
FROM SOCIAL DRINKING TO PROBLEMATIC ALCOHOL USE: A CASE STUDY OF A WOMAN IN SIKKIM

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Abstract

Background: Alcohol use among women is an emerging public-health concern in Sikkim, where alcohol consumption is closely intertwined with social and cultural practices. Despite comparatively high levels of alcohol use among women, alcohol-related problems may remain under-recognized because of stigma, normalization of drinking, gender-related barriers and limited help-seeking. Understanding the pathways through which social drinking progresses to problematic alcohol use is important for developing culturally appropriate community-based interventions.

Case Presentation: This case study describes a middle-aged woman living in a rural community of Sikkim whose alcohol use progressively increased from occasional social and culturally sanctioned drinking to problematic consumption. The progression occurred in the context of family stress, psychological distress, low self-esteem and inadequate family support. Initially, alcohol was consumed primarily during social gatherings and cultural occasions. Over time, drinking became more frequent and was increasingly used as a coping strategy for emotional and family-related difficulties. The case illustrates the interaction of individual, family and community-level determinants in the development and maintenance of problematic alcohol use among women.

Discussion: Women's alcohol use in Sikkim should be understood within its broader sociocultural and psychosocial context. A study among women of reproductive age in urban Sikkim reported an alcohol-use prevalence of 36.6%, with social customs and stress identified

among the reported reasons for consumption. National Family Health Survey-5 data also indicate a substantially higher proportion of women aged 15–49 years reporting alcohol consumption in Sikkim than at the national level. These findings underscore the need for gender-sensitive, culturally responsive and community-based approaches to screening, early intervention and relapse prevention.

Conclusion: The progression from socially accepted drinking to problematic alcohol use among women may involve an interplay of cultural normalization, psychosocial stress, family relationships, self-esteem and motivation for change. Community health nurses are strategically positioned to contribute to early identification, brief intervention, counselling, family engagement, relapse-prevention support and linkage with appropriate de-addiction and mental-health services. A community-based, family-inclusive approach may help address the multiple determinants contributing to women's problematic alcohol use.

Keywords: *Women; alcohol use; Sikkim; problematic alcohol use; self-esteem; family functioning; psychosocial stress; community health nursing*

1. INTRODUCTION

Alcohol is a psychoactive and dependence-producing substance associated with substantial physical, psychological and social consequences. Globally, alcohol consumption was attributable to approximately 2.6 million deaths in 2019, and an estimated 400 million people aged 15 years and older were living with an alcohol use disorder.³ Although alcohol-related mortality and consumption remain higher among men in most populations, women's alcohol use represents an important and increasingly recognized public-health concern.³

Women's alcohol use differs from men's use in several important respects. Gender norms influence patterns of drinking, access to alcohol, social acceptability, exposure to stigma and willingness to seek treatment. The World Health Organization has emphasized the need for gender-responsive approaches because alcohol policies and services have historically been insufficiently sensitive to differences between women and men.⁴

Women may also experience distinctive barriers to seeking treatment for problematic alcohol use. Shame, guilt, fear of social judgement, childcare responsibilities, inadequate social support and concerns about family consequences may delay help-seeking.⁵ These barriers can be particularly important in communities where women's drinking is simultaneously normalized in certain social contexts and stigmatized when it becomes excessive.

Sikkim presents an important sociocultural context for understanding women's alcohol use. Alcoholic beverages are incorporated into several social and cultural practices, and alcohol consumption may occur during festivals, family gatherings and other social occasions. A cross-sectional study of 284 women aged 15–49 years in urban field-practice areas of Sikkim reported an overall alcohol-consumption prevalence of 36.6%. Social customs were reported as a reason for drinking by 36.5% of alcohol-consuming women, while 25% identified stress as a reason.¹ The same study found that although low-risk drinking was predominant, approximately one-fourth of women demonstrated hazardous drinking patterns and approximately 3% each had harmful and dependent drinking patterns.¹

National Family Health Survey-5 data similarly demonstrate a comparatively high level of

reported alcohol consumption among women in Sikkim. According to the Government of India's compilation of NFHS-5 indicators, 16.2% of women aged 15 years and above in Sikkim reported consuming alcohol, compared with 1.3% nationally.²

