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Predictors of Relapse among Individuals Recovering from Alcohol and Substance Use Disorder in Rehabilitation Centres in Nairobi, Kenya

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ABSTRACT
Relapse remains one of the most persistent challenges in the treatment of alcohol and substance use disorder (SUD). The objective of this study was to determine the key predictors of relapse among individuals recovering from alcohol and substance use disorder in rehabilitation centres in Nairobi County, Kenya. The study was primarily guided by the Psycho-Spiritual Wellbeing (PSWB) Theory proposed by Egunjobi (2024), with additional support from the Trans-theoretical Model of Behavior Change (TTM) developed by Prochaska and DiClemente (1992). Using a phenomenological approach, semi-structured interviews were conducted with six purposively selected participants drawn from rehabilitation centres from the county. The data were analyzed using thematic content analysis, and the findings were presented narratively according to the emerging themes. Findings on the predictors of relapse among individuals recovering from alcohol and substance use disorder in rehabilitation centres included: Psychological and emotional distress, environmental and social triggers, and inadequate social support and family challenges. The study recommends that rehabilitation centres should integrate structured emotional regulation and distress-tolerance training into standard treatment protocols, equipping clients with alternative coping strategies for the stress, loneliness, and negative thinking that participants identified as primary relapse gateways.

Keywords: *relapse predictors, alcohol and substance use disorder, rehabilitation, qualitative thematic analysis, Nairobi, Kenya.*

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I. INTRODUCTION

Relapse constitutes one of the most persistent and clinically significant concerns in the treatment of alcohol and substance use disorder (ASUD). Despite the availability of a wide range of treatment modalities, a substantial proportion of individuals experience relapse within the first year following successful treatment, with prevalence estimates ranging between 40% and 60% (Guliyev et al., 2022). Because recovery does not follow a linear trajectory, identifying the specific factors that predict relapse is essential for designing effective interventions and supporting the long-term maintenance of sobriety.

International research has examined this question from multiple psychological, behavioral, and clinical angles. In the United States, Senn et al. (2020) studied 99 patients with alcohol use disorder using the Trans-theoretical Model to assess treatment motivation and behavior change, finding that higher scores on the action stage of change and stable employment were associated with lower relapse risk, though the study did not examine whether spiritual purpose or faith-based discipline might further strengthen individual resolve. Dandaba et al. (2020), studying 77 patients receiving alcohol rehabilitation in the same country, found that relapse was more likely among individuals with low insight into their drinking and a strong unconscious preference for alcohol, but the study stopped short of measuring emotional or spiritual awareness, such as the capacity for moral reflection or connection to higher values.

Evidence from Asia adds further nuance. In Vietnam, Nguyen et al. (2020) followed 95 veterans in residential alcohol treatment over six months and found a 69% relapse rate, with anhedonia and daily cigarette smoking emerging as the strongest predictors, reflecting the role of diminished motivation and emotional instability. In Japan, Yamashita et al. (2021) found that greater resilience and stable employment were both associated with a reduced likelihood of relapse among stimulant users. In China, Guliyev et al. (2022) followed 247 individuals receiving inpatient treatment and found that depression risk, motivation, probation status, and

substance use intensity significantly predicted relapse outcomes at three and twelve months post-discharge; notably, the study did not examine spiritual connectedness or emotional transcendence, dimensions that carry particular weight in many cultural settings where communal worship and pastoral counselling support emotional regulation. In Pakistan, Hansen et al. (2020) analysed relapse predictors among 2,130 individuals in outpatient alcohol treatment and identified premature dropout, psychiatric illness, and younger age as key predictors, again without assessing inner emotional regulation strategies or spiritual frameworks for managing stress.

A broader synthesis by Solmi et al. (2023), an umbrella review of 403 studies and 117 systematic reviews across mental health disorders including substance use, found that symptom severity, anxiety, and negative life events were consistently associated with relapse, while higher education and stable relationships predicted better outcomes; the review, however, did not examine spiritual wellbeing, emotional peace, or moral stability, dimensions that often shape daily motivation for recovery in African contexts.

