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

Anjali.K. K.

PhD Research Scholar, Department of Liberal Arts,

Indian Institute of Technology, Hyderabad

Kandi, Sangareddy district

Telangana – 502285

Contact Number: 8142991090

Email: [la14m15p100001@iith.ac.in](mailto:la14m15p100001@iith.ac.in)

Dr Shubha Ranganathan

Associate Professor, Department of Liberal Arts

Indian Institute of Technology, Hyderabad

Kandi, Sangareddy district

Telangana – 502285

Email: [shubha@la.iith.ac.in](mailto:shubha@la.iith.ac.in)

Abstract

The paper points to certain lacunae in de-addiction programs in Kerala, which adopt a heavily medicalized approach. It draws attention to problems in the way in which de-addiction treatment in Kerala is designed as well as imagined by participants. Qualitative interviews with people accessing de-addiction treatment as well as their spouses reveal a heavily medicalized approach to the problem of addiction, with little appreciation of the complex socio-cultural, economic, and familial issues involved in addiction. Ultimately, this paper calls for 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. A broader, multi-pronged approach towards de-addiction is suggested, in which the medical treatment of addiction is only one aspect, and sufficient attention is also paid to other dimensions such as rehabilitation, livelihood, gender inequalities, etc.

Keywords: heavy alcohol use, medicalization, domestic violence, mental health

**Introduction and background**

The southern state of Kerala has a long history of progressive social movements. It also has a good record of education and health, as reflected in development indicators for the same. Literacy rate is very high in this state when compared to several other Indian states. Unlike many other states of India, primary education in the rural areas of the state also maintains a good quality. The ‘Kerala model’ – which is widely discussed in academia - refers to the state’s achievements in the material conditions of living, social development, income rate, literacy, employment, life expectancy, health, and low level of infant mortality. Further, mental health services are also well-established 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. 8.3 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). According to WHO, the alcohol consumption rate has increased from 2.4 liters to 5.7 from 2005 to 2016 in India (The Hindu, September 23, 2018).

Manoj (2016) observed that while Kerala has the high per capita alcohol consumption of 8.3 litres per annum, the national average is only 4 litres. One report found that the state government earned 195.29 crores from the beverages department in 2017 (Times of India, December 28, 2017). Further, alcohol and drugs have been held responsible for domestic violence in 60% of the cases in Kerala (Karthika, 2015). The Kerala Women’s Commission also maintains that in most of the domestic violence cases, the husbands are alcoholic (Koshi, 2014). Dr. Pramila Devi, a member of the Kerala Women’s Commission, specified that in 50% of domestic violence cases, women reported their partner’s excessive alcohol consumption (The Time of India, August 29, 2014).

There was a statewide ban on alcohol in 2014. The government allowed alcohol to be served only in five-star restaurants, shutting down several local/unlicensed shops. However, this ban was lifted after two years when the next government came into power due to the negative impact on the economy. The state’s approach to the problem of alcohol use has been to engage in a blanket ban against alcohol use without looking at the underlying issues and contexts in which alcohol use becomes a problem. De-addiction treatment is largely available in three different kinds of spaces: (1) specialized de-addiction centers, (2) hospitals (including psychiatric hospitals and hospitals of alternative medicine) (3) community organizations and non-government organizations. In this paper, we discuss the increasingly medicalized nature of de-addiction treatment, which is provided in all these sites, pointing to problems in the way in which de-addiction treatment in Kerala is designed as well as imagined by participants. 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, a medicalized approach was found even in community-based de-addiction centers.

We became familiarized with de-addiction treatments in Kerala through research on domestic violence. 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 that 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’ expenditure 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.

Counselors, police officers, NGOs, women’s welfare centres providing legal and other domestic violence services also tended to suggest de-addiction treatment as a solution. No doubt, this treatment of heavy alcohol use as a psychiatric 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 occurred when individual heavy drinking habits came to be characterized as ‘alcohol addiction’ or ‘alcohol dependence’. 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 whose husbands were receiving de-addiction treatment regarding their understanding and experience of the role of de-addiction treatment. Fieldwork with people accessing de-addiction treatment revealed the glaring gaps in this treatment, which showed little appreciation of the complex socio-cultural, economic, and familial issues involved in addiction. Ultimately, this paper calls for 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.