Research among women with alcohol use disorders in India has also demonstrated an association between alcohol use and stressful or traumatic life experiences. In one study, women with alcohol use disorders reported significantly more stressful life events than community controls, with interpersonal trauma and adverse experiences being prominent.⁶ More recent qualitative research among Indian women with alcohol use disorder has similarly described alcohol as a means of coping with trauma, stress and difficult life circumstances, while lack of social support and barriers to seeking help may sustain problematic drinking.⁷

Against this background, the present composite case study describes a pathway from socially accepted drinking to problematic alcohol use in a woman living in a rural community of Sikkim. The case focuses on the interaction between sociocultural acceptance, psychosocial stress, self-esteem, family functioning and motivation for abstinence.

2. CASE PRESENTATION

2.1 Nature of the case

The present report describes a case constructed to illustrate a clinically and socially plausible pathway of problematic alcohol use among women in rural Sikkim. The case synthesizes patterns relevant to women's alcohol use, including social drinking, cultural acceptance, family stress, low self-esteem, impaired family functioning and difficulty maintaining motivation for abstinence.

2.2 Initial pattern of alcohol use

The woman initially consumed alcohol predominantly in social and culturally accepted settings. Drinking was associated with family gatherings, celebrations, festivals and other social occasions. At this stage, alcohol consumption was perceived as a normal component of social interaction rather than as a health problem.

The social context was important because drinking did not initially carry the characteristics commonly associated with problematic use. Alcohol was consumed in the presence of others and was linked to social participation. Consequently, neither the woman nor people around her initially perceived a need for intervention.

This pattern is consistent with findings from Sikkim in which social customs were identified as an important reason for alcohol consumption among women.¹

2.3 Progression toward problematic alcohol use

Over time, the pattern of drinking changed. Alcohol consumption became increasingly frequent and was no longer restricted to social occasions. The woman gradually began using alcohol as a means of coping with psychological distress and family-related difficulties.

The transition can be conceptualized as follows:

Social and culturally sanctioned drinking → increased frequency → drinking in response to stress → alcohol as a coping mechanism → interpersonal consequences → reduced self-esteem

and family functioning → difficulty sustaining abstinence.

The change in drinking behaviour was gradual rather than abrupt. This gradual progression contributed to delayed recognition of the problem by both the woman and people around her.

2.4 Psychosocial stressors

Family-related stress emerged as an important contextual factor. Difficulties within family relationships contributed to emotional distress and feelings of inadequate support.

Rather than functioning solely as a consequence of alcohol use, family stress also appeared to contribute to continued drinking. Alcohol increasingly served as an immediate coping strategy for distress. However, this coping strategy was followed by additional interpersonal difficulties, thereby creating a potentially self-reinforcing cycle.

This bidirectional relationship between adverse experiences and alcohol use has also been described among Indian women with alcohol use disorders.⁶

2.5 Self-esteem and emotional consequences

As alcohol use became increasingly problematic, the woman experienced reduced confidence and negative perceptions of herself. Her self-esteem appeared to be affected by interpersonal conflict, difficulties in fulfilling family responsibilities and awareness that her alcohol use was becoming problematic.

The relationship between alcohol use and psychological well-being is potentially bidirectional. Psychological distress may contribute to alcohol use as a coping strategy, while continued problematic alcohol use can subsequently worsen interpersonal and emotional difficulties.

The case therefore illustrates the importance of assessing self-esteem and psychosocial functioning in addition to the quantity or frequency of alcohol consumption.

2.6 Family functioning

Family functioning was increasingly affected as alcohol use became more frequent. Interpersonal conflict developed within the household, communication became more difficult and the woman's perceived ability to fulfil family responsibilities was affected.

Family functioning is an important component of alcohol-related assessment because alcohol-related problems frequently extend beyond the individual drinker. Indian literature has documented substantial effects of alcohol-related problems on families and caregivers, including stress, impaired relationships and reduced quality of life.⁸

In this case, family difficulties were both a consequence of increasing alcohol use and a factor contributing to its continuation.

2.7 Motivation for abstinence

The woman demonstrated an ambivalent relationship with alcohol cessation. On one hand, she recognized the negative effects of drinking on her family relationships, self-confidence and daily functioning. On the other hand, alcohol continued to provide temporary emotional relief during periods of stress.

