**Re-imagining ‘de-addiction’ in Kerala: Moving beyond the medical model**

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The recent COVID-19 crisis in the world has brought a specific kind of sub-crisis in Kerala – the crisis of (un)availability of access to liquor. In the first week of lock down, nine men committed suicide when they could not get access to alcohol. Reports say that around 1.6 million people are heavy alcohol users in Kerala. (news18.com, March 29, 2020). After all these incidents, the government decided to permit people to avail restricted quantities of alcohol by obtaining a doctor’s prescription. The argument for doing this was that many regular alcohol users developed serious withdrawal symptoms following the lockdown. This stirred controversy, with the Indian medical association (IMA) criticizing this move. The chief minister of Kerala responded by asserting that a statement from a qualified medical professional could be legitimately used in the current situation to prevent social unrest during the lockdown. In turn, psychiatrists and psychologists from Kerala have declared that heavy alcohol use must be regarded as a mental health issue for which de-addiction treatment and hospitalization is required. Yet, there are concerns that hospitalization would raise other sets of problems, such as increasing burden on health care system given the COVID-19 situation. At present, the government has set up a toll free helpline to provide support for people with withdrawal problems. Recent reports have revealed that primary health centers are also receiving cases of people with mild withdrawal symptoms (The Hindu, March 28, 2020). People staying in villages have begun making arrack (locally brewed form of alcohol) in their houses. Police have been tracing these people and arresting them for their illegal activities, and asking them to seek de-addiction treatment for heavy alcohol use. Clearly, the issue of de-addiction as a medical and social issue has become an intense topic in Kerala during the COVID-19 pandemic.

In thinking about this issue, it should not come as a surprise that what is defined by experts as a medical / psychiatric problem, namely, ‘addiction’, reveals itself as simultaneously a social problem. To give a bit of a background, Kerala is a state known for a relatively good health sector and good indicators of education. Further, mental health services are working well in the state, and mental health literacy is high compared to other states in India (Thomas, 2014). At the same time, Kerala also has the highest per capita consumption of alcohol in India, viz. 8 litres per person in a year (BBC News, June 9, 2017). One recent report says that Kerala spent nearly 500 crores on alcohol during the *Onam* festival in 2018, viz. the annual harvest festival in the state (The Hindu, September 13, 2019).

To tackle this issue, a large number of alcohol de-addiction centers have also emerged. De-addiction treatment in Kerala is largely available in three different kinds of spaces: (1) specialized de-addiction centers, (2) biomedical spaces such as psychiatric hospitals and government hospitals, and (3) ayurvedic medical facilities. Apart from this, there are also various community organisations and non-government organisations providing de-addiction treatment. In this paper, we discuss the increasingly medicalized nature of de-addiction treatment, which is provided in all these sites. While this may not be unexpected when it comes to sites such as hospitals, whether general or psychiatric, whether biomedical or ayurvedic, as they are, after all, medical spaces, it was found that even in community-based de-addiction centers, a strongly medicalized approach to heavy alcohol use[[1]](#endnote-1) prevails. Fieldwork with people accessing de-addiction treatment revealed the glaring gaps in this treatment, which showed little appreciation of the complex sociocultural, economic and familial issues involved in addiction. Ultimately, this paper calls for an overhauling of de-addiction treatments and approaches, arguing that without taking a holistic approach to the problem of ‘addiction’, these treatments are bound to fail.

We became familiarized with de-addiction treatments in Kerala through research on domestic violence. The data collected are from counseling centers, NGOs, shelter homes as well as home visits in the locality of Kozhikode situated in Kerala, India. The interviews were taken from women and their family members with their consent while they approached the registered organizations to report domestic violence issues and to seek help. In this research, we were constantly confronted with narratives linking domestic violence to heavy alcohol use. Women spoke of their husband’s violent behavior as being caused by drunkenness, and felt confident that successfully treating their addiction would solve the problem of violence. Other scholars have also found women in Kerala to report that addictive alcohol consumption by their partners had ruined their lives (Colley, 2016). Many of them faced financial problems due to their husbands squandering savings on alcohol. They also underwent physical abuse, injuries, threats, and mental torture. Palmer, Patra, Bhatia, Mishra, and Jha (2016) conducted seven studies in which a total of 80,353 women were surveyed about their violence experience from their male partners. In all these narratives, the partners’ drinking habits were self-reported by the women participants. For women, alcohol emerged as the source of all miseries in their lives. One participant said, “I am ready to adjust with his control, suspiciousness and verbal abuse. But physical torture is not bearable”.