African and regional evidence brings the spiritual and communal dimensions of relapse risk into sharper focus. In Ethiopia, Teshome and Bekele (2023) found that youth experiencing high community judgment and unresolved trauma faced significantly greater relapse risk, while participants who practiced spiritual routines such as Orthodox Christian liturgies, fasting, and confession showed greater resilience. In Nigeria, Abiola et al. (2021) conducted qualitative research on traditional Islamic healing in substance use recovery, finding that Qur'anic recitation, fasting, and communal prayer countered psychological craving and improved emotional regulation, offering participants both moral clarity and hope, though relapse occurred when these practices were discontinued or when reintegration into faith communities failed after discharge. In Rwanda, Kabisa et al. (2021) found a relapse rate of nearly 60% at the Icyizere Psychotherapeutic Centre, with broken family structures, peer pressure, and short hospitalization periods identified as major predictors, though the study did not incorporate spiritual support as a variable despite Rwanda's strong Christian and indigenous spiritual traditions. In Tanzania, Mohammed (2021) found that relapse was strongly associated with poor community support, limited coping skills, and the absence of post-rehabilitation social work, while participants also cited unemployment and unstructured daily routines as triggers, again without examining spiritual or religious coping.

Studies conducted within Uganda and Kenya illustrate both the promise and the limits of faith-integrated recovery models. In Uganda, Okello and Musisi (2020) found that prayer, fasting, and spiritual deliverance sessions reduced anxiety and increased post-treatment motivation among young adults in Pentecostal-based rehabilitation, with spiritual mentors and congregational support providing psychological reinforcement during emotional setbacks; however, relapse occurred when clients lost regular access to spiritual support after discharge, underscoring the need for continued mentorship. In Nairobi County, Kibera and Karega (2023) found a strong negative association between family resilience and relapse risk among former substance users in Alcoholics Anonymous groups, using the Family Adjustment and Adaptation Response framework to demonstrate that emotional closeness, communication, and shared responsibility reduced relapse likelihood, though the study did not examine psycho-spiritual wellbeing as a contributing factor. Owuor (2021), working in Kiambu County, found high comorbidity between relapse and depression (80.7%), post-traumatic stress disorder (65.4%), and bipolar disorder (56.8%), alongside early trauma and dysfunctional family environments, and noted that reduced participation in support groups or faith-based networks diminished emotional resilience, though the buffering role of spiritual wellbeing itself remained unexamined. Kelvin (2024), studying psychosocial determinants of relapse in Meru County, found that peer pressure, unemployment, and financial strain functioned as external triggers, while anxiety and poor coping skills operated as internal ones; although the regression models did not yield statistically significant predictors, qualitative responses indicated that spiritual routines such as prayer and group fellowship provided emotional balance, a dimension the quantitative analysis did not formally measure. Gathuci (2020), evaluating Motivational Interviewing Therapy among students at Mount Kenya University, found significantly lower relapse rates among those who received the intervention, though the study did not explore whether spiritual orientation or belief in a higher purpose influenced motivational outcomes.

The role of self-efficacy as a predictor of relapse has also received growing empirical attention, particularly given its documented interaction with psycho-spiritual wellbeing. Chichevo (2025) identifies self-efficacy, an individual's belief in their capacity to resist substance use in high-risk situations, as one of the core psychosocial determinants differentiating individuals who sustain recovery from those who relapse, finding that low self-efficacy combined with inadequate social support and high environmental trigger exposure formed the strongest predictor cluster; participants in that study described an inability to envisage life without substances, a struggle linked to an absence of meaning and purpose, dimensions directly addressed by the psycho-spiritual wellbeing framework. Njuguna (2025) similarly found that social anxiety, closely related to low self-efficacy, was significantly associated with relapse among men in addiction treatment centres in Kiambu County, who reported difficulty resisting peer pressure and navigating social situations without relying on substances as a coping mechanism. Liu et al. (2025) extended these findings by showing that higher addiction severity and inadequate social support collectively predicted motivational decline, with psychosocial resources functioning as critical moderators between environmental vulnerability and recovery outcomes. Importantly, the relationship between

self-efficacy and psycho-spiritual wellbeing appears bidirectional: Schnitker et al. (2020) found that individuals with higher spiritual wellbeing report stronger self-efficacy for recovery, as connection to transcendent purpose and supportive faith community reinforces belief in the possibility of lasting change.