This ambivalence is important because motivation for abstinence is not necessarily static. Motivation may fluctuate according to stress, family support, perceived benefits of drinking and confidence in the ability to change.

Consequently, a purely directive approach may be insufficient. Motivational and psychosocial approaches may help individuals explore their own reasons for change and strengthen confidence in behaviour change.

3. CASE FORMULATION

The case can be understood using a biopsychosocial and ecological perspective.

Individual-level factors

- Increasing reliance on alcohol for coping
- Psychological distress
- Reduced self-esteem
- Difficulty sustaining abstinence motivation

Family-level factors

- Family stress
- Interpersonal conflict
- Inadequate perceived support
- Deterioration in family functioning

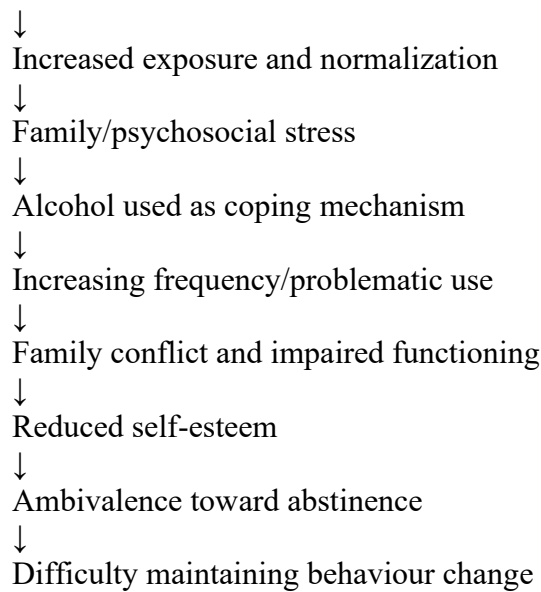
Community and sociocultural factors

- Social acceptability of alcohol consumption
- Alcohol use during cultural and social occasions
- Easy normalization of drinking
- Potential stigma surrounding problematic drinking among women

These factors interacted dynamically rather than independently.

Figure 1. Conceptual pathway from social drinking to problematic alcohol use

Cultural/social acceptance
↓
Occasional social drinking



4. ASSESSMENT AND POTENTIAL CLINICAL APPROACH

A woman presenting with a similar pattern should undergo systematic assessment rather than being labelled solely on the basis of drinking frequency.

Assessment should include:

1. Alcohol-use screening, preferably using a validated instrument such as the Alcohol Use Disorders Identification Test (AUDIT).
2. Assessment of drinking frequency, quantity, context and consequences.
3. Assessment of withdrawal symptoms and dependence-related features where clinically indicated.
4. Assessment of psychological distress and other mental-health concerns.
5. Assessment of self-esteem and coping mechanisms.
6. Assessment of family functioning and social support.
7. Assessment of readiness and motivation for change.
8. Assessment of domestic violence, interpersonal safety and other psychosocial risks where appropriate.
9. Identification of available family, community and professional resources.

The WHO recommends screening and brief interventions for hazardous and harmful alcohol use in primary healthcare and other frontline settings.⁹ Individuals with persistent harmful consumption or alcohol dependence may require referral for specialized treatment.⁹

5. DISCUSSION

This composite case illustrates how problematic alcohol use among women may emerge from a complex interaction between sociocultural acceptance, psychological stress, family relationships and individual coping.

The finding that social and cultural practices can facilitate alcohol consumption among women is particularly relevant in Sikkim. The study by Konthoujam et al. found that 36.6% of women aged 15–49 years in an urban Sikkim field-practice setting reported alcohol consumption.¹ Social customs were the most commonly reported reason, followed by stress.¹ These findings suggest that alcohol use cannot necessarily be interpreted solely through an addiction-focused biomedical framework.

At the population level, NFHS-5 reported that 16.2% of women aged 15 years and above in Sikkim consumed alcohol compared with 1.3% of women nationally.² The difference should be interpreted cautiously because the indicators describe reported alcohol consumption in different populations and do not by themselves establish alcohol use disorder or problematic drinking. Nevertheless, they demonstrate the importance of examining alcohol use among women in Sikkim.

