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FROM CURIOSITY TO RECOVERY: A SOCIOLOGICAL STUDY OF SUBSTANCE ABUSE AND REHABILITATION IN A REHABILITATION CENTRE IN GUWAHATI

Sociology

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ABSTRACT

Substance abuse is no longer only a medical or legal problem; it affects families, schools and the way a society treats its young people. Most writing on the subject speaks about persons with substance use disorder rather than listening to them. This paper draws on fieldwork at Faith Foundation, a rehabilitation centre in Kharguli, Guwahati, in March 2021, using interviews with the owner and 10 recovered patients, a structured questionnaire and observation. It examines how a person comes to use substances, how use affects relationships and health, and how rehabilitation works in the Assamese context. Use usually began at 14 to 15 years with alcohol, cannabis and cigarettes, driven mainly by curiosity and peer pressure, followed by easy money, family history and trigger events. Heroin was the main substance among those admitted. Patients described rehabilitation as a return to "old good habits" and saw family support in aftercare as important as treatment. The paper argues that addiction is better understood as an attempt to escape a painful reality than as a moral failing, and that stigma is a major obstacle to recovery.

KEYWORDS

Substance Abuse, Rehabilitation, Addiction, Guwahati, Ass

INTRODUCTION

Substance abuse is the excessive use of harmful substances such as alcohol and drugs. Its effects do not stay with the user: it changes behaviour, damages physical and mental health, and slowly pushes a person away from family and society. Rapid modernisation and urbanisation in the twenty-first century have increased its pace, and in India drug use among younger people has drawn growing attention.

Assam is no exception. Newspaper reports from 2020 noted that drug-related cases in the state rose by nearly 50 per cent in two months (Parashar, 2020). Guwahati is one of the state's most populous and fast-developing cities, yet poverty, slums and street children live alongside this growth and are especially vulnerable. Drug use is also seen among privileged young people, which raises the question why those who seemingly have everything turn to substances. Weak bonds with family and school, peer pressure and social inequality are among the reasons suggested.

Many rehabilitation centres and NGOs have been set up in Guwahati, but their work remains incomplete without family and social understanding. This paper studies one such centre, Faith Foundation, and asks (1) what factors lead a person to drugs, (2) whether substance use creates relationship problems for those around the user, and (3) what the process of rehabilitation is and how it is understood socially and culturally in Assam. My aim was to look at the matter from the patient's point of view.

Review of Literature

Early writing described drug abuse in the language of disease. Kleiman et al. (1987) argued that some users move from experimentation to chronic, compulsive dependence, and that heavy use causes organic damage. The American Psychiatric Association (n.d.) similarly describes substance use disorder as continued use despite harm, to the point of losing the ability to function in daily life.

Regional studies show how widespread the problem is. Hazarika et al. (2000) found that, among 312 participants at Bandardewa on the Assam-Arunachal border, 40.4 per cent used tobacco and 36.5 per cent abused alcohol. Islam et al. (2014) found that around 81 per cent of street children studied in Guwahati were substance users, with glue sniffing most common. Armstrong et al. (2014) linked risky injecting practices among young people in Manipur and Nagaland to the spread of HIV, and Goswami (2014) pointed to the Golden Triangle as a major source of opium and heroin for the northeast.

Sociological work has looked at causes. Shaw (2002) reads substance use through perspectives such as anomie, social control, social learning and subculture. Fraser (1984) found that strong parent-child bonds reduce drug misuse, while family normlessness, alienation from home and parental drug use push young people towards it. On rehabilitation, Danquah-Amoah and Charan (2017) define it as helping a person reach the maximum level of function, quality of life and independence. What is largely missing, especially for Assam, is the voice of the person in recovery, and this study tries to contribute it.

Objectives and Methodology

The study aimed to understand rehabilitation as a process, to examine the reasons leading to addiction, and to gain brief insight into its effect on physical and mental health. It was conducted at Faith Foundation, Kharguli, in March 2021 using a mixed-methods approach with purposive sampling. The main tools were interviews with the owner and recovered patients and a structured questionnaire covering age, age of first use, substances used, reasons for involvement, effects on relationships, health and work or study, withdrawal symptoms and the decision to enter rehabilitation. Informal discussions and observation added to this. Individual respondents are not identified.