The neuropsychological dimension of relapse further contextualizes these psychological and spiritual predictors within a biological framework. Mehari et al. (2026) established, through phenomenological analysis, that the subjective experience of relapse is consistently described by recovering individuals in terms of overwhelming emotional dysregulation, an inability to tolerate negative emotional states without chemical relief, converging with contemporary evidence on the neuropsychological impairments produced by chronic substance use. Hand et al. (2024) confirm that emotional dysregulation is among the most potent proximal predictors of relapse, activating neural reward circuits that prioritize immediate affective relief over consciously held recovery goals, a process operating largely outside conscious awareness and therefore not adequately addressed through willpower alone. Witkiewitz and Tucker (2025) argue that effective relapse prevention must address the full ecological context of recovery, including the meaning-making, spiritual connectedness, and transcendent purpose that psycho-spiritual wellbeing encompasses, since these dimensions provide internal regulatory resources capable of substituting for the neurochemical relief substances have historically provided. Liu et al. (2025) support this integrated view, finding that environmental cues mediated approximately 40% of the variance in relapse risk, while psychosocial support resources significantly buffered this effect.

The literature reviews revealed conceptual, methodological, and contextual gaps that this study sought to address. Conceptually, studies such as Nguyen et al. (2020), Yamashita et al. (2021), and Senn et al. (2020) focused on psychological and behavioural predictors, depression, anhedonia, and treatment motivation, without incorporating the psycho-spiritual dimension of emotional compassion, spiritual connectedness, and moral realignment into the relapse framework. Similarly, Dandaba et al. (2020) and Solmi et al. (2023) confined their analysis to cognitive and clinical variables without considering how spiritual awareness or faith practices might influence relapse behaviour. Even where spiritual routines were acknowledged, as in Okello and Musisi (2020) or Molefe and Khumalo (2023), psycho-spiritual wellbeing was not conceptually unpacked into measurable constructs such as awareness, connectedness, meaningfulness, compassion, and transcendence. Methodologically, studies such as Kelvin (2024) and Kibera and Karega (2023) employed regression or correlational designs without incorporating psycho-spiritual constructs into their statistical models, while studies such as Mohammed (2021) and Adalla (2023) associated relapse only with psychosocial or psychiatric factors, leaving the potential buffering role of spiritual wellbeing unexamined. Contextually, none of the reviewed studies directly evaluated relapse predictors among individuals undergoing treatment in Nairobi County's rehabilitation centres, despite Kenya's rich spiritual environment and the widespread incorporation of faith-based practices in addiction programmes.

II. OBJECTIVE OF THE STUDY

The objective of this study was to determine the key predictors of relapse among individuals recovering from alcohol and substance use disorder in rehabilitation centres in Nairobi County, Kenya.

III. THEORETICAL FRAMEWORK

This study was anchored on two complementary theoretical frameworks: the Psycho-Spiritual Wellbeing (PSWB) Theory and the Trans-theoretical Model of Behaviour Change (TTM). While the PSWB framework, developed by Egunjobi (2024), conceptualizes wellbeing as the integration of psychological health and spiritual development across the domains of self-awareness, connectedness, meaningfulness, compassion, and self-transcendence, the TTM offers a particularly direct lens for understanding relapse. Developed by Prochaska and DiClemente, the TTM conceives behavior change as a progression through five stages, pre-contemplation, contemplation, preparation, action, and maintenance, and treats relapse not as a terminal failure but as a recognized and often recurring point within this cyclical process (Prochaska & Velicer, 1997). This stage-based conceptualization is directly relevant to the objective addressed in this article, since it frames relapse as an event embedded within an ongoing process of change rather than as evidence that recovery has permanently failed, and it implies that the predictors of relapse identified through participants' narratives are best understood as forces capable of destabilizing progress through the stages of change at any point in the recovery journey, rather than as isolated triggers operating outside a developmental trajectory.