Counselors, police officers or doctors encountering women facing domestic violence at the hands of their husbands often suggest de-addiction treatment as a solution.[[2]](#endnote-2) Importantly, NGOs, women’s cells and other women’s welfare centres providing legal and other services for domestic violence also tended to focus on the role of alcohol in domestic violence, therefore putting their energies into de-addiction treatment. While this assumption that successful de-addiction treatment would effectively address the problem of violence is a telling reflection of how the issue of domestic violence is understood, in this paper, we focus not so much on attributions about the causes of violence but on the medicalized nature of de-addiction treatment in general. First, we describe the nature of treatment offered in all these sites. Subsequently, we draw on interviews with women at the receiving end of domestic violence, regarding their understanding and experience of the role of de-addiction treatment. Findings reveal that treatment strategies tend to be overly medicalized, and do not probe into the socio-psychological and cultural factors. Heavy alcohol use is not only a medical issue, but is always associated with several social and cultural factors. Crime, accidents, domestic violence and divorce have been linked with alcohol consumption (Manoj, 2016). We argue that the increasing medicalization of de-addiction treatment in Kerala is a reflection of increasing psychiatrization in Kerala. Chua (2014) observes that pharmaceuticals are intensively used for the treatment of mental illness in Kerala. In the case of suicide, psychiatrists suggest treating the social problem with antidepressants. In another context, Mills (2013) similarly found that the complex sociopolitical issue of farmers’ suicides in Maharashtra was addressed by the state through initiatives such as having medicines posted to people. These are all ways of medicalizing a social problem. Similarly, Kitanaka (2012) explores how depression in Japan became a national disease because of medicalization. Illness, abnormality and talking about depression came to be deeply rooted in the lives of ordinary Japanese people. Similarly, in Kerala, the idea of treating heavy alcohol use through de-addiction treatment is very common and popular among people.

**De- addiction treatments in Kerala**

De-addiction centers are booming in Kerala. In both rural and urban places, you can see billboard advertisements for alcohol de-addiction and treatment services. In 1988, there was only one de-addiction center in Kerala (Manickam, 2018). At present there are several de-addiction centers in each district. A national household survey conducted by NIMHANS (2013) found that one in seven alcohol users in Kerala are below 21 years old. The study also pointing out that according to the Indian Psychiatric Society, the flagship body of professional psychiatrists in India, heavy alcohol use triggers the rise of other psychotic disorders such as depression and schizophrenia. In Kerala de-addiction centers are mushrooming everywhere in the state. There are many de-addiction centers in private and government hospitals. In addition, there are separate de-addiction clinics as well. De-addiction treatment is the same in all the centers. However, the treatment duration is different. Some of the private hospitals have ten days of treatment. In all districts, government hospitals have a de-addiction ward as part of the psychiatry department. The duration of treatment in government hospitals and mental health hospitals is 21 days. Some religious/charitable institutions have 21-45 days of treatment. Some hospitals require a ward to accompany the patient; some do not. This is all dependent upon hospital rules and regulations.

The first phase of the treatment is detoxification i.e., the period during which the patient is medically supervised and managed through his physical withdrawal from the substance. During this phase, psychological help via counselling to the patient and family, either individually, or in groups, or couples is given. In the next phase, follow-ups and counselling are continued while focusing on avoiding relapses. In the last phase, therapies help to developing new coping skills for healthy relationships. A drug-free lifestyle, employment and money management are also follow.

A cursory glance at the above hospital-based de-addiction treatment reveals that de-addiction wards in hospitals function like other medical wards, and people with heavy drinking issues are treated as any other patients suffering from a disease. No doubt, this treatment of heavy alcohol use as a disease is a welcome shift from moralistic perspectives of heavy alcohol use as a social evil. Menon (1995) observed that a major shift in Kerala was when individual heavy drinking habits came to be characterized as ‘alcohol addiction’ or ‘alcohol dependence’. Yet, taking an exclusively medicalized approach without addressing the other related problems that heavy alcohol use involves is inadequate.

Apart from hospital-based treatments, there are community-based sensitization programs that advise patients to seek medical treatment for addiction issues. These programs also seek to address problems regarding employment, livelihoods, etc. stemming from addiction. The focus is on changing attitudes, improving lifestyles and restoring the social connections that the substance users had lost. This is done by helping the person to get a job, be accepted in his family and society, take up recreation and hobbies, etc. However, there are several challenges in complete rehabilitation due to the complex nature of heavy alcohol use (which is discussed in more detail below). One of the major hurdles is that a comprehensive approach to addiction issues requires long-term individualized psychosocial care.