The work proceeded in three phases: a pilot stage of reading and preliminary visits, a fieldwork stage with a gatekeeper and scheduled interviews, and a post-fieldwork stage of data processing. The COVID-19 pandemic limited access to primary sources.

The Setting: Faith Foundation

Faith Foundation was established in 2008 in Kharguli by a brother and sister who had both been addicts themselves. It began with a male wing, and a female wing was added in 2020. At the time of the study there were about 50 in-house patients, three of them women, and 10 to 15 outpatients. The owner described the early days as difficult, since people did not respond positively. His argument was that a rehabilitation centre is like a hospital and addicts are its patients; if rehab is seen as bad, so must a hospital be. Awareness programmes slowly changed community attitudes.

All staff were once addicts themselves, and patients can become staff after counselling, which keeps the two groups close. The centre also runs social media pages for campaigns and to reach new families. The atmosphere, in my observation, was homely.

Findings

Beginnings and reasons for use

Most patients began using substances at around 14 to 15 years, often hiding it from family and friends, and reached the centre by about 20. They usually started with alcohol, cannabis and cigarettes. Among those admitted, heroin was the major substance, followed by cannabis, alcohol and nicotine, and many used more than one substance at a time. Curiosity and peer pressure came up again and again. Patients described being offered something unknown by friends and being unable to refuse, and plentiful pocket money made it easier. Because of their curiosity, many did not realise they were already addicted. For some, a trigger event such as alienation from family or society, or relationship problems, lay behind it. Family history of addiction was also important.

Effects on relationships and health

Substance use damaged relationships in many cases, leading to fights with friends and family. Mental and physical health were both affected, and some patients described feeling joyful under the influence but sad when it wore off. Some had trouble with work or study. The effects reach the whole family, and domestic violence is often linked with alcohol misuse.

Rehabilitation as a process

Patients described rehabilitation as a way "to regain our old good habits", such as waking early, following a timetable and respecting parents and elders, and to restore mental and physical health.

The process had four broad phases: intake, in which substance use, family history and financial arrangements are discussed; detoxification under medical supervision, since withdrawal can be dangerous and may involve heavy stomach pain, vomiting, tingling in the limbs and extreme weakness; rehabilitation proper, with individual, group and family therapy to understand the issues behind addiction; and recovery and aftercare, described as lifelong, with support groups such as Alcoholics Anonymous and Narcotics Anonymous. Life at the centre follows a tight schedule of exercise, meditation, yoga, group discussions, prayers and timely meals. Some patients come on their own, but many are sent by family and friends.

Recovery and relapse

Most recovered patients considered choosing rehabilitation one of the best decisions of their lives, prompted by their own realisation and family pressure. Some had relapsed but overcame it and were, as they put it, totally clean. They stressed that aftercare matters and that family and friends must be supportive, comparing it to the care a person with diabetes needs.

DISCUSSION

Addiction in this setting begins with ordinary things: curiosity, friends, spare money and a difficult home. This fits Fraser's (1984) findings on family and peer influence and the social learning and social control perspectives in Shaw (2002). It suggests that prevention should begin in school and at home, and that mental health awareness should be part of school and college education.

Society shows concern for physical illness but treats addiction as shame, weak will or low moral character. This makes recovery harder, because people hide their use and delay treatment. The owner's comparison of rehab with a hospital was thus an argument for treating addiction as a health condition. The peer-led model, in which recovered addicts become staff, also seems to build trust.

Families are both a cause and a cure. Busy, absent or unaware parents may leave a child without affection that money cannot replace, while family support in aftercare was repeatedly described as decisive. Finally, people do not become addicted simply because of a substance; it is the desperate need to escape an unbearable reality. Rehabilitation works when it gives them something to return to.

Limitations

The study rests on a single centre and a small, purposively chosen group, so findings cannot be generalised. The pandemic restricted primary access. Recovered patients may also speak more positively of rehabilitation than those who left or relapsed, whose voices future work should include.

CONCLUSION

Through the experiences of recovered patients at Faith Foundation, this paper shows that use begins early, usually through curiosity and peer pressure, and is worsened by easy money, family history and unresolved distress. It harms relationships and health and affects families as much as individuals. Rehabilitation, moving from intake and detoxification to therapy and aftercare, gave these patients a way back to a structured and healthier life, but its success depends heavily on the acceptance of family and society. If addiction is accepted as a serious health problem and not a moral failure, more people will be able to begin that journey earlier.

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