Note on terminologies:

In this paper, we use the term ‘heavy alcohol use’ to refer to people who were identified (either by themselves or by spouses) to have problems with alcohol consumption. Since this paper does not seek to make any conclusions about the diagnostic status of alcohol-related issues, we prefer the neutral, non-diagnostic phrase ‘heavy alcohol use’, a term defined by the National Institute of Alcohol Abuse and Alcoholism (NIAAA) rather than diagnostic categories drawn from ICD-10 or DSM-V. This is also based on feedback received from other scholars. Thus, we are bracketing the question of psychiatric diagnosis here. Our intention is not to presume that alcohol consumption is (always) a problem, but rather to look at the issue through the lens of those who are seeking redressal for heavy alcohol use. Using the neutral phrase of ‘heavy alcohol use,’ we steer clear from making judgments about ‘addiction’ and alcohol dependence. In keeping with the approach to foreground the perspectives of our interlocutors, we consider heavy alcohol use as a ‘problem’ to the extent that it is experienced as such by the men and women in our study.

**Methods**

We used qualitative approaches as the interest was to people’s experiences on their own terms rather than to fit their responses within pre-defined categories (Willig, 2008; Flick, 2009). Data was collected from counseling centers, NGOs, hospitals, shelter homes as well as home visits in the locality of Kozhikode situated in Kerala, India. While the data is drawn from a larger study of women experiencing domestic violence, in this paper, we focus on people’s experiences of de-addiction treatment.

In-depth interviews were carried out using an unstructured open-ended interview guide, with 15-20 questions for the study, following the guidelines of Willig (2008) and Flick (2009). These questions were designed to serve as a guide for the in-depth conversations that followed. The interview guide was translated into Malayalam (the local language in Kerala). We then asked experts to back-translate it into English, compared both the English versions of the interview guide and made certain corrections to finalize the interview guide. The first author’s native language is Malayalam. Seventy women between the ages of 22 and 52 affected by domestic violence were interviewed for the present study. Each interview lasted from 45 to 90 minutes. Pseudonyms are used for participants and organizations mentioned in the paper.

**Ethical issues**

Ethical issues play a very important role in sensitive issues like de-addiction and domestic violence. The research was presented before the Institutional Ethics Committee (IEC) of the Indian Institute of Technology Hyderabad. After making the required modifications based on their suggestions, the study was approved for IEC clearance. In carrying out the research, privacy in conducting interviews was respected by talking to each participant alone in an empty closed room. Confidentiality was ensured by anonymizing the names. However, in addition to participant anonymity, we also confronted the important issue of keeping anonymous the contexts and sites in which people were interviewed (e.g. names of organizations). Despite all attempts to protect the identity of informants, if the surrounding contexts are known, identification becomes a theoretical possibility. In view of this, we have deliberately been rather vague about the field sites in which the research was conducted. Along the lines of Saunders, Kitzinger, and Kitzinger (2015), we understand ‘anonymity’ to be a complex issue that goes beyond simply protecting participants’ identities; it requires using various tailor-made context-sensitive strategies for maintaining confidentiality while also preserving the richness of the interview data.

We understood from prior research experience that many participants, although willing to participate in the research, hesitated to give written consent due to the sensitive nature of the topic. In such circumstances, we proceeded after obtaining oral consent. Here, we follow the guidelines by other researchers engaged in ethnographic or qualitative research. Riessman (2005), who has a long-standing research engagement with Kerala, draws attention to the importance for a context-based understanding of ‘ethics’. During her research on infertility narratives, she frequently experienced women’s reluctance to put their signatures on an ‘informed consent’ document, which they often cannot read. Similarly, Weis (2019) studying commercial surrogacy in Russia calls for the need for a ‘situational ethics’. Our own approach was to focus more on building ethical relationships with informants and institutions, and not stop with merely complying with universal guidelines about ‘confidentiality’, ‘informed consent’, and other ethical principles.

Interviews were carried out in a separate closed space, using a digital audio recorder whenever possible. The data was later transferred onto a personal computer. It was important to allot sufficient time for each interview to allow them to process their difficult emotions, which often came up in the course of the interview.

**Analysis**

For analyzing the data, the thematic analysis approach described by Braun and Clarke (2006) was used for identifying, analyzing and reporting patterns (themes) within the data. The following illustration depicts the process of analysis.

**De-addiction treatments in Kerala**

De-addiction centers are mushrooming everywhere in Kerala, as seen by prominent billboard advertisements in both rural and urban areas. In 1988, there was only one de-addiction center in Kerala (Manickam, 2018). At present, there are several de-addiction centers in each district, as alcohol consumption increases every year. Recently in Kerala, there are rapid increases in the number of centers (Manoj, 2016). At the same time, in India, there is a larger gap between people who need treatment and those who receive treatment (Ministry of Social Justice and Empowerment, Government of India, 2019). In Kerala, de-addiction centers are available in most government hospitals and also in some private hospitals. In addition, there are separate de-addiction clinics as well. While the treatment process is the same in all the centers, the duration varies. Some 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 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-up and counselling are continued while focusing on avoiding relapses. In the last phase, therapies help in developing new coping skills for healthy relationships.

The above description about the counseling that is provided at hospital settings may provide an impression of a holistic approach towards de-addiction that pays attention to psychosocial care beyond the medical. Yet, family members faced challenges in accessing such counseling, given the other financial constraints they faced. One woman whose husband was availing of treatment for heavy alcohol use said:

*Most family members will not attend the meeting during the counseling session for various reasons. I went and attended twice, but the counselling did not help me in any way. What I wanted was my husband to give up drinking and not to create any troubles at home. I was already spending a lot of money for his treatment; in addition, every time I went for group therapy, I would lose my pay. This is also an important reason to be mentioned.* (Prabha, daily wage worker).

Therefore, in that context, the relevance of family or group counselling is questionable. As part of this project, we also spoke to counselors about their work as part of de-addiction. One counselor working in a hospital offered a description of what ‘counseling’ entails:

*De-addiction treatment is quite important when the person is either causing a nuisance to others or is unable to manage himself. In our hospital, we aim to provide the best possible de-addiction treatment during which the patient must stay in the hospital for 21 days continuously. The first phase of treatment is detoxification and in the following phase, psychoeducation is provided where we try to educate the patient regarding the treatment strategies he will undergo. After the detoxification phase, we provide individual as well as group counselling.*

Another counselor opined:

*Alcohol addiction is a psychological disease. We must use some motivating techniques every day. In addition, providing family therapy, group therapy, cognitive behavior therapy motivation enhancement therapy, and employing the 12 steps technique of AA is also effective. In addition, we check whether any personality disorder is associated with the patient. If it is there, we treat that as well.*

Terms such as ‘psychoeducation’ or ‘counseling’ or ‘psychosocial intervention’ are commonly used as in the above interview. At the same time, as other scholars have also noted (e.g. Manoj, 2016) what counseling often amounts to in the field is little more than generic advice-giving, often with strong moralistic tones. The term ‘counseling’ is used in a variety of public health contexts in India in such a generic manner to refer to a range of activities (advising, persuading, convincing, coaxing, giving information, building awareness etc.). This, in itself, is indicative of the generalized understanding about ‘counseling’, both among the public and in public health. In other cases, the counseling techniques employed (as described in the second excerpt) such as CBT or the 12 step model are often artificial and foreign to those with heavy alcohol use issues. This also points to problems with the practice of mainstream counseling, which is often disconnected from the class, context, and lifestyle of marginalized groups (Fox, Prillentensky, & Austin 2009). As the topic of the ethics and practice of counseling is a broader issue beyond the scope of this paper, here, we seek only to flag these issues in the context of de-addiction treatment.

During field visits to hospital-based de-addiction centres, it was observed 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.

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 lost social connections. 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 incomplete 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. To achieve a long-term solution for heavy alcohol use, bringing structural changes is necessary. 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. 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. Apart from support groups like AA, the Government of Kerala has started several other programs as well. Punarjani[[1]](#footnote-1) and Vimukthi[[2]](#footnote-2) are the prevalent de-addiction programs in Kerala.

Given that de-addiction treatment is increasingly being resorted to in Kerala, due to the high mental health literacy in the state, how do men and women actually experience de-addiction treatment? In the next section, we consider informants’ narratives about the futility and failures of de-addiction treatment and reflect upon the implications of these failures. Through these narratives, we also seek to reflect on women’s understanding about de-addiction treatment and their expectations. Although some women are aware about the possibilities of relapse with de-addiction treatment, there is also a largely medical approach adopted towards de-addiction.

**Failure of De-addiction treatment**

Many participants had sought allopathic de-addiction treatment, often multiple times. 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. Family members, particularly wives affected by their husband’s alcohol consumption, hope that de-addiction treatment will help to change the behavior of their husbands and that once cured of their addiction-related issues, they will no longer undergo domestic violence and other related stresses. The following narratives from some of the wives interviewed illustrates women’s expectations from de-addiction treatment.

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 again but no changes were visible. I had to manage all the household work and financial matters alone. When the violence was unbearable for me, I came to take help.*

Greeshma’s narrative 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 through formal mechanisms. Clearly, Greeshma hoped that de-addiction would provide a permanent solution to her problems. Such expectations were commonly encountered among women whose husbands availed of de-addiction treatment, and often resulted in people making multiple attempts at de-addiction treatment, as the following cases illustrate.

Thirty-six year-old Kala was 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 one 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, an educated woman, explained her problem beginning with a sentence that her husband was an ‘alcoholic’, using the English term. Other researchers like Chua (2012) have observed that educated Malayali women tend to understand and talk about ‘alcoholism’ through a clinical lens. Kala 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 expended her time, money and effort to treat him six times.

Another middle-class participant, 42-year-old Saritha, from the Thiyya community 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 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.*

Saritha’s narrative illustrates her disillusionment after three failed attempts at de-addiction treatment. Families also experienced the financial burden of de-addiction treatment, which was expensive for them.

When interviewing counselors about their experiences counseling people about the possibilities of relapse, one psychologist opined:

Response to the treatment varies for each individual depending upon their personality. There exists a notion that those who are voluntarily approaching for de-addiction treatment shall not have a relapse, while those who undergo treatment by compulsion are more likely to have a relapse. However, in our experience, it was the other way round. Therefore, it has to be understood that relapse also arises from their biological systems' response.

Another counsellor Sreevidya said that in certain cities like Kochi and Trivandrum, AA programs were successful in treating those patients who were internally motivated and attended meetings regularly. However, she added that in rural areas, it was very difficult to implement as many people did not attend regular meetings. Their friends’ circle pulled them back into drinking behaviour. Moreover, for those going for daily wage work, it was difficult to skip work and attend the meetings regularly. According to this counselor, class, geographical area, and self-motivation played a role in successful rehabilitation. From this counselor’s point of view, successful rehabilitation from addiction-related issues was largely the responsibility of the client.

Another factor affecting the possibility of relapse or successful rehabilitation was stigma.

Confidentiality is very important in the treatment of substance use in the Indian context because of the stigma associated with de-addiction treatment (Parmar, Patil & Sarkar, 2017).

Despite the expense involved and the possibility of relapses, in the Indian context, when heavy alcohol use results in associated family disturbances, often the only concrete and easily available solution sought by families is de-addiction treatment. This is evident from the narrative of Babitha, a 30-year-old woman working as a salesperson:

*I took him to a hospital for de-addiction treatment because my children and I were suffering from beating, kicking and verbal abuse from him every day. The counselor told me that there may be a relapse because he started the habit of alcohol consumption long ago. However, I did not have any alternative ways to escape from the violence and hence I decided to proceed with the treatment. Once the treatment was over, we were living peacefully for six months. Now again, the situation has become even worse and I am unable to bear his abuse*.

Babitha’s narrative reveals an awareness about the possibility of relapse after de-addiction treatment, which is an existing reality across the globe. Her narrative also raises the question about how women are counseled about their expectations from de-addiction treatment, since part of the issue has to do with women’s unrealistic expectations about obtaining a permanent cure from de-addiction treatment.

When people with heavy alcohol use are staying in a general hospital for de-addiction treatment, they are regarded as normal patients. However, if the treatment is done in a specialized psychiatric hospital, they are treated as psychiatric patients. A participant woman’s husband described the treatment in a psychiatric hospital in the following words:

*It was almost like a jail - we cannot go anywhere out of the ward without someone accompanying us. The adjoining wards included patients with mental illness. So whoever visited the hospital might think that we also have some mental health problems. Otherwise, society has a negative attitude towards those taking psychological medications to treat alcohol issues (madhyapaana prashnangal). That is why I refused treatment all the time.*

Clearly, several factors affect rehabilitation and counselors were also aware about the risk of relapse and families were counseled accordingly. Yet, with few other options, families often persisted in seeking de-addiction treatment multiple times, hoping for a permanent cure. To understand why women and men repeatedly resort to de-addiction treatment, we need to understand the psychiatric context of Kerala, which has converted substance-related issues into mental illnesses.

**Mental health and Medicalization in Kerala**

Kerala has achieved a high level of awareness and development in the mental health sector as compared to other states of the country. As a result, people are more likely to seek help for mental illnesses and psychological distress. According to recent studies, depression has become a major public health concern in the state of Kerala (Lang, 2018). In our present study, we observed that many women voluntarily approached a psychologist for help to get rid of their mental stress. Their stress and tension related to their domestic violence experiences resulted in sleep disorders and other physical pain. Typically, when they approached a psychiatrist about their sleep disturbances, they were immediately prescribed psychiatric medication.

Other studies on the practice of psychiatry in India have also found a tendency to largely rely on psychotropic drugs, with little resort to psychosocial therapies (e.g. Addlakha, 2008; Ecks, 2013). In fact, psychiatrists in India are known for a tendency towards polypharmacy (Nunley, 1996). Even in programs which are specifically designed as community mental health programs, there is a focus on pills as the primary form of treatment (Jain & Jadhav, 2009). Addlakha’s (2008) ethnographic study on the treatment of mentally ill women in a psychiatry department of a hospital in New Delhi found that women’s narratives contained frequent references to domestic violence and abuse, either directly or obliquely. In most cases, psychiatrists colluded with family members to blame women for this, rather than addressing their distress. Addlakha’s (2008) work is important in calling attention to the gendered practice of psychiatry in India.

Zola’s (1972) classic article on medicalization describes it as a process whereby more and more issues become identified as medical issues to be dealt with through medical means. In the context of psychiatry, medicalization results in a focus exclusively on the individual experience of emotional or psychological issues (e.g. loneliness, sadness, fear, hopelessness, etc.) without looking at the structural bases of the problems such as marginalization, financial insecurity, violence against women etc. Medicalization, thus, he argues, becomes an institution of social control. Lang’s (2018) research on depression in Kerala points to the state’s increasingly medicalized approach to ‘mental health’, where depression and anxiety become recognized as mental illnesses of largely biomedical origin, without paying attention to the prevailing inequality or marginalization behind the distress. In their ethnographic research on community mental health in Kerala, Kottai and Ranganathan (2020) found that community mental health volunteers in Kerala are trained to pay attention only to the reported symptoms, without delving into the psychosocial factors such as violence against women, sex trafficking, discrimination, migration, unemployment, social exclusion etc. Chua’s (2014) research on suicide in Kerala also found that pharmaceuticals are extensively used for the treatment of mental illness in Kerala. Here, antidepressants become important symbols of pharmaceutical citizenship, as the state seeks to promote the development logic of providing free psychiatric medication for the marginalized (Ecks, 2006). 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.

In the context of Kerala, which has a very high degree of mental health literacy and an effective medical system, it is important to remember the hold that the ‘medical’ has for most persons. Thus, our observations from personal experience and other research suggests that the Malayali subjectivity is one in which “medicalization from below” (Kitanaka, 2012) is a process that has already occurred, to the extent that the medical discourse over determines Malayali subjectivity. Other research (e.g. Kottai & Ranganathan, 2020; Lang, 2018) has found the dominance of the medical even in community care in Kerala. It could be due to this that despite the failures of de-addiction treatment that patients and their families experienced, there was little critique of the medicalized nature of this treatment emerging from them. While much of the literature on medicalization has focused on psychiatric illnesses, there is little examination of how addiction-related issues and treatments have become medicalized. We argue that this medicalization has important implications for public health policy and practice. In the final section, we reflect on what kinds of changes are required to imagine treatment approaches for heavy alcohol use that are both equitable as well as effective.

**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. 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 and envision models beyond the medical model for treatment of heavy alcohol use.
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. The psychiatric sector 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. Research in critical psychiatry and critical psychology has drawn attention to the need for employing a social justice framework in research and practice in mental health (Fox, Prilleltensky, & Austin, 2009). Insights from scholars such as Davar (2001) and Vindhya (2003) who have worked on women’s distress and discrimination and emphasized the need for a rights-based perspective to mental health in India, would be invaluable in enabling us to re-structure de-addiction treatments 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 discussion of the social determinants of health, especially women’s health (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.
6. Incorporating perspectives from the interdisciplinary field of medical humanities. Scholars have called for the need for drawing on the humanities and social sciences perspectives by re-thinking the medical curriculum through the lens of medical humanities (Prabhu, 2019; Ramaswami, 2012). Govind and Chowkhani (2020) have critically examined how questions of gender and sexuality are either not addressed or inadequately addressed in the new medical curriculum, calling for the introduction of not just modules on doctor-patient communication and attitudes, but also scholarly literature from the humanities and social sciences. As Prabhu (2019) has emphasized, medical humanities is a rich and varied field drawing on a range of humanities and social sciences disciplines, and cannot simply be reduced to capsules of information on specific skills or attributes (e.g. ‘listening’, ‘communication’, ‘ethics’, etc.) but needs to engage with the theories and methodologies of disciplines in the humanities and social sciences. While this is a larger issue and beyond the subject of this paper, we seek to add to the recent voices in this journal that call for a broader medical humanities pedagogy in the medical curriculum, which would be gender-sensitive.

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

References

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](http://www.thehindu.com).

Alcohol intake in India doubles in 11 years (2018, Septher 23), *The Hindu.* Retrieved from <https://www.thehindu.com/sci-tech/health/alcohol-intake-in-india-doubles-in-11-years/article25017213.ece#:~:text=Per%20capita%20alcohol%20consumption%20in,by%20women%2C%20the%20report%20said.>

1. Karthika, K. G. (2015, August 06). Domestic violence increases. *Mathrubhumi*.Retrievedfrom http://www.mathrubhumi.com

Koshi, S, M. (2014, September 23). In Kerala, more than 50% crimes are fuelled by alcohol. *NDTV*. Retrieved from <https://www.ndtv.com/south/in-kerala-more-than-50-crimes-are-fuelled-by-alcohol-669625>

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.

Drinking Levels Defined. Retrieved from [*https://www.niaaa.nih.gov/*](https://www.niaaa.nih.gov/)

1. Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Berkshire: Open University Press.
2. Flick, U. (2009). *An Introduction to Qualitative Research*, 4th ed. Los Angeles: Sage Publications.

*Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: challenges and compromise in practice. Qualitative research : QR, 15(5), 616–632.*

1. Riessman, C. K. (2005). Exporting Ethics: A narrative about narrative research in South India. *Health*, 9(4), 473-490.
2. Weis, C. (2019). Situational ethics in a feminist ethnography on commercial surrogacy in Russia: Negotiating access and authority when recruiting participants through institutional gatekeepers. *Methodological Innovations,* 1-10.
3. Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). 77-101.
4. Manickam, L. S. (2018, December 20). *Management of alcohol dependence: A community based multi model approach.* Retrieved from www. Psychology4all.com.

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

Fox, D., Prilleltensky, I. and Austin, S. (2009) Critical Psychology: An Introduction. Sage Publications Ltd., London.

1. 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. Chua, J. L. (2012). The Register of “Complaint”: *Medical Anthropology Quarterly*, 26(2), 221–240.
3. 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.
4. Lang, C. (2018). Inspecting Mental Health: Depression, Surveillance and Care in Kerala, South India. *Culture, Medicine, and Psychiatry, 43(4), 596–612.*
5. Addlakha, R. (2008). *Deconstructing mental illness: An ethnography of psychiatry women and the family.* New Delhi: Zubaan.
6. Ecks, S. (2013). *Eating Drugs: Psychopharmaceutical Pluralism in India*. New York: New York University Press
7. Nunley, M. (1996). Why psychiatrists in India prescribe so many drugs. *Culture, Medicine and Psychiatry, 20*, 165-197.
8. Jain, S., & S. Jadhav (2009). Pills that swallow policy: Clinical ethnography of a community mental health programme in Northern India. *Transcultural Psychiatry 46(1)*, 60–85.
9. Zola, I. K. (1972). Medicine as an Institution of Social Control. *The Sociological Review,* 20(4), 487–504.
10. Kottai, S. R., & Ranganathan, S. (2020). Task-shifting in Community Mental Health in Kerala: Tensions and Ruptures*. Medical Anthropology, 1–15.*

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

1. Ecks, Stefan. (2006). Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India. *Anthropology & Medicine, 12*, 239-254.

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

1. Kitanaka, J. (2012). *Depression in Japan: Psychiatric Cures for a Society in Distress.*  United Kinngdom; Princeton University Press.
2. Fox, D., Prilleltensky, I., & Austin, S. (Eds.). (2009). *Critical psychology: An introduction*. Sage.
3. Davar, B. V. (Ed.). (2001). *Mental health from a gender perspective*. New Delhi: Sage.
4. Vindhya, U. (Ed.). (2003). *Psychology in India: Intersecting crossroads*. New Delhi: Concept Publishing Company.
5. Lang, C. (2018). *Depression in Kerala : Ayurveda and mental health care in 21st century India.* New York;Routledge
6. Sanghvi R. ( 2018). Gender perspectives in medical education. *Indian Journal of Medical Ethics.* 4(2).
7. Prabhu, G. (2019). The disappearing act: Humanities in the medical curriculum in India. *Indian Journal of Medical Ethics, 4*(3 (NS)), 194-197. Retrieved from <https://ijme.in/articles/the-disappearing-act-humanities-in-the-medical-curriculum-in-india/>
8. Ramaswamy, R. (2016). Embracing the unknown: introducing medical humanities into the undergraduate medical curriculum in India. *Indian Journal of Medical Ethics*, 9 (3), 174. Retrieved from https://ijme.in/articles/embracing-the-unknown-introducing-medical-humanities-into-the-undergraduate-medical-curriculum-in-india/
9. Govind,N., & Chowkhani, K. (2020). Integrating concerns of gender, sexuality and marital status in the medical curriculum. *Indian journal of medical ethics.*5 (2), 92-4. Retrieved from https://ijme.in/articles/integrating-concerns-of-gender-sexuality-and-marital-status-in-the-medical-curriculum/?galley=pdf

1. 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 and medical care available with advanced holistic therapies and support for complete healing of mind, body, and spirit. [↑](#footnote-ref-1)
2. Vimukthi is an anti-narcotics campaign started by the government of Kerala. It creates awareness about drug and alcohol addiction among students, youth, and the public. It is 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, there are counselors who got specialized training to manage de-addiction problems. [↑](#footnote-ref-2)