Therefore, these two theoretical frameworks suggest that relapse predictors operate at the intersection of psychological readiness for change and the presence or absence of psycho-spiritual resources, self-awareness, connectedness, meaning, compassion, and transcendence, capable of sustaining an individual's resolve when internal distress or external triggers threaten to destabilize progress. This theoretical lens informed both the design of the interview guide used in this study and the interpretation of the themes.

IV. METHODOLOGY

A research design is a structured framework that guides the researcher in collecting, analysing, and interpreting data to effectively address the research problem. It provides a systematic approach for translating research questions into empirical evidence and supports the generation of valid, reliable, and meaningful findings (Afen, 2026). A phenomenological design was selected because it enables a comprehensive description and narrative account of participants' lived experiences of relapse within their unique institutional and cultural contexts, allowing dimensions of relapse risk that quantitative instruments alone cannot capture, such as the subjective texture of craving, emotional distress, and social pressure, to be surfaced directly from participants' own accounts.

Six participants were purposively selected for in-depth, semi-structured interviews Participants were recruited through purposive sampling, a non-probability sampling method commonly employed in qualitative research to deliberately select individuals with direct experience of the phenomenon under study. This approach enabled the researcher to identify participants who could provide rich, relevant, and in-depth information aligned with the research objectives. Before commencing data collection, eligible participants were identified and recruited based on the predetermined inclusion criteria, thereby supporting a comprehensive understanding of the phenomenon under investigation (Etikan & Bala, 2017).

The sample size was determined based on the principle of data saturation, which is reached when further interviews no longer generate new themes, concepts, or meaningful insights. Achieving saturation suggests that adequate and sufficiently rich information has been collected to develop a thorough understanding of the phenomenon being studied. Methodological research indicates that in relatively homogeneous qualitative samples, saturation may often be attained within approximately 6 to 12 interviews, although the exact point depends on the complexity of the research questions and the depth of the information obtained (Guest et al., 2006; Hennink et al., 2017). Accordingly, six participants were deemed sufficient to provide adequate and information-rich data for the present study.

Further, data were gathered through individual face-to-face interviews guided by a semi-structured interview schedule consisting mainly of open-ended questions. This method provided participants with an opportunity to express their experiences, views, and perceptions comprehensively, while also enabling the researcher to ask follow-up questions and seek clarification when necessary. Following the participants' informed consent and adherence to relevant ethical requirements, all interviews were audio-recorded to facilitate accurate documentation of their responses. The recordings were then transcribed verbatim to maintain the integrity and authenticity of the participants' accounts. Each transcript was subsequently reviewed and carefully edited to address typographical, spelling, and punctuation errors while preserving the original meaning of the participants' responses. The researcher repeatedly read the transcripts to become familiar with the data prior to undertaking systematic thematic analysis. Thematic analysis was subsequently employed to identify, examine, and interpret recurring patterns and themes emerging from the participants lived experiences and perceptions of suicidal behavior. The participants varied in their socio-demographic characteristics, including age, gender, and year of undergraduate study. This diversity provided a broad range of perspectives and contributed to a more comprehensive understanding of the phenomenon under investigation.