The transition from social drinking to problematic use may be influenced by stress. Research among Indian women with alcohol use disorders has identified a greater burden of stressful and traumatic experiences compared with community controls.⁶ The authors reported a bidirectional relationship between adverse life experiences and alcohol abuse.⁶ This is consistent with the present case formulation, in which stress both preceded increased drinking and was subsequently intensified by alcohol-related family difficulties.

The role of coping is also important. Alcohol may provide short-term perceived relief from distress while contributing to longer-term problems. Qualitative research among Indian women with alcohol use disorder has described drinking as a strategy for coping with trauma and stressful circumstances, with limited social support and barriers to treatment potentially sustaining alcohol use⁷.

Family functioning represents another important dimension. Alcohol-related difficulties can affect communication, emotional relationships, responsibilities and overall family well-being. Indian research has documented substantial effects of alcohol-related problems on family members and caregivers⁸. Therefore, interventions that focus exclusively on the individual woman may overlook important contextual factors.

Women may also face specific barriers to accessing treatment. A review of interventions for women with alcohol use disorder identified barriers including shame, guilt, childcare responsibilities, limited social support and other social and service-related factors.⁵ Gender-responsive treatment may therefore require attention to the woman's social environment, safety, family responsibilities and support system.

The WHO has emphasized gender-responsive approaches to alcohol policy and services, noting that gender norms influence both alcohol consumption and alcohol-related harm.⁴ The present case reinforces the relevance of such an approach in community settings.

6. IMPLICATIONS FOR COMMUNITY HEALTH NURSING

Community health nurses are strategically positioned to identify women whose alcohol use may otherwise remain hidden.

Their role may include:

- Routine, confidential screening for problematic alcohol use.
- Identification of women at risk before severe dependence develops.
- Provision of brief, non-judgmental counselling.
- Motivational interviewing and support for behaviour change.
- Identification of stress and maladaptive coping strategies.
- Strengthening of self-efficacy and healthy coping mechanisms.
- Family education and engagement where appropriate and safe.
- Identification of domestic violence and other psychosocial risks.
- Relapse-prevention education.
- Follow-up through community-based services.
- Referral to de-addiction, psychiatric and other specialist services when required.

WHO guidance supports screening, brief interventions and linkage to appropriate treatment services as important components of reducing alcohol-related harm.⁹ Psychosocial interventions, including motivational interventions, behavioural approaches and other structured interventions, may also be considered in the management of alcohol dependence.¹⁰

A community-based nursing approach may be particularly valuable in settings where women are reluctant to attend specialized addiction services because of stigma or fear of social judgement.

7. STRENGTHS OF THE CASE

This case has several conceptual strengths.

First, it moves beyond viewing alcohol use solely as an individual behavioural problem and highlights the interaction between individual, family and community determinants.

Second, it focuses specifically on women's alcohol use in the sociocultural context of Sikkim, an area in which women's drinking deserves greater research attention.

Third, it highlights the importance of early identification before social drinking progresses to more harmful patterns.

Finally, it demonstrates the potential role of community health nursing in screening, counselling, family engagement and referral.

8. LIMITATIONS

This report has important limitations. First, the case does not provide longitudinal quantitative measurements of alcohol consumption, self-esteem or family functioning. Future case reports should incorporate validated measures such as AUDIT and, where relevant, standardized measures of psychosocial functioning.

Third, causal relationships cannot be established from a case narrative. The association between stress, family difficulties and alcohol use may be bidirectional.

Finally, findings from one case cannot be generalized to all women who consume alcohol in Sikkim.

9. CONCLUSION

The progression from socially accepted drinking to problematic alcohol use among women may occur gradually and can remain unrecognized when drinking is embedded within accepted social and cultural practices. In the present composite case, alcohol use was conceptualized as the result of an interaction between social normalization, psychosocial stress, family difficulties, reduced self-esteem and fluctuating motivation for abstinence.

The case emphasizes that women's alcohol use should be addressed through a gender-sensitive and culturally responsive approach rather than solely through an individual biomedical model. Early screening, confidential counselling, family-sensitive interventions, strengthening of coping and self-efficacy, relapse-prevention support and appropriate referral may provide important opportunities for community health nurses to reduce alcohol-related harm.

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