**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" \t "_blank)

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

In this paper, we explore the medicalization for heavy alcohol use in Kerala. From our qualitative research conducted, we observed that the process of medicalization relies solely on the few existing modern medical protocols while disregarding the psychosocial background of these issues. Often, women and children are victims of several households, and husband’s alcohol overuse is considered as an illness. The fact that even alternative treatment sectors such as Ayurveda is providing deaddiction treatments indicates how widespread the medicalisation of alcohol overuse has become. This paper also provides an insight on how victims of domestic violence women narrate their husband’s alcohol heavy use and existing treatment strategies to overcome the issues.

Keywords: Alcohol heavy use, medicalization, Ayurveda, alcohol consumption, mental health

**Introduction and background**

The southern state of Kerala has a long history of several 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 - in 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, 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, 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, after two years, when the next government came into power, they realized the negative impact of the ban on the economy generated from tourism. Hence, the state announced that licensed bars and airport outlets can serve alcohol. 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. Further, alcohol use is often treated as a medical problem with socio-moral implications, and a number of de-addiction centres have emerged to tackle the issue. De-addiction treatment 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 organizations and non-government organizations 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 prevails. In this paper, we use the term ‘heavy alcohol use’ to address people who had concerns with alcohol consumption. Our intention is not to make a psychiatric diagnosis based on the DSM-5 or ICD-10, and hence we avoid diagnostic terms.

whose husbands were receiving de-addiction treatment 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.

**Methodology**

We used qualitative approaches to understand women’s experiences of domestic violence as the interest was to understand domestic violence in their own terms rather than to fit their responses within pre-defined categories (Willig, 2008; Flick, 2009). Our focus in research was listening to experiences and highlighting the voices of those most vulnerable. Qualitative approaches are most appropriate for unfolding the meaning of experiences.

Field Sites

The data collected are from counseling centers, NGOs, hospitals, 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. The first author spent about nine months in the field to collect data.

Methods

We decided to take face-to-face in-depth interviews from participants, whom were met at the service providing centers. Following the guidelines of Willig (2008) and Flick (2009), we constructed an unstructured open-ended interview guide, with 15-20 questions for the study. These questions were designed to serve as a guide for the in-depth conversations that followed. Then 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 minutes to 1:30 hours. Pseudonyms are used for participants and organizations mentioned in the paper.

Ethical issues

Ethical issues play a very important role in a sensitive topic like 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 Institutional Ethics Committee clearance. In carrying out the research, privacy in conducting interviews was respected by talking to each woman 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 women 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.

In carrying out the interviews, the first author met participants at the respective centers, and obtained their oral consent for the interview. 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 the prominent billboard advertisementsn 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 When alcohol consumption increases over the year, de-addiction centers are also growing faster. Recently in Kerala, there are rapid increases in the number of centers (Manoj, 2016). At the same time in India, there are is a larger gap between people who need treatment, and those who receive treatment (Ministry of Social Justice and Empowerment, Government of India, 2019). 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 pointed 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 located in (most private and government 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 to developing new coping skills for healthy relationships. A drug-free lifestyle, employment and money management also follow.

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. 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. Scholars have pointed out how in the name of ‘counseling’ for de-addiction, often what is provided is little more than moralistic advice-giving (Manoj, 2016). 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’. 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. 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-2) and Vimukthi[[2]](#footnote-3) 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 with de-addiction treatment (Parmar, Patil & Sarkar, 2017). That is one of the causes for people preferring Ayurvedic treatment for de-addiction. 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 are mainly followed. 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.

This 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*are also available. 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.

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) observed 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.*

The above narrative illustrates the trust that women and men put in de-addiction treatment. Despite the repeated failures of treatment, Saritha sought it again and again. Families also experienced the financial burden of de-addiction treatment, which was expensive for them. 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 the 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, 2019). 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 for 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 emotional or psychological issues (e.g. loneliness, sadness, fear, hopelessness, etc.) without looking at the root problems such as marginalization, financial insecurity, violence against women etc. Medicalization, thus, he argues, becomes an institution of social control. Lang’s (2019) 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 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.

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. 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. Research in critical psychiatry and critical psychology have 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). One suggestion has been to revamp the medical curriculum by seriously incorporating the perspectives from the interdisciplinary field of medical humanities (Prabhu, 2019). 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. 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-2)
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-3)