Ethical principles were upheld throughout the study to safeguard the rights, dignity, privacy, and wellbeing of all participants. Ethical clearance was secured from the Catholic University of Eastern Africa (CUEA) and Africa International University, and a research permit was obtained from the National Commission for Science, Technology and Innovation (NACOSTI). Permission to conduct the study was also obtained from the respective rehabilitation centres. Before participation, individuals were provided with adequate information regarding the purpose and procedures of the study, potential risks and benefits, the voluntary nature of participation, measures for maintaining confidentiality, and their freedom to withdraw from the study at any stage without any adverse consequences. Informed consent was subsequently obtained from all participants.

To ensure adherence to the ethical principles of confidentiality and anonymity, the identities of the participating institutions were not disclosed and were instead represented using coded identifiers throughout the study. This measure was adopted to safeguard the institutions against possible stigma, discrimination, or reputational consequences associated with sensitive matters such as alcohol and substance use disorder among individuals undergoing recovery in rehabilitation centres in Nairobi County, Kenya. Table 1 provides a summary of the socio-demographic characteristics of the study participants. To further maintain anonymity, the code "RP" (Research Participant) was used to identify participants rather than their actual names. Table 1 presents the demographic characteristics of the qualitative participants, including their gender, age, and level of study.

Table 1

Qualitative Respondents

Code	Gender	Age	Level of Education	Interview Date

RP1	M	44 years	College/Diploma	6/3/2026
RP2	F	49 years	University degree	9/3/2026
RP3	F	28 years	University degree	6/3/2026
RP4	M	51 years	No formal education	8/3/2026
RP5	M	46 years	Postgraduate	10/3/2026
RP6	M	32 years	Secondary school	10/3/2026

The qualitative sample comprised four males and two females, spanning a range of educational backgrounds and age groups. This diversity was intentional. It allowed interrogation of how lived experience of relapse and recovery varies across sociodemographic lines, and ensured that the emergent themes reflected not a single profile of addiction but the range of human encounters with substance use disorder within rehabilitation settings.

V. FINDINGS

The objective of this study was to examine predictors of relapse among individuals recovering from alcohol and substance use disorder in Rehabilitation Centres in Nairobi County, Kenya. The participants' narratives and lived experiences were systematically analyzed using thematic content analysis. The analysis generated several major themes that illustrate the complex and multifaceted nature of recovery and the factors associated with relapse among individuals undergoing rehabilitation: Psychological and emotional distress, environmental and social triggers, and inadequate social support and family challenges.

Psychological and Emotional Distress

Across the interviews, participants consistently described internal emotional turbulence, including stress, loneliness, anger, guilt, and persistent negative thinking, as a primary gateway to relapse. The pattern that emerged was not one of weakness but of learned coping: substances had functioned as the most reliable emotional regulator these individuals knew, and under sufficient psychological pressure, the mind reverted to what it recognized.

One participant described this pattern directly:

> Let me say I'm going through, more or less it has been deep personal stress, loneliness, and negative thinking. I've been going through a lot and it hasn't been easy... In the past, whenever I felt that way, I always turned to alcohol or smoking to calm myself down... So, when stressful situations come again, the mind easily goes back to those old habits because that is what I used to rely on (RP1, male, 44 years).

The significance of this account lies not in the stress itself but in its cognitive architecture: the mind returns to old habits because it has a well-worn pathway there. This is precisely the conditioned response mechanism that Arabshahi et al. (2023) describe when explaining how unresolved trauma and inadequate coping skills sustain relapse vulnerability even after treatment. Hand et al. (2024) confirm that emotional dysregulation is among the most potent proximal predictors of relapse, activating neural reward circuits that prioritize immediate affective relief over consciously held recovery goals. This neurological framing helps explain why willpower alone is insufficient: relapse is not simply a moral failure but a neurobiological response to unmanaged distress that treatment must directly address.

A second participant's account added an existential dimension to this theme:

> The thing I know I have always felt is... an immense loneliness or emptiness in my heart... Even when I drink, it does not necessarily go away; it only makes me forget about it for that moment... after the effect wears off, the feeling comes back again (RP3, female, 28 years).