The most well-known approach providing such care is the approach of the Alcoholics Anonymous, an international group of men and women with substance issues. One hundred Alcoholics Anonymous (AA) groups are working in Kerala (Manoj, 2016). They have regular meetings and members share their experience of having been an alcoholic and their journey of a sober life. They hold meetings with family members also. However, there are several challenges in the implementation of AA strategies. For instance, to deal with the cases of heavy users of alcohol, bringing structural changes is very difficult as such people come from diverse occupations and social backgrounds. For example, if someone who is a daily labourer (e.g. construction workers) has discarded his drinking habits, they still experience pressure that comes from associating with peers and friends who are heavy alcohol users. The social environment often continues to remain the same, leaving open the possibility of relapse.[[3]](#endnote-3) In addition, while the AA approach in general seeks to be all-inclusive, in terms of the members included in the support group, in the context of Kerala. Apart from support groups, the Government of Kerala has started several other programs as well. Punarjani[[4]](#endnote-4) and Vimukthi[[5]](#endnote-5) are the prevalent de-addiction programs in Kerala.

Confidentiality is very important in the treatment of substance use in the Indian context, because of the stigma associated (Parmar, Patil & Sarkar, 2017). That is one of the causes for people preferring Ayurvedic treatment for de-addiction. Apart from biomedical and community-based treatments for substance use, Ayurvedic treatment is increasingly being preferred. Scholars have shown how Ayurvedic treatment is generally viewed as being less invasive or aggressive for patients. Halliburton, in his book *Mudpacks and Prozac* (2016) describes how Ayurvedic treatment in Kerala is experienced by patients as generally offering a more pleasant process of treatment with no side effects. This is a big draw for heavy alcohol users who typically find detoxification to be a painful and unpleasant process. This could be also a reason to turn to Ayurvedic treatment for alcohol heavy use.

**Ayurvedic treatment for Alcohol de-addiction**

A recent trend that has emerged in Kerala in de-addiction treatment is Ayurvedic treatment. In Kerala, Ayurveda is an established and institutionalized system of medicine that is widely resorted to for a range of illnesses.Eventually, Ayurvedic psychiatry has also become a well-established practice of medicine (Halliburton, 2011). In a psychiatric hospital, there is a separate ward for de addiction. It creates a lot of stigma for patients with substance use issues as they are now considered as ‘mental patients’ and have to undergo the same restrictions in their movement as other psychiatric patients in inpatient or custodial care. None of them can go outside the therapy center. Many of them experienced this as a jail and therefore started thinking about other alternatives. In addition, society retains a negative attitude towards the mentally ill seeking psychiatric care. Contrary to this, in an Ayurvedic hospital there is no specific treatment protocol for de-addiction. It is quite common for people to get an Ayurvedic massage or treatment program in general, just for better health without any illness. There is, therefore, little stigma in seeking treatment from an ayurvedic hospital.

In recent times, one comes across increasing number of advertisements for Ayurvedic treatment of addiction. *Panchakarma* and *Rasayana* therapies[[6]](#endnote-6) are mainly followed. Ayurveda therapy is also used to foster self-discipline or help in development of the self (Halliburton, 2018). Generally, one to three-month treatments are required in Ayurveda, depending upon age and other medical conditions. A study conducted by Jiljith and Jithesh (2018) on Ayurvedic management of alcohol withdrawal in Kerala found that alcohol-related disorders and symptoms are mentioned in ancient Ayurvedic texts. In severe conditions, *Rasayana* and *Sodhanachikithsa[[7]](#endnote-7)* are also available. Along with medication, there are general counseling services also available. One counsellor said that sometimes counselling is more powerful than medicine, because it helps to change the person’s beliefs and thoughts (personal communication. There is also a trend in Kerala to treat alcohol de-addiction through counselling. Most of these ‘counseling’ services, however, do little more than moralistic advice-giving, advocating notions about becoming a ‘man of virtue’ in the view of the family as well as whole society, apart from invoking religious beliefs and fear of God. As far as Kerala is concerned, the existing scenario is that anyone without having sufficient qualification, training or expertise could easily become a ‘counselor’ for alcohol de-addiction and other related issues (Manoj, 2016). This is also seen more generally in India, where the term ‘counselor’ is used in such a broad and generic manner in to include all kinds of professional activities from information-giving (e.g. HIV/AIDS counseling) to advising (e.g. career counseling) to convincing (e.g. public health outreach activities). Most of the time, these do not refer to psychological counseling. Given that de-addiction treatment is increasingly being resorted to in Kerala, due to the high mental health literacy, how do men and women actually experience de-addiction treatment? In the next section, I consider informants’ narratives about the futility and failures of de-addiction treatment and reflect upon the implications of these failures.

**Failure of De-addiction treatment**

Many survivors of domestic violence reported that their violence experience is an outcome of their husband’s heavy use of alcohol. Some of them have sought allopathic de-addiction treatment, often multiple times, for their husbands. The treatment protocol failed in many cases. The mental health sector is highly developed in Kerala; so people get information about de-addiction treatment through media, health centers and so on. Women who experience domestic violence usually attempt to treat their husbands’ heavy alcohol use. Affected wives firmly believe that de-addiction treatment will help to change the behavior of their husbands and they will have a peaceful life. From the interviews, I understood that most of them tried to get their husbands treated at the de-addiction center. This is seen in the following narratives.

Greeshma is a 35-year-old computer technician from the Nair community. She is from a middle class family. She had a love marriage at the age of 22. She said:

*My husband is a drunkard (madhyapaani). He was irresponsible at work and physically abused me. He never contributed to household work. I had many problems daily. I had to quit my job when I was pregnant. He used to leave the home without informing me. I got him treated for alcohol addiction. After my second delivery, his heavy drinking resumed. He continued with physical and verbal harassment. I got treated him for his alcohol consumption and no changes were visible. However, I had to manage all the household works and financial matters alone. When the violence was unbearable for me, I came to take help.*

Greeshma’s narrative also illustrates how there are a host of issues associated with heavy alcohol use (e.g. ‘irresponsible’ behavior, physical abuse, financial issues, etc.) and yet it is only a medicalized kind of de-addiction treatment that finds its way being addressed.

Thirty-six year-old Kala has been working as a teacher in a college. She had an arranged marriage at the age of 22. She belongs to the middle class and is from the Thiyya community. She said:

*My husband is an ‘alcoholic’ for several years. I got him to undergo de-addiction treatment six times. However, he did not change a bit. He continued to drink heavily and was not ready to change his behavior. I was forced to leave my job due to these issues and I have decided to take legal action*.

Kala explained her problem beginning with a sentence saying that her husband is an ‘alcoholic’. She used the English term. She is educated and she was working as a teacher in a college. Educated women have a better knowledge of the condition of their husbands. Chua (2012) observes that educated Malayali women tend to understand and talk about ‘alcoholism’ through a clinical lens. Kala’s usage of the term ‘alcoholic’ when she reported her trouble is one of the best examples of this. She considers her husband’s problem as a medical issue and hopes that it is possible to change his condition through medication. That is why she spent her time and money to treat him six times. Treatment for heavy alcohol use nearly six times is grueling. It involves immense wastage of money, time and effort and there exists the risk of treatment not being successful. It shows the problems in de-addiction treatment. Both the above women reported continuing domestic violence after the failure of de-addiction therapy.

Another participant, 42-year-old Saritha, is a homemaker. She had a love marriage at the age of 22. She belongs to the Thiyya community and middle class. She said:

*My husband is a police officer. He used to consume alcohol since the time of our wedding. During that time, it was controlled. He did not create any problems at home. After a few years, he started to create problems. He would beat my children and me as well. Initially he was reluctant to come for the treatment. Then, after everybody insisted that he take treatment, he agreed. However, he did not stop drinking. He had taken treatment three times. Now he has retired. He is drinking every day. He has squandered all the wealth through this. Even now, he is ready to take treatment, but I do not think that he will stop his drinking behavior. In addition, de-addiction treatment is very expensive.*

These women report that de-addiction treatment is very expensive and has failed several times for them. Relapses are common also. Heavy alcohol use is not only a medical issue but also a social problem in the family and the society.

**Conclusion: Lessons for re-imagining de-addiction**

What are some of the lessons that can be drawn from the above findings? Observations in hospital and community settings suggest that ‘de-addiction’ is still envisioned as a medical process that needs to be established through medical means such as medicines, detoxification, and hospitalization. The entire process of (de)addiction is understood in medical terms. While this is clearly preferable to previous moralistic perspectives about heavy alcohol use as a ‘sin’, a weakness, an evil, etc., we need to ask ourselves whether an exclusively medicalized focus discounts the wider psychosocial ramifications of heavy alcohol use. In this concluding section, we outline some suggestions for re-imagining de-addiction, thereby improving its effectiveness.

1. Destigmatizing de-addiction treatment so that more individuals come forward willingly: One of the strategies of destigmatizing has largely been medicalization, by emphasizing addiction as a medical condition rather than a social evil. This is evident in the IEC materials and awareness campaigns. Yet, medical treatment of addiction in hospital and psychiatric settings is also stigmatizing and hence it is important to emphasize community-based treatments for addiction.
2. Nesting de-addiction treatment within a range of other allied services such as psychosocial care, livelihoods, and financial support: Women and children are typically the victims of violence in several homes. Many of them have persistent trauma, which eventually leads to, depression, poor resilience and helplessness overtime (Sreekumar, Shubhalakshmi & Varghese, 2016). Every de-addiction center should have a psychotherapy department to cater to the distress of these women as well. Similarly, an allied social work department can provide the necessary economic and legal support that might be required for families in distress. Given the stigma of divorce in Indian society, women often require support for separating from abusive partners as they tend to regard the abusive marriage as an inescapable context and feel trapped with no solutions (Colley, 2016).
3. Taking an intersectional approach towards de-addiction treatment: It is also important to look at the interplay of caste and class. Psychiatric clinical practice needs to change in the Indian context in the case of alcohol use disorder. It should address the individual’s socio-cultural background and understand the person’s lifestyle as well.
4. Including a gender lens in medical education and medical curricula so that doctors are sensitized to gender-based violence: In medical texts there is a lack of social determinants of health, especially women’s health cares (Sanghvi, 2018). In many instances women experiencing domestic violence seek treatment in hospitals for burns and injuries on the face and body, and often it’s the attending doctor who treats them who is the first to come to know about the violence. It is important, therefore, that doctors have the requisite information about resources that women in distress could turn to or professional social workers who could assist them. This, in turn, requires liaison between hospitals and other institutions in society.
5. Using existing self-help groups or other networks such as the *Kudumbasree* programme in Kerala to create support networks: The important point is to integrate de-addiction treatment within other existing services and networks that are functioning effectively.

All of these indicate a glaring need to re-imagine the field of ‘’de-addiction’ moving beyond the medical.

1. In this paper, I am using the term heavy alcohol use to address people who use alcohol excessively, causing issues for themselves and their families. My intention is looking at heavy alcohol use is not to make a diagnosis based on the DSM-5 or ICD-10, and hence I avoid diagnostic terms. [↑](#endnote-ref-1)
2. The ‘Orange Day’ campaign was organized by the Government of Kerala on 25 November 2015 to mark the International Day of Elimination of Violence against Women. The organisers commented that ‘the orange color stands for the bright and optimistic future which is free from violence against women and girls, majorly committed by men under the influence of alcohol and drugs’ (The Hindu, 24 November 2015). This description also leans heavily towards characterizing violence against women as a natural consequence of alcohol addiction. [↑](#endnote-ref-2)
3. In Kerala, it is customary to offer alcohol as a reward for various categories of labourers. For instance, during a housewarming ceremony of a newly build house, the family typically arranges for a sumptuous meal accompanied with alcohol for the workers involved in the house construction. [↑](#endnote-ref-3)
4. There is a new clinical experiment in de-addiction called ‘Punarjani’, which is run by people who recovered from alcohol use. Punarjani is a de-addiction center is situated in Thrissur. It is a charitable trust. It provides detoxification for alcoholic de-addiction. Some of them prefer Ayurveda treatment for detoxification. Counseling, hypnotherapy, education, psychoanalysis, meditation, yoga therapy, and allied methods through motivation and personal assistance. (De-addiction centers.in). Only when the whole person is treated, not just the symptoms, but the underlying causes can recovery truly begin. They combine clinical & medical care available with advanced holistic therapies and support for complete healing of mind, body, and spirit. There are many types of services for alcohol users available that linked to hospitalization and detoxification, Psychological therapy, counseling, recreational activities, and community outreach. Apart from counseling and providing medication. [↑](#endnote-ref-4)
5. Vimukthi is an anti-narcotics campaign started by the government of Kerala. It aims the addiction-free Kerala trough campaign. It makes awareness about drug and alcohol addiction to the students, youth, and public. It implemented with the help of student police, vimukti anti-drug cadets in the school and colleges, national service scheme, kudumbasree, anti-alcoholic organization, youth and women organization. Vimukthi started de-addiction centers in all districts in government hospitals, health departments and counseling centers. People get OP services, detoxification, pharmacotherapy, counseling, recreational facility (TV, books, games, etc.) yoga therapy, and withdrawal management. (Vimukthi.keralagov. in). In addition, available counselors who got specialized training to manage de-addiction problems. [↑](#endnote-ref-5)
6. Panchakarma is a systematic five-step approach towards total mind-body rejuvenation using herbal oil massages, steam baths, cleansing enemas, diet, and other purifying practices that eliminate toxins from the body. The aim is to offer a holistic approach towards promotion of health, and prevention and cure of diseases. Rasayana therapy uses herbal approaches to increase natural immunity, enhancing general wellbeing, and improving the functions of the all fundamental organs of the body. [↑](#endnote-ref-6)
7. The term shodhana means to go away. Our lifestyle often includes unhealthy patterns in health. This therapy focuses on eliminating toxins from the body. The treatment detoxifies and purifies the body through oil massage along with a healthy diet.

   **References**

   Viswanath, C. A Different Tragedy Strikes Kerala During COVID-19 Lockdown Due to Non-Availability of Alcohol. (March 29, 2020) *News18.* Retrieved from www.news18.com.

   Rajagopal, S. Guidelines for alcohol-use disorders. (March 28, 2020) *The Hindu*, retrieved from www.thehindu.com.

   Thomas, S.C. (2014). *Mental health literacy survey to assess the Knowledge and beliefs about mental disorders in the rural community of Kollam district* (doctoral dissertation). Retrived from www. sctimst.ac.in.

   Padanna, A. India's Kerala state eases alcohol ban. (June 9, 2017) *BBC News*. Retrieved from https://www.bbc.com.

   *Kerala Spent Nearly ₹500 Crore On Alcohol This Onam*, (September 13, 2019) *The Hindu*, retrieved from www.thehindu.com.

   Colley, A. J. (2016). Deception in the Service of the Family: Observations on Alcoholism Treatment in Kerala, India. *Journal of Groups in Addiction & Recovery*, 11 (3),194-204.

   Palmer, M. D., Patra, J., Bhatia, M., Mishra, S., & Jha, P. (2016). Risk of Intimate Partner Violence and Alcohol Use. *Economic and political weekly*. LI (14), 86-87.

   Manoj, N.Y. (2016). *Alcohol as Object: An anthropological Study on alcohol consumption in Kerala.* (Doctoral dissertation). Retrieved from www.shodhganga.com.

   Chua, J. L. (2014). In Pursuit of the Good Life: Aspiration and Suicide in Globalizing South India. London; University of California Press.

   Mills, C. (2013). Decolonizing Global Mental Health: The psychiatrization of the majority world. London; Routledge.

   1. Kitanaka, J. (2011). *Depression in Japan: Psychiatric Cures for a Society in Distress.*  United Kinngdom; Princeton University Press.
   2. Manickam, L. S. (2018, December 20). *Management of alcohol dependence: A community based multi model approach.* Retrieved from www. Psychology4all.com.
   3. Menon, D.M. (1995). From Pleasure to Taboo: Drinking and Society in Kerala. *India International Centre Quarterly.* 22 (2/3), 143-156.

   Parmar A, Patil V, Sarkar S. (2017). Ethical management of substance use disorders: the Indian scenario. *Indian Journal of Med Ethics*. 2(4) 265-270.

   1. Halliburton, M. (2016). *Mudpacks and Prozac: Experiencing Ayurvedic, Biomedical, and Religious Healing.* London; Routledge.
   2. Halliburton, M. (2003). The Importance of a Pleasant Process of Treatment: Lessons on Healing from South India. *Culture, Medicine and Psychiatry*, 27(2), 161–186.
   3. Jijith, A. &Jijesh,M. (2018). Ayurvedic Management of Alcohol Withdrawal Syndrome- A Case Report. *Medical Journal of Clinical Trials & Case Studies.* 2(6).
   4. Chua, J. L. (2012). The Register of “Complaint”: Medical Anthropology Quarterly, 26(2), 221–240.
   5. *Kerala to organise 'Orange Day' campaign to end violence against women,* (November 24, 2015). *The Hindu*. Retrieved from www.thehindu.com.
   6. Sanghvi R. ( 2018). Gender perspectives in medical education. *Indian Journal of Medical Ethics.* 4(2).

   [↑](#endnote-ref-7)