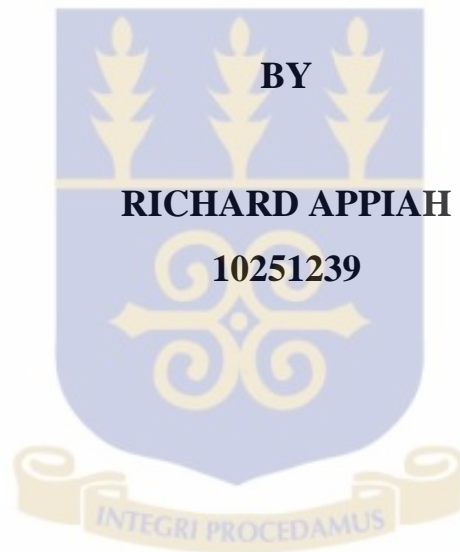


**UNIVERSITY OF GHANA
DEPARTMENT OF PSYCHOLOGY
LEGON**

**PSYCHOSOCIAL PRECIPITANTS AND RATE OF RELAPSE OF
SUBSTANCE ABUSERS: A CASE STUDY OF SUNYANI METROPOLIS**



**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR
THE AWARD OF MPhil CLINICAL PSYCHOLOGY DEGREE**

JUNE, 2014

DECLARATION

I, Richard Appiah, the author of this thesis do hereby declare that except for references to other people's work, which I have duly acknowledged, the study herein presented is the first of its kind to be carried out in the Department of Psychology, University of Ghana, Legon, during the 2013/2014 academic year under objective supervision of Professor Samuel. A. Danquah and Dr. Kingsley Nyarko. This work has never been submitted in any form, whole, or part for a degree in this University or elsewhere.

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This work has been submitted for examination with our approval as supervisors.

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(Co-Supervisor)

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DATE

DEDICATION

To the Lord God Almighty for the Grace

To the Adu Gyimah family for supporting and cheering me on

To the Dogbey family for believing in me

To my lecturers for passing on the love of knowledge



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ABSTRACT

This study aimed to explore the psychosocial precipitants and rate of relapse among substance abusers in the Sunyani Metropolis, Ghana. A total of 30 respondents comprising 15 relapsed (with their primary care-givers), 10 non-relapsed, 3 psychiatric nurses, 1 psychiatrist and 1 psychotherapist were recruited for the study. The study employed a qualitative research design. Data was analysed using Thematic Analysis. The rate of relapse was computed quantitatively using relapsed respondents' retrospective data. Consistent with literature, the study found a number of psychosocial factors at the individual, familial, societal and treatment facility levels that worked together to precipitate relapse. A number of personal, clinical and some contextual relapse prevention strategies have been successfully used by non-relapsed respondents in preventing relapse. Some biopsychosocial consequences of relapse were reported by respondents. Findings are expected to guide clinicians and caregivers in identifying psychosocial factors that militate against relapse prevention efforts and to develop a more effective relapse prevention strategy.

CHAPTER ONE

INTRODUCTION

1.0 Background to the study

Relapse among substance abusers after treatment is an old phenomenon that has always been the nemesis of nations all around the world (Golestan, Abdullah, Ahmad & Anjomshoa, 2010). For long, studies have found that through several generations, relapse to substance abuse after treatment remains one of the greatest challenges in the treatment of all forms of substance abuse including alcohol, marijuana, heroin and cocaine (Marlatt & George, 1984; Polivy & Herman, 2002; Witkiewitz & Marlatt, 2004).

Many a study posits that when people attempt to change an undesired or problematic behavior, there is a high possibility of an initial lapse (Golestan et al., 2010; Marlatt & George, 1984; Witkiewitz & Marlatt, 2004). Drug dependency has been typified as a persistent relapsing disorder (McLellan, Lewis, O'Brien & Kleber, 2000). In clinical terms, relapse is defined as a return to a maladaptive use of substance, such as marijuana, alcohol, tobacco, heroin, cocaine or other illicit psychoactive drugs after having been previously treated for the same substance abuse disorder (Witkiewitz & Marlatt, 2004).

Researches on the substance abuse phenomenon indicate that on the average, within a year of receiving treatment, most patients revert to previous levels of substance use (Hall, Havassy & Wasserman, 1990; Witkiewitz & Marlatt, 2004). Substance abuse clients and counselors both consider relapse as a major challenge militating against substance abuse prevention strategies (Golestan et al., 2010). Global statistics on the rate of relapse to

substance use is disturbing. Both counselors and clients admit that whereas it is tough for a client to quit the use of drugs, it is even tougher to stay off the drug after intensive treatment (Ducray, Darker, Smyth, 2012; Moeller et al., 2001). Notwithstanding the client-focused and intensive treatment modules available for substance abuse, most treated clients return to the use of the abused substance after a period of abstinence (Polivy & Herman, 2002).

Substance abuse is shrouded with personal and social problems including the health of society regarding its political, social, economic and cultural issues in various degree (Hendershot, Witkiewitz, George, & Marlatt, 2011). The price for using and abusing illicit drugs are weighty and incontestable. The attendant health complications, poor psychosocial functioning and adverse economic implications such as government's expenditure on treatments and rehabilitation of substance abusers have all been well documented (Burger, 2008; Parrott, Morinan, Moss, & Scholey, 2004; Pressley & McCormick, 2007; United Nations Office on Drug and Crime's report, 2013). Piggot, Carson, Saha, Torbeyns, Stock and Ingenito (2003) have stated that relapse to substance abuse could lead to such consequences as cognitive impairment, non-adherence to medication, personal distress, imprisonment and hospitalization.

