent, with the most recent factors at play being colonial influences and state-specific policies (Sharma et al., 2010). In this case, urban stressors and weakened family support may contribute to problematic drinking, while family denial and limited access to treatment reflect potential barriers observed in urban settings. This case report explores AUD's biological, psychological, and social dimensions in urban Indian men, contextualizing the case within historical, regional, and demographic data, and advocates for interventions like counseling and psychotherapy.

Keywords: alcoholism, alcohol use disorder, urban Indian men, social stigma, de-addiction counseling, psychotherapy

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Rushabh Shah,[1] Sneh Babra,[2] Deeksha Parthsarthy,[3] Nitin K Sethi[4]

[1]Neuropsychology Intern, University of Delhi, Delhi, India
[2]Neuropsychology Intern, National Forensic Sciences University, Gandhinagar, India
[3]Clinical Neuropsychologist, Pushpawati Singhania Research Institute, New Delhi, India
[4]Department of Neurology, New York-Presbyterian Hospital, NY, USA, and Pushpawati Singhania Research Institute, New Delhi, India

Correspondence: Nitin K Sethi, MD, MBBS, FAAN, Chairman Neurosciences and Senior Consultant, PSRI Hospital, New Delhi, India, Tel 2127465519

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Introduction

This case report examines alcohol use disorder (AUD) in a 39-year-old urban Indian man presenting with chronic alcohol consumption and withdrawal symptoms, reflecting broader public health challenges in urban India. Alcohol consumption in India has deep historical roots across distinct periods, shaping its gendered patterns. In Vedic times (1500–500 BCE), alcohol, particularly soma and sura, was accepted among Kshatriyas (warrior caste) for ritual and social purposes, but condemned as a sin for Brahmins, with texts like the Rig Veda prohibiting its use for women and priestly classes.[1] During British colonial rule (18th–19th centuries), distilleries established in 1805 and military canteens increased male-dominated alcohol consumption, while westernization among urban male elites positioned alcohol as a status symbol, rarely extending to women due to social norms.[1] Post-independence (1947), the nationalist movement, led by figures like Kasturbai Gandhi picketing liquor shops, influenced Article 47 of India's Constitution, advocating prohibition to curb male drinking cultures.[1] However, state-specific regulations led to varied policies, with only Gujarat, Nagaland, Mizoram, and Manipur maintaining bans due to economic reliance on alcohol taxes and challenges with illicit liquor networks, which often supply cheaper alcohol to men in lower socioeconomic groups.[1] In the context of this case, urban stressors, such as occupational pressures following the patient's work suspension, and the absence of a cohesive and supportive family system may exacerbate problematic drinking. The family's denial of long-term treatment and financial concerns suggest stigma and systemic barriers, such as limited insurance coverage and scarce de-addiction centers, which are common in urban India.[2] Among adolescents and young adults (10–24 years), alcohol is the second-highest contributor to disability-adjusted life years.[3]

Case report

A 39-year-old hypertensive, diabetic male presented to the emergency department reporting sleeplessness for several days. He disclosed consuming approximately half a bottle (375 mL) of whiskey daily on a chronic basis. On examination, his blood pressure was 140/80 mmHg, and he was tremulous raising concern for impending delirium tremens (DT), alcohol withdrawal seizures and other medical comorbidities associated with alcoholism. He was advised admission for medical stabilization, but the family declined, citing financial constraints. The family volunteered that he had started drinking after he was suspended from work for financial irregularities. They sought a prescription for insomnia but were reluctant to pursue long-term AUD treatment.

Discussion

Alcohol consumption in India varies widely by demographics. Among adolescents and young adults (10–24 years), alcohol is the second-highest contributor to disability-adjusted life years.[3] Lifetime alcohol use among adolescents ranges from 3.9% in school students (12–18 years) to 69.8% in medical students (22–23 years), with urban areas showing higher rates (5.23–23.08%) than rural areas (7.37–20%).[4] Among adolescent males, lifetime use ranges from 9.79% to 47%, and among females, from 6.5% to 52%.[4] Among medical students (18–23 years), hazardous drinking prevalence is 19.29%, alcohol dependence 3.7–10%, binge drinking 14–30%, and problem drinking 41.46%.[4] Among adolescent street children (11–19 years), 37% have AUD, defined as recurrent use causing role failures, hazardous situations, or legal problems.[5] In older adults (>60 years), current drinking prevalence is 8.5% in rural areas and 12.5–31.7% in urban areas, with males showing higher rates (e.g., 42.1% in urban slums); female alcohol consumption ranges from 0.3% to 11.6%.[6] Alcohol dependence in urban dwellers over 65 is 4%, and in semi-urban dwellers over 60, alcoholism is 8%.[6] Overall, 15.8% of males and 2.4% of females, and hence, 8.7% of the total population, abuse alcohol.[7]

AUD, per the DSM-5, involves impaired control, continued use despite consequences, and physiological dependence.[8] Chronic alcohol use causes cardiovascular (e.g., hypertension), neurological (e.g., Wernicke-Korsakoff syndrome), hepatic (e.g., cirrhosis), endocrine

(e.g., worsened diabetes), and immune system damage.[9,10] Alcohol-related disorders contribute 7.9% (95% CI 6–10) to global disability years.[2] In India, alcohol caused 340,000 deaths and 14.7 million disability-adjusted life years in 2019, with per capita consumption rising from 2.3 liters (2000) to 5.5 liters (2018).[11] Withdrawal ranges from mild (anxiety, tremors) to severe (seizures, DT), with 3–5% of dependent individuals at risk of fatal complications.[12] In this case, the patient's comorbidities heightened these risks, necessitating urgent care.

In the context of this case, social factors observed may have contributed to AUD leading to the following hypotheses: (1) The patient's increased drinking following work suspension suggests that urban occupational stressors may exacerbate problematic drinking. (2) The family's nuclear structure and reluctance to pursue long-term treatment may reflect weakened social support and stigma, common in urban settings.

Gender separation in Indian society fosters male-only drinking groups, potentially encouraging heavy drinking as a display of masculinity, which may lead to risky behaviors.[1] Family and peer influences are significant, with men from drinking families or under peer pressure more likely to consume alcohol.[13,14] Surrogate advertising and Bollywood's glorification of drinking may promote alcohol use among urban youth.[15] Lower religiosity is linked to higher alcohol acceptance, potentially relevant to urban contexts like this case.[16]

The family's response (denial) reflects common psychosocial barriers healthcare workers encounter while treating alcoholism. Seeking a quick fix for insomnia while avoiding the core issue of alcoholism suggests denial and minimization of AUD. Families often view AUD as a character flaw, not a medical condition, due to societal stigma. Insurance policies in India frequently exclude AUD-related care, further fueling the larger discourse around the problem being self-inflicted. This overlooks AUD's complex etiology, including heritability and environmental factors such as advertising and marketing, discrimination factors, and how neighborhoods, families, and peers influence alcohol use.[13] The family's financial concerns, despite the patient's alcohol spending, highlight a lack of awareness about untreated AUD's long-term costs. Such passivity along with limited treatment access perpetuates the difficulties in addressing the problem head-on.

De-addiction counseling and psychotherapy remain critical interventions. Interventions observed as potentially beneficial in this case include de-addiction counseling and psychotherapy. Cognitive-behavioral therapy (CBT) could address triggers (such as occupational stress), building coping skills, and reducing drinking frequency. Motivational interviewing (MI) may enhance motivation for change, addressing the patient's and family's denial.[17] Family-based therapy could tackle denial, strengthen support, and improve outcomes at 3–9 months.[18] Alcoholics Anonymous (AA) offers accessible and affordable peer support.[19] A trial of Counseling for Alcohol Problems (CAP, a lay counselor-delivered intervention) in India reduced harmful drinking, suggesting applicability to cases like this.[2] Pharmacotherapy (e.g., naltrexone, acamprosate) could complement psychotherapy but is underused due to cost and awareness, as seen in the family's financial concerns.[18] Integrated care for comorbidities like diabetes, evident in this case, is crucial.[9,10]

The family's refusal of admission due to financial constraints highlights potential systemic barriers, such as insurance exclusions and limited de-addiction facilities, with only 19.8% of AUD individuals receiving care.[20] Regional variations, driven by alcohol policies, religious diversity, and economic disparities, may further complicate treatment access in urban settings.[11] Public health campaigns to destigmatize AUD and policy reforms for insurance coverage could address barriers observed in this case. Community-based programs, like TTK Hospital's camps, show high retention and positive outcomes, potentially applicable to urban patients.[18, 21–25]

Conclusion

Alcoholism among urban Indian men is a silent epidemic, driven by urban stressors and rapidly changing social and cultural norms. The case here underscores AUD's medical urgency, family denial, and societal stigma in India. Prevalence data highlight men's disproportionate burden, while biological consequences demand timely intervention. Counseling, psychotherapy, and pharmacotherapy offer solutions, but stigma and systemic barriers limit access. Addressing this requires destigmatizing AUD, expanding treatment, and reframing it as a public health priority.

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Conflicts of interest

The authors declare there is no conflict of interest.

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