This account reframes the psychological predictor of relapse as more than emotional dysregulation; it describes an emptiness that substances cannot fill but can only temporarily mask, a void that psycho-spiritual wellbeing, through meaning, connectedness, and transcendence, is theoretically positioned to address. Malik et al. (2023) identify emotional dysregulation, co-occurring mental health disorders, and unresolved trauma as the core psychological factors sustaining relapse risk, and the present data confirm and deepen this understanding by giving it a first-person texture that quantitative predictor models cannot capture.

Environmental and Social Triggers

A second prominent theme concerned the power of environmental cues and social contexts to activate substance-use memories and cravings. Participants did not describe relapsing in a vacuum; rather, they relapsed in particular places, with particular people, in response to particular social scripts.

One participant described the pressure of a workplace celebration:

> Our company every year we always have that company party where everyone comes together to celebrate. During those events, drinks are usually served freely... being in that kind of environment sometimes brings back those memories and cravings... I remember feeling pressured by the situation and by the people around me. Eventually, I felt coerced and I ended up taking a sip (RP5, male, 46 years).

Another participant described a similar dynamic around a routine social activity:

> Sometimes myself, if I have friends watching football, most of them when they watch football, they tend at least to have drinks... Being in that round table with them, it becomes difficult because we are used to sharing those moments together... you feel the pressure to join them so that you don't look different from the rest (RP4, male, 51 years).

A third participant emphasized how reconnecting with former substance-using peers reactivated cravings:

> When they start going back to old friends, there are chances that you are likely going to experience cravings. These are the same people you used to drink or use with before, so when you meet them again, the memories of those moments easily come back (RP1, male, 44 years).

These accounts illustrate what Mehari et al. (2026) describe as conditioned cue reactivity, a well-established mechanism in substance use disorders whereby environmental stimuli repeatedly associated with prior use acquire the capacity to elicit craving and approach behaviour independently of conscious intent. The social dimension is equally powerful: Owens and McCrady (2014) demonstrate that peer influence and environments where substance use is normalised constitute major situational relapse predictors, while Chichevo (2025) adds that the physical availability of substances within communities directly lowers the threshold for relapse when coping mechanisms are momentarily overwhelmed. This is consistent with Liu et al. (2025), who found that higher addiction severity, peer influence, and inadequate social support collectively predicted motivational decline, with environmental cues mediating approximately 40% of the variance in relapse risk. The participants' accounts confirm that it is not merely the substance itself but the entire social and environmental context, the football match, the company party, the old peer group, that carries the weight of addiction memory.

Inadequate Social Support and Family Challenges

The third theme concerned the absence of inadequacy of social and family support as a driver of relapse vulnerability. Participants who felt unsupported, whether through family disengagement, relational rupture, or the social consequences of their addiction, described this isolation as a persistent source of distress that increased their susceptibility to relapse.

One participant described the absence of family involvement in her treatment:

> My family was not that much involved in my treatment. They knew that I had gone to rehabilitation and that I was trying to change, but they were not really part of the process... Sometimes I felt like I had to handle the recovery journey mostly on my own (RP3, female, 28 years).

Another participant reflected on the relational damage caused by past addictive behavior:

> I did things that betray people when I am deep into the addiction... I might steal something from home or from someone close to me and sell it just so that I can feed my addiction... Those actions hurt people and break their trust in me. When that happens, it builds a lot of resentment with people around me (RP6, male, 32 years).

Thus, these accounts illustrate a reciprocal damage cycle: substance use damages relationships, damaged relationships reduce social support, and reduced social support in turn escalates relapse risk. A third participant described the particular pressure of marital tension:

> I've been having issues with my wife. She even threatened to divorce me if I go back to drinking, so I'm having that inner pressure... I want to stay sober, but at the same time, the arguments and pressure make me feel anxious and sometimes overwhelmed (RP5, male, 46 years).

This account of inner pressure from relationship tension confirms Sinha's (2024) finding that marital conflict functions as a primary emotional trigger for relapse. Kibera and Karega (2023) similarly identify limited family involvement in recovery as a direct precursor to relapse within Kenyan settings, having found a strong negative association between family resilience and relapse risk among former substance users in Nairobi. The present data reinforce this call for family-inclusive rehabilitation models, showing that family disengagement is not a peripheral concern but a central driver of the isolation that participants directly linked to their relapse experiences.

VI. DISCUSSION

The three themes identified in this study, psychological and emotional distress, environmental and social triggers, and inadequate social support, converge on a single underlying pattern: relapse predictors in this Kenyan rehabilitation sample are rarely purely biological or purely social, but emerge from the interaction between unmanaged internal distress and an external environment that repeatedly cues substance use while offering insufficient relational support to counteract it. This pattern is consistent with Witkiewitz and Tucker's (2025) argument that effective relapse prevention must address the full ecological context of recovery rather than isolated risk factors. None of the three themes, notably, centered explicitly on spiritual disengagement as a standalone predictor; rather, participants' accounts of emptiness, isolation, and damaged relationships point toward unmet needs for meaning, connectedness, and belonging, precisely the constructs that a psycho-spiritual wellbeing framework is designed to address, suggesting that psycho-spiritual interventions may hold particular promise as a cross-cutting response to all three identified predictor domains.

This study examined the key predictors of relapse among individuals recovering from alcohol and substance use disorder in selected rehabilitation centres in Nairobi County, Kenya, drawing on in-depth qualitative interviews with six purposively selected participants. Thematic analysis identified three interconnected predictors: psychological and emotional distress, in which unresolved stress, loneliness, and existential emptiness drove a learned reliance on substances for emotional regulation; environmental and social triggers, in which specific places, occasions, and peer relationships reactivated craving through conditioned cue responses; and inadequate social support and family challenges, in which relational rupture and family disengagement compounded isolation and undermined recovery.

VII. CONCLUSION

This study affirm that relapse in this population is not attributable to a single cause but arises from the interaction of internal emotional vulnerability and an external environment that, absent sufficient relational and structural support, repeatedly reactivates the pathways associated with substance use. The findings further revealed that existing predictor models, which have often centered on psychological, cognitive, or purely social variables, may be incomplete without attention to the meaning-making, connectedness, and belonging that participants' own narratives repeatedly gestured toward, even where spirituality was not named explicitly. This points to the continued relevance of a psycho-spiritual lens in understanding and addressing relapse risk within Kenya's rehabilitation landscape.

VIII. RECOMMENDATIONS

Based on these findings, several recommendations are proposed for stakeholders involved in addiction treatment and recovery support in Nairobi County and comparable settings.

Rehabilitation centres should integrate structured emotional regulation and distress-tolerance training into standard treatment protocols, equipping clients with alternative coping strategies for the stress, loneliness, and negative thinking that participants identified as primary relapse gateways. Given the prominence of environmental and social triggers in participants' accounts, centres should incorporate explicit relapse-prevention planning that helps clients anticipate and develop concrete strategies for high-risk social situations, such as workplace celebrations, peer gatherings involving alcohol, and contact with former substance-using acquaintances, rather than relying on generic abstinence messaging alone.

Family-inclusive treatment models should be prioritized, given the clear link participants drew between family disengagement and relapse vulnerability. Rehabilitation centres should actively engage family members throughout the treatment process, not only at admission or discharge, and should provide psycho-education to help families understand their role in supporting, rather than inadvertently isolating, a relative in recovery.

Counsellors should also be trained to help clients and families address the relational damage caused by past addictive behavior, including trust repair and communication strategies, since unresolved relational rupture emerged as a direct source of ongoing psychological distress.

The Ministry of Health and bodies such as NACADA should recognize relapse not as an isolated clinical failure but as a predictable and, to a significant extent, preventable event embedded within the recognized stages of behavior change. National treatment guidelines would benefit from explicitly incorporating the three predictor domains identified in this study.

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