Decades of research on substance abuse have implicated psychosocial factors such as mental health, significant life events and social functioning as playing critical roles in influencing the relapse rates and the abuse of drugs among clients who have previously been treated for substance abuse disorders (Hammerbacher & Lyvers, 2005; Melberg,

Lauritzen, & Ravndal, 2003). Contextual factors such as living and working environments have been considered as relevant when accounting for relapse precipitants in substance abusers (Reece, 2007). Consistently, researchers have identified psychosocial factors including self-efficacy, negative affects, ineffective coping responses and a host of high-risk situations as precipitating the relapse to substance use (Connors, Maisto & Zywiak, 1996; Larimer, Palmer & Marlatt, 1999; Marhe, Waters, Van de Wetering & Franken, 2013; Mattoo, Chakrabarti & Anjaiah, 2009; Reece, 2007).

Several other psychosocial factors including fights and interpersonal conflicts, peer pressure, divorce, strained relationship with friends, family and co-workers (Broome, Simpson & Joe, 2001; McLellan et al., 2000) have been found to increase the risk of relapse to substance abuse. Community supports (Ibrahim & Kumar, 2009), support from family and friends (Broome et al., 2001) and stressful life events (Wills, Vaccaro & McNamara, 1992) have also been found to determine clients relapse state after rehabilitation. Information about psychological and social (contextual) factors relating to relapse and substance abuse may both be critical and important for planning clinical intervention strategies as well as contribute to aftercare and community-based interventions.

Literature is replete with studies correlating cultural and religious variables to relapse to substance abuse. Ethno-cultural identity and religiosity have been found to moderate substance use among particular groups of people (Chen, Dormitzer, Bejaró & Anthony, 2004). In particular, there has been a significant negative correlation found among people

with higher levels of religious practice (religious devotion) and substance abuse (Chen et al., 2004; Kliewer & Murrelle, 2007).

Since four decades ago when scientific approach into the study of relapse has started (Marlatt & Gordon, 1984), there has been ample evidence that suggest various relapse rates for various substances. In one earlier study, about 90% of alcoholics who received treatment experienced at least one relapse over a 4-year period (Polich, Armor, & Braiker, 1981). In another study, Cornelius et al. (2003) found that 66% of the respondents had resumed their drug use within six months after treatment. There exist various relapse rates for the various substances of abuse. Differences in these rates could be attributed to several factors including the definition of relapse, individual's variables, characteristics of the addiction and the effectiveness and success of treatment (Connors et al., 1996).

In general, substance use is attributed to a number of factors, including, psychosocial, biological and contextual variables (Nordfjærn, 2011). In particular, psychosocial factors have been known to be critical determinants of relapse to substance abuse. Significant life events, psychosocial distress and self-efficacy have all been identified as significant predictors of relapse to substance abuse (Hendershot et al., 2011; Nordfjærn, 2011). Studies have found major positive and negative events, similar to those found in the general population, have significant influence in the lives of substance abusers (Melberg et al., 2003; Witkiewitz & Marlatt, 2004). Periods such as the loss of a loved one, or social occasions and events such as funerals, wedding celebrations, and birthday parties have been found to have influenced the return to alcohol and drug abuse (Melberg et al., 2003;

Saunders & Kershaw, 2006). For instance, a client discharged from a substance abuse rehabilitation facility after treatment could remain sober for a long period only to lapse during a funeral or wedding celebrations.

Irrefutably, the role of psychological distresses, including depression, interpersonal conflicts, and anxiety in substance abuse and relapse have long been noted (Grant et al., 2004). Continuous interpersonal conflicts with a spouse or a co-worker, for example, could lead to relationship tensions, emotional instability, or outburst of anger and frustrations. The individual could revert to alcohol and drugs to either help cope with the situation or to empower him or her to face the person involved. Empirical supports linking psychological distress to substance use and abuse exist. In one study, clients with psychological distress were found to abused alcohol and drugs than those without any psychological distresses (Grella, Hser, Joshi, & Rounds-Bryant, 2001).

Self-efficacy, defined as one's belief that a task can be carried out successfully to achieve a desired outcome (Bandura, 1997), has been associated with substance abuse and relapse (Nordfjærn, 2011). Clients who show low levels of self-efficacy, for instance, have been found to have shown high levels of alcohol and substance abuse (Hendershot, Witkiewitz, George, & Marlatt, 2011). Individuals who lose confidence in themselves and in their efforts to succeed, could for long remain depressed and frustrated, resorting to substance use, amid the frustration, to enflame some happiness. Gradually from a lapse, the substance abuse behavior may continue and lead to a full blown relapse.

Substance abuse and the relapse phenomenon have been conceptualized and explained through a number of theories. In particular, the Cognitive-Behavioral Model of Relapse Process (Marlatt & Gordon 1984, 1985; Witkiewitz & Marlatt, 2004) and the Relapse Syndrome Model (Gorski & Miller, 1982; Gorski, 1990) have expansively explained the process and indicators involved in relapse to substance abuse. Other theories that explicate relapse to substance abuse include the Stress-diathesis Model (Gatchel, 1993), the Self-medication Hypothesis (Duncan, 1974; Khantzian, Mack, & Schatzberg, 1974), the Bidirectional Model (Biafora, Vega, Warheit & Gil., 1994), the Psychological Distress Model (Mercier et al., 1992) and the Behavioral Choice Model (Bickel & Vuchinich, 2000). The Cognitive-Behavioral Model of Relapse Process and the Relapse Syndrome Model which are the foundations of this study are discussed comprehensively in the next chapter.

1.1 Statement of the problem

Unquestionably, the abuse of alcohol and drugs remains problematic in most countries of the world. The 2013 *World Drug Report* by the United Nations Office on Drug and Crime (UNODC) revealed that over 35 million people, representing 0.8% of the adult population worldwide use heroin, cocaine or a combination of both. Of this population, it is estimated that 10-13% will become drug dependent and will forfeit their sobriety (UNODC Report, 2013). The UNODC's statistics for 2013 on the worldwide estimate of substance abuse is even more frightening. The report revealed that in 2012, between 167 and 315 million people aged 15–64 were estimated to have used an illicit substance in the preceding year.

West Africa is not excluded from the problem of drug trafficking and abuse. About a decade ago the region was declared as a transit route for hard drugs (Drug News Africa, 2012). According to the *Ghana Demographic Health Survey Report (GDHS)* for 2009, the sub-region had become not only a transitory route, but more disturbingly, a consumer market of these illicit psychoactive drugs (GDHS Report, 2009). The report concluded that the abuse of hard drugs was on the increase and had attracted the attention of most health professionals in Ghana (GDHS Report, 2009).

The *Out-patient Monthly Morbidity Returns (OMMR)* records for 2012 from the Department of Psychiatric of the Regional Hospital, Sunyani, showed that of the 2,284 patients who accessed the facility for the year, about 596(26%) were alcohol and drug abuse related cases. In the same year, out of the 1,047 new cases seen, 413 were substance abuse related disorders, with 138 having been either re-admitted or treated on at least one other occasion for the same diagnosis. This statistics showed a 12% increase in substance abuse and relapse cases as compared to that of the preceding year (*OMMR for Psychiatric Unit: Regional Hospital, Sunyani, 2012*).

The *Drug News Africa* states that about 1.25 million Ghanaians in 2012 had drug addiction problems, mostly marijuana (Drug News Africa, 2012). Studies on substance abuse in Ghana (Affinnih, 1999a; Lamptey, 2005; Redvers, Appiah-Poku & Laugharne, 2006) estimate more worrisome statistics. In no doubt, more people may be abusing drugs in Ghana than is estimated. This is very disturbing since the rates of relapse to substance abuse after treatment remain high. For instance, Brandon, Vidrine and Litvin (2007) noted

that the relapse rates for most individuals after the cessation of alcohol or tobacco for a year ranges from 80 – 95%. Notwithstanding the type and frequency of the drug in use, the penalties are always grave. Witkiewitz and Marlatt (2004) noted that violence, legal problems, depression and suicide attempts are some of the adverse consequences of substance use. The availability and the increasing use of these illicit psychoactive drugs results in its dependence with its attendant psychosocial adverse effects.

Certainly, substance abuse has profound health, economic and psychosocial consequences on the individual, family, community and nation. Studies (Berk, 2007; Large, Sharma, Compton, Slade, & Olav, 2011; Witkiewitz & Marlatt, 2004) have shown a number of psychological, social and health-related consequences following the continuous use and abuse of substances. At the personal level, substance abuse has been associated with such adverse biopsychosocial consequences as heart failure, erectile dysfunction, hypertension, cancer, stroke and capillary haemorrhages, irritability and restlessness, mild paranoia, physical exhaustion, mental confusion, loss of weight; fatigue or depression and unemployment (Davison, Neale, & Kring, 2004; Kring, Davison, Neale & Johnson, 2007). Similarly, the families of substance abusers also share in the consequences. In particular, the loss of productive hours in care of the substance abuser as well as the financial expenditure on treatment have been documented (Moos, 2007; Redvers et al., 2006). A number of social and economic implications have also been noted at the community and national levels. Increase in crime rates, unemployment, poor academic or job performance, school dropout, divorce and the diversion of scarce national resources for treatment and rehabilitation of substance abusers have been noted as some

consequences of substance abuse (Burger, 2008; Parrott et al., 2004; Pressley & McCormick, 2007).

1.2 Aim and objectives of the study

Willig (2008) argues from a pragmatic viewpoint that the aim of research is not about generating abstract truth free from the experience of people but rather to provide insight that will inure to the benefit of humanity. Hence the aim of this study is to explore the psychosocial precipitants of relapse and the rate of relapse among substance abusers in the Sunyani Metropolis. More specifically, the objectives of this study are:

1. To explore the various psychosocial factors that contribute to relapse of substance abusers in the Sunyani Metropolis
2. To estimate how often respondents return to pre-treatment levels of substance abuse after treatment
3. To explore the role of the family, culture and religion in relapse or abstinence among respondents.
4. To explore the preventive/coping strategies clients use to prevent relapse.
5. To explore the psycho-socioeconomic consequences of relapse to the respondents, their families and society.

1.3 Relevance of the study

Reece (2007) postulates that contextual and environmental factors are critical determinants of relapse among substance abusers. Certainly the environmental conditions of Europe and elsewhere are significantly different from those in Ghana and the rest of Africa. Consequently, one cannot readily attribute the factors found to have precipitated substance

abuse and the resultant relapse of a different context to that in Ghana. To this extent, findings from this research would aid Clinical Psychologists, Psychiatrists, Psychiatric Nurses, policymakers and relatives of clients to better understand the psychosocial factors that precipitate the relapse phenomenon and the rates at which relapse to substance abuse occur when deciding how best to offer treatment options to develop effective relapse preventive strategies which are contextual in the management of the relapse phenomenon.

Furthermore, although there are studies on substance abuse in Ghana (Affinnih, 1999a; Lamptey, 2005; Redvers et al., 2006), there is a paucity of data regarding the psychosocial factors that influence relapse to substance abuse. The rates of relapse to substance abuse among substance abusers have also not been well documented.

Of equal importance, the findings from this study would add to the literature on the relapse phenomenon.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

In this chapter, literature pertaining to psychosocial factors that precipitate relapse to substance abuse after treatment and the rate of relapse were reviewed. The literature review served as a guide to identifying relevant theoretical frameworks that defined the research problem, set the foundation for this study, instigate new research ideas, and established gaps or discrepancies in the body of the research (Polit, Beck & Hungler, 2004).

2.1 Theoretical framework

Research on substance abuse relapse has postulated that relapse is not simply a condition where a person moves directly from a state of abstinence to one of perpetual relapse (Khantzian et al., 1974; Marlatt & Gordon, 1985; Strandheim, Wold & Bentzen, 2007). A number of theoretical frameworks have been proposed to explain the construct of the substance abuse relapse process.

2.1.1 The Cognitive-behavioral Model of Relapse Process

One of the most comprehensive and notable theoretical model that explains the process of relapse and its prevention among alcohol and drug abusers was proposed by Marlatt and his colleagues (Marlatt & Gordon, 1985; Marlatt & George, 1984). The principles of this model, following its revision (Witkiezie & Marlatt, 2004) have successfully been applied to manage other addictions, including overeating and compulsive gambling. In Marlatt's

original cognitive-behavioral model of relapse process, the client's high-risk situations and the coping response to the situation was central. A high-risk situation arises when a person finds himself or herself in a situation that tends to threaten their commitment to abstinence, that is, when they lack effective coping skills.

One of three events may precipitate a lapse – a single or few non-maladaptive episodes of substance use without reaching the pre-treatment level. Firstly, a lapse is possible when the individual has not discovered an appropriate coping skills or mechanism to maintain sobriety. Secondly, a lapse is imminent when the person expects positive effects from the substance use. Here, the person anticipates a pleasurable effect and thus discounts any negative consequences, a phenomenon called the *Problem of Immediate Gratification* (PIG). Lastly when the person deems the situation that calls for the use of the substance as unavoidable, external, global or uncontrollable, a lapse is likely to occur (Marlatt & Gordon, 1985). The model states that the three events, coupled with an ineffective coping skills can result in an initial lapse. In turn, this lapse could lead to a feeling of failure and guilt, a phenomenon described as the Abstinence Violation Effect (AVE) – the guilt, shame and anxiety about a person's inability to remain sober and thus fueling their relapse. The model concludes that in the presence of this abstinence violation effect, as well as the positive outcome expectation, relapse then becomes highly probable.

The Cognitive-Behavioral Model of Relapse Process also proposes the concept of Self-Efficacy. According to Bandura (1997), self-efficacy refers to an individual's perception of his or her capability to resist or engage in a particular behavior within a specified time

and place. A high self-efficacy enables individuals in treatment for substance abuse to initiate a behavioral change such as the inhibition of an old behavior and the acquisition of new ones.

Two decades after propounding the Cognitive-Behavioral Model of Relapse Process, Witkiewitz and Marlatt (2004) reformulated the model to lay more emphasis on the dynamic processes involved in relapse. The revised model, called the Dynamic Model of Relapse, views relapse as a non-linear, complex interplay of various factors that act together to influence and determine relapse timing and its severity. Central to the current model are the Tonic Process and the Phasic Response. Tonic processes involve relatively stable factors that determine a person's primary threshold for relapse. Factors such as personality, genetic, or familial risk factors, drug sensitivity, drug related outcome expectancies, global self-efficacy as well as the person's personal beliefs about abstinence or relapse forms the tonic process (Witkiewitz & Marlatt, 2004). The tonic process initiates susceptibility to relapse.

On the contrary, Phasic responses refer to transient factors that tend to either motivate or thwart lapses. Phasic responses, which spans across time and context, include cravings, mood, or temporary changes in outcome expectancies, self-efficacy and motivation. In general terms, whilst Tonic processes determine who is susceptible to relapse, Phasic processes determine at what time the relapse may occur (Witkiewitz, van der Maas, Hufford, & Marlatt, 2007).

Although very comprehensive in detailing the relapse process and prevention, the Cognitive-Behavioral Model of Relapse Process carries some shortfalls. Firstly, the model places less emphasis on interpersonal factors as a channel to relapse and relapse prevention, despite many clinical studies implicating interpersonal factors as playing a major influence to relapse to substance abuse (Gorski, Kelley & Havens, 1993; Saunders, & Kershaw, 2006). Hunter-Reel, McCrady, Hildebrandt (2009) and Stanton (2005) have suggested the need for more emphases on interpersonal factors in relapse prevention. Secondly, the model advances a nonlinear dynamic approach to relapse prevention, underlined with a number of theoretical and statistical approaches, which may not be readily applicable to clinical interventions (Maisto & Connors, 2006).

2.1.2 The Relapse Syndrome Model

The Relapse Syndrome Model (Gorski, 1986, 1990) accentuates the role of personal distress a substance abuser encounters in their recovery process. The model posits that relapse results following the interplay of two precipitating factors – internal and external. Internal factors, such as distressing emotions, irrational thoughts and painful memories could interact with external factors such as chronic daily stress, ruinous life events and physical pain in influencing a substance abuser to return to substance use after treatment, especially in the absence of effective coping skills.

The risk for relapse, Gorski argued, is worsened by the *Post Acute Withdrawal Syndrome* (PAWS), manifested by irritability, anxiety, low enthusiasm, disturbed sleep, cloudiness of thoughts, memory deficits and emotional reaction. Following this psycho-physiological

reactions, the individual may begin to occasionally return to the use of the substance to relief these distressful symptoms.

In spite of its simplicity and correctitude in identifying high risk situations with its subsequent interventions, Gorski's Relapse Syndrome Model is without some weaknesses. The development of the model is largely based on Gorski's personal observations and clinical experiences in treating chemical dependence clients, than from scientific outcomes. Gorski's earlier clinical work illustrates the fundamentals to the development of the model (Gorski, 1989). To this extent, the model, although clinically oriented, lacks rigorous scientific evaluation.

2.2 Review of related studies

Relapse to substance abuse after treatment has been considered a chronic and challenging problem in the addictive behaviors the world over (Witkiewitz & Marlatt, 2004). Subsequently, various studies to explore the factors influencing and precipitating clients' relapse to substance abuse were conducted with different research methodologies and samples. Researchers have found that on the average, between two-thirds and four-fifths of adolescent and adult substance abusers return to substance use within the first six months after previously receiving treatment for substance abuse disorder (Brown, D'Amico, McCarthy, & Tapert, 2001; Brown, Vik, & Creamer, 1989). Generally, when a person attempts to alter a behavior that is problematic, a setback in the early stage is highly possible and clinically expected. Following this initial lapse, it is then highly probable for the individual to make a gradual return to the problem behavior to the degree

of the pre-treatment level of use (Witkiewitz & Marlatt, 2004). Relapse to substance abuse is a multifaceted and dynamic phenomenon that has been attributed to biological, psychological, social and contextual variables (Mattoo et al., 2009). Similar to non-communicable diseases such as diabetes, asthma, and hypertension, substance abuse disorders are chronic and have high relapse rates (McLellan et al., 2000).

Credit is given to Marlatt (Marlatt & Gordon, 1985) as well as Brownell and colleagues (Brownell, Marlatt, Lichtenstein & Wilson 1986) for their earlier works on the subject. Seeing relapse as a process, rather than event or a breakdown of will-power, these scholars used the methods of functional analysis to study the antecedents and consequences of substance abuse. The relapse phenomenon has been attributed to several factors that seem to augment each other. Moos (2007) noted that psychosocial factors play a critical role in the relapse state of substance abusers after abstinence. Marlatt, George and Witkiewitz (2002) explored the theoretical link between high risk situations that include psychosocial and contextual factors and the relapse to substance abuse. Through research and clinical practice for over three decades, Marlatt and his colleagues developed an empirically derived taxonomy for these high-risk situations.

2.2.1 Psychological Precipitants

The relapse literature is replete with studies that strongly postulate the influence of intrapersonal factors in the relapse process. Intrapersonal factors that emanate from within the individual, and his or her reactions to non-personal environmental events, have been implicated in relapse (Marlatt, Parks & Witkiewitz, 2002). In particular, psychological

factors including negative emotional states (mood and affects) such as frustration and anger and other unpleasant or aversive emotional states such as the feeling of loneliness, sadness, boredom, worry, loss, grief, apprehension, tension, fear and other comparable states have been identified as having precipitated the return to substance use after periods of abstinence following treatment (Hammerbacher & Lyvers, 2005; Moos, 2007).

Evidence exists that suggest that negative emotional states predict relapse to substance abuse. In their study to identify the factors associated with relapse among clients in Australian substance use disorder treatment facilities, Hammerbacher and Lyvers (2005) administered a retrospective self-report questionnaire to 104 recruited clients who were taking part in the substance abuse programme. The findings of the study identified factors such as negative moods and a desire for positive mood states as the principal reasons for respondents relapse after 12 months of abstinence. The study also identified other factors such as social and family problems and external pressure to use drugs. The result goes to suggest that a desire to satisfy an individual's internal factor (mood state) appears to play a prodigious role in the relapse process. This finding is consistent with earlier studies (McKay, 1999; McLellan et al., 1994).

In another study, Cornelius et al. (2003) examined factors that initiate a rapid relapse following treatment for substance use disorders among adolescents. The findings showed that a person's depressive mood as well as low levels of social support increases the predisposition of the person to relapse to substance use. This finding is congruent with the Self-medication Hypothesis proposed by Khantzian et al. (1974) and Duncan (1974). The

hypothesis posits that people who are faced with negative emotional stress use substances to assuage the stress. Relatedly, Moos (2007) has argued that other psychological factors, such as anxiety, play a major role in determining whether a drug user will relapse or remain sober after treatment. Moos contended that substance abused rehabilitated clients who rank high on anxiety have a higher propensity to relapse. In a previous work, Okasha, Khalil, El Fikih, Fahmy and Ghanem (1990) explored the psychological understanding of Egyptian heroin users with 78 male heroin addicts admitted to two private hospitals in Cairo. The study showed that participants who continued to abuse heroin scored moderately on anxiety and depression. These findings are however contrary to that of an earlier study by Schadé et al. (2005) who found that even when the symptoms of anxiety were reduced in alcohol and addicted clients, there was no more significant reduction in the relapse rates among respondents after they were treated. The type of substance of abuse and the severity of abuse may have contributed to this contradictory finding.

The study by Wallace (1989) as cited in Connors, Donovan and DiClemente (2001) is noteworthy in that it rates the degree of influence of emotional states, aftercare treatment and environmental stimuli on relapse to substance abuse. The study noted that as precursors to relapse, negative emotional states accounts for 40 per cent of relapse. Non-adherence to aftercare treatment and rehabilitation also accounts for 37 per cent, whilst conditioned environmental stimuli are responsible for about 34 per cent return to substance abuse. Following several years of clinical practice and research which influenced the development of the Relapse Screening Questionnaire, Spurgeon and his colleagues found that relapse is more common among persons with ineffective coping

strategies, making them unable to cope and manage their negative emotions. Spurgeon, McCarthy-Tucker and Water (2000) therefore reiterated and affirmed the argument that negative emotions precipitate relapse.

The argument that emotional states significantly influence relapse have also been found in studies conducted in Africa. Exploring the causes of relapse post treatment for substance dependency within the South African Police Services, Chetty (2011) found negative emotional states such as anger, frustration and anger as main trigger to relapse. In a similar finding, Lawal, Adeyemi, Orija and Awofisayo (2004) recruited eighty-two participants to determine the precipitants of relapse among patients admitted to a Psychiatric Hospital in Nigeria for substance abuse. The study showed that coping with negative emotional states and enhancement of positive emotions were the two most cited reasons for participants relapse.

Literature on the relapse phenomenon posits that the frustration associated with the failure to attain a target goal, maintain a job or provide adequately for a family could result in untoward pressure and frustrations, resulting in relapse. This argument, which follows the Stress-Diathesis Model (Gatchel, 1993), is supported by the work of McCoy and Lai (1997), who, in examining the challenges of drug addicts after rehabilitation, found that when former addicts are unable to get a job or maintain one, after discharge from rehabilitation centers, the addicts become frustrated and return to their drug use. The proclivity to relapse is worsened when the addicts had to face financial difficulties. On the other hand, Mazlan, Schottenfeld and Chawarski (2006) stated that the challenges of

accessibility and effectiveness of treatment and rehabilitation programs could frustrate former addicts, thus resulting in their relapse.

Consistently, studies have shown that the desire for feelings of pleasure, freedom, joy, celebrations and other such occasions precipitate relapse to substance abuse. Exploring the factors influencing relapse among physicians in recovery from substance dependence disorders, Gable (2006) provides evidence that positive life events, such as acquisition of a valuable property, job, marriage or such blissful celebrations could precipitate the urge to use and abuse substances. The individual's response to such a positive life change is critical and psychologically demanding and challenges the individual's efforts to maintain sobriety. The work of Bardo et al. (2007), with similar findings also asserts that people are likely to return to the use of hard drugs in their search for excitement and pleasure.

Saunders and Kershaw (2006), conducting a community study on spontaneous remission from alcoholism, concluded that significant positive life events influenced alcohol use among people with alcohol addiction. Other factors such as curiosity (Kashdan, Rose & Fincham, 2004) and a quest to explore one's consciousness and religion (Helman, 2001) have also been identified as personal factors that can predict relapse. Most hard drugs, including amphetamine-type substances contain sedative psychopharmacological effects. The derived sedating effects from these drugs accounts for the dependency on drugs (Hendrickson, Schmal & Ekleberry, 2004).

The test for effectiveness of treatment or to measure their personal control and mastery over the use of the substance by former addicts has also been implicated in the relapse process. The work by Ruiz, Strain and Langrod (2007) is noteworthy in that it elaborates the role that the test of willpower could play in the relapse phenomenon. Studies have emphasized the importance and implications of developing a personal control to be able to adhere to treatment regimen and stay sober. An earlier work by Kashdan et al. (2004) whose findings were in congruence with the work of Ruiz and his colleagues, state that individuals who were previously treated for substance abuse could return to the use of the same or similar effect-producing drugs through their curiosity to explore the taste new brand of a substance or to briefly re-experience the effects and feelings associated with the use of the substance. Helman (2001) has noted that some individual's quest to explore their consciousness is a contributory factor that can predict their relapse.

Closely linked to the phenomenon of personal control is self-efficacy. Defined as the extent to which a person feels self-assured and capable of executing a certain behavior in a specific situational context, self-efficacy has been found as an important relapse predictor. The belief that a person can successfully perform a set-out and desired behavior is an important part of substance abuse treatment. Sergrin (2001) provides evidence that self-efficacy has an indirect influence on interpersonal distress, and thus relapse. Sergrin's research findings suggest that an individual who shows higher levels of self-efficacy stand a better chance of maintaining sobriety after treatment than those with lower self-efficacy, as they may demonstrate a higher confidence in their coping strategies when faced with high-risk situations. Greenfield et al. (2000) report comparable findings and suggest that

individuals with high levels of self-efficacy stand better chance of improving from and quitting alcohol consumption. Previous works (Graham & Wexler, 1997; Mahmood, Shuaib & Ishak, 1998) have also concluded that a positive self-esteem is a true predictor of a good relapse treatment outcome.

Using a variety of research methodologies, researchers, including Ibrahim and Kumar (2009) and Oei, Hasking and Phillips (2007) showed that the degree of self-efficacy of an individual invariably predicts how confident the individual could be in developing new sets of behavioral and social skills needed for abstinence. For their study, Ibrahim and Kumar (2009) recruited 400 drug addicts from eight drug rehabilitation centers throughout Peninsular, Malaysia. Through self-administered questionnaires, factors influencing the relapse of these drug addicts were explored. The study found low self-efficacy as the main factor influencing the addicts' high tendency for relapse to substance use.

Clinicians and researchers in the addictive behaviors have adjudged craving as a principal precipitator of relapse after treatment (Rosenhow & Monti, 1999). Former addicts report they relapsed because they experienced intense internal desire to use the substance, even without the influence of an external factor (Marlatt, Parks & Witkiewitz, 2002). Contextual cues such as passing by a drinking bar, seeing an advert on alcohol or cigarettes, or actually running across a bottle of alcoholic beverage or a pack of cigarette could precipitate or induce the crave for the use of the substance (Marlatt et al., 2002). Strong, sudden internal cravings for substance use could also exist without the presence of a cue. Evidence suggests that individuals with high levels of cravings show a poor

outcome for substance abuse recovery treatment, especially for alcoholism (Cooney, Litt., Morse, Bauer, & Gaupp, 1997; Mattoo et al., 2009). O'Connor, Gottlieb, Kraus, Segal, and Horwitz (1991), for instance, have found that outpatients having a higher craving do have increased rate of dropout during alcohol withdrawal treatment.

The role of urges or cravings on relapse to substance abuse has been well noted (Gorski, 1990; Marlatt & Gordon, 1985; Witkiewitz & Marlatt, 2004). In one study to assess the influence of urges to drink alcohol in a group of individuals undergoing treatment in a Veterans' Affairs facility, Monti et al. (1993c) found individuals who rated higher on urges to drink had an actual lesser frequency of drinking. This claim has been confirmed by Drummond and Glautier (1994) whose study recorded a longer interval before returning to drinking in individuals with higher urge ratings. The researchers explained that when the relapse trigger, in this case the urge to drink, was identified earlier, both clients and clinicians directed much effort into fighting and controlling the urge.

There exists some empirical evidence on the role of negative physical and physiological states in the relapse phenomenon. When individuals undergoing substance abuse rehabilitation face up with some overwhelmingly unpleasant physical and physiological states, they stand a greater chance of returning to drug use, especially when there is a genetic predisposition (Gatchel, 1993). Negative physical and physiological stimuli or events such as craving associated with withdrawal and other undesirable withdrawal symptoms can go a long way to thwart the efforts by substance abusers to maintain their sobriety. Consistent with the Behavioral Choice Model (Bickel & Vuchinich, 2000), the

challenge of having to cope with pain, injury, illness, fatigue and specific disorders such as migraine have been associated with prior substance use and subsequent relapse.

The evidence of craving in relapse has also been provided in a recent work in Kenya. Exploring the factors associated with relapse and remission of alcohol dependent persons after community-based treatment in Kenya, Kuria (2013) identified the severity of alcohol use, craving for alcohol at intake and the age of onset of alcohol drinking as the three reasons participants stated as having influenced their return to alcohol abuse.

2.2.2 Social Precipitants to Relapse

The role of social factors serving as precipitants in the relapse process among substance abusers has been well documented. In most literature on the subject, and unlike the psychological precipitants which are considered intrapersonal or as a reaction to a non-personal environmental events, social precipitants have been considered as those relapse factors that are primarily associated with other interpersonal factors. Social precipitants comprise the influence of a current or previous interaction with another person or persons as well as the environment. Consistently, researchers have found the implication of interpersonal conflicts in the relapse process. Individuals who have recently undergone treatment and rehabilitation for substance abuse risk a relapse when they continually face interpersonal problems associated with a valued relationship. Conflicts with a spouse, a family member, a close friend or a colleague at the workplace could serve as an impetus to return to the use of alcohol and drugs (Nordfjærn, 2011).

Exploring the drug abuse relapse in Malaysia to ascertain the contributory factors and treatment effectiveness using qualitative methodology, Lian and Chu (2013) found that the third most cited reason by their twenty respondents was interpersonal conflicts with their family and others. In a similar vein, a study by Connors et al. (2001) showed that 39% of their respondents attributed their return to substance abuse to interpersonal conflicts and social pressure. In an earlier study, Westermeyer (1989) found social factors such as conflicts, arguments and the loss of supportive relationships increased the plausibility of relapse.

According to Donovan and Marlatt (2005), some of the most common recurrent situation attributed to relapse includes anger and resentment, which is as a result of interpersonal conflicts. In their study to explore relapse precursors after rehabilitation, the study further showed that negative emotional states, peer or social pressure, and dire need for acceptance into a group are other major relapse precipitants. Negative emotions are accompanied by some level of tensions and anxiety which serves as a precursor for relapse among marijuana addicts (Arendt, Rosenberg, Foldager, Perto, & Munk-Jorgensen, 2007; White et al., 2004). Where there are no effective coping mechanisms, the individual may resort to the use of the substance which offers some 'good feelings' to curb these tensions and anxieties.

Marlatt et al. (2002) have argued that other conflicts emanating from interpersonal sources other than from anger and frustration could also serve as social factors coercing individuals to relapse. Feelings and emotions such as worry, fear, concern and anxiety associated with interpersonal conflicts have all been linked to relapse.

There is a large empirical research on the role of social pressure in relapse. It is well argued that heightened, direct or indirect pressure from an individual or group of individuals on another to use substance accounts for one major social reason for relapse (Mahmood, Shuib, Lasimon, Muhamad, & Rusli, 1999; McIntosh & McKeganey, 2000; Nordfjærn, 2011). The unflinching desires to belong, or be part of a social group or be accepted were found to have forced some adolescents to yield to their peers' pressure and thus return to drugs use. In one previous study to explore the role of family and friends as social environments and their relationship to young adolescents' use of alcohol, tobacco, and marijuana, Hundleby and Mercer (1987) found peer substance use to play a significant role in predicting adolescent drug use. In a related study, McDonald and Towberman (1993) showed that for immature adolescents seeking to belong to a gang or group, there is a strong requisition to experiment with drugs. In a recent study, Nordfjærn (2011) indicates that individuals may also yield to the temptation to use drugs or abuse it because that would enable them to be accepted into a specific social group.

Yet another social factor precipitating the relapse of drug addicts has been their association with old friends who still use drugs. A number of studies have shown that individuals who receive treatment for substance abuse and yet go to associate with peers who abuse drugs stand a higher risk of being influenced to return to the drug abuse behavior. In one earlier study, Mahmood et al. (1999) revealed that 50% of the study respondents who had received treatment and were discharged from a rehabilitation center were influenced by peers to return to the use of the drug. The study further revealed that

76% of the study respondents who were in rehabilitation centers receiving treatment were being supplied with drugs by old friends, thus inducing relapse whilst at the rehabilitation center or prolonging their stay. Against this backdrop, McIntosh and McKeganey (2000) assert that one of the most helpful coping mechanisms for rehabilitated substance abusers is to dissociate themselves from the company of peers and other networks that use drugs. In their study, Ibrahim and Kumar (2009) have argued that support from peers could help a recovering addict to maintain sobriety. Their findings indicated that factors such as spiritual and emotional support can significantly raise an addict's self-efficacy and reduce the tendency to relapse. Consequently, low relapse and high abstinence rates have been found in rehabilitated individuals living in social environments devoid of drugs (Gregoire & Snively, 2001).

The argument that persons who have undergone treatment and rehabilitation for drug abuse become vulnerable to relapse through their observation (or modeling) of other people or group abusing the substance has been supported by many studies. To a greater extent, people who continue to abuse substances tend to serve as models to those who have recently been rehabilitated for drug abuse. Family members, friends, co-workers and celebrities serve as models for individuals, especially the adolescents and young adults for drug abuse. Studying the influence of parental drug use on adolescents' behavior, Andrews, Hops, and Duncan (1997) found a similar parental-child drug use relationship. The study revealed that fathers who were abusing marijuana served as models to their wards. Mothers who were using cigarette also served as models when there was a strong parent-child relationship.

Through the decades, studies have correlated significant life events and family support to relapse to substance abuse. The work by Wills et al. (1992) is noteworthy in this regard. Examining the influence of life events, family support, and competence in adolescent substance use, the researchers noted that negative life events and contemporary psychological distress precipitated the abuse of hard drugs such as cannabis, alcohol and nicotine among the respondents. A more recent work by Kostecky (2005), conducted to identify the role of negative life events as a precipitant for substance use and relapse, also affirmed the relationship. Taking a contrary view, Tate, Brown, Glasner, Unrod & McQuaid (2006) argued that although chronic stressors precipitated substance use and relapse, the influence of recent significant life events as a precipitant for drug abuse cannot be underestimated.

The unavailability of treatment facilities and shortage of medications, inadequate health personnel and the use of ineffective traditional treatment and rehabilitation models have been found as contributory factors to the relapse of former drug addicts (O'Brien, 2006; Reid, Kamarulzaman & Sran, 2007). These results contribute to the growing body of evidence that the family, community and employers support remain invaluable in protecting former substance abusers from relapsing. The study by Ibrahim and Kumar (2009) also supports this argument. The roles of peers, side effects of psychotropic drugs, poor family role, poor referral system, lack of home visits, non-compliance and stigmatization in the substance abuse relapse process were also found in one South African study. Examining the factors influencing relapse of psychiatric outpatients in the

rural communities of the Eastern Cape Province, Mahamba (2009) identified the interplay of these psychosocial factors in the relapse process.

2.2.3 Cultural and Religious Factors in Substance Abuse Relapse

Studies on substance abuse, relapse and relapse prevention have also identified protective factors against the use, abuse and subsequent relapse of substance abusers. In particular, ethno-cultural identity and religiosity have been found to be protective of substance abuse and relapse (Chen et al., 2004). Personal devotion, fundamentally expressed through prayers to God (Miller, Davies, & Greenwald, 2000), parental religiosity (Kliwer & Murrelle, 2007), weekly participation in religious activities (Blum et al., 2003) and the value given to religion (Herman-Stahl, Krebs, Krontil, & Heller, 2006) have all been found as protective of substance use, abuse and subsequent relapse.

Several studies conducted to find the relationship between religiosity and drug use have shown a significant negative correlation. For instance, Chen et al. (2004) found higher levels of religious practice and religious devotion as reasons for drop in or non-initiation of alcohol consumption amongst adolescents from Central America. However, this correlation does not hold across all religious sects. Significant differences have been found among different religious sects and their influence on the use and abuse of drugs, especially alcohol. In one study, Dalgarrondo, MarínLeón, Botega, Barros and Oliveira (2008) found that Protestants and Spiritist denominations showed less alcohol dependence than do Catholics in Brazil. Christian adolescents in Lebanon, for instance, have been found to consume more alcoholic beverages than their Druzes and Muslim counterparts

(Ghandour, Karam, & Maalouf, 2009). In contrast seven countries in Latin America showed a lesser use of alcohol in Protestants than Catholics (Chen et al., 2004). In particular, highly religious Africans have been found to consume less alcohol and drugs (Koeing, McCullough & Larson, 2001).

Culture remains an essential factor that affects adolescent development in relation to problematic behaviors, including alcohol and drug use (Castro & Alarcón, 2002). The consumption of alcohol, for instance, is partly determined by ones geographical location, the focus of one's worship and the socio-cultural norms and values that directs and control behavior. Cultural attitudes can promote or prevent substance abuse (Castro & Alarcón, 2002).

2.2.4 Relapse Preventive Strategies

Researchers and clinicians concerned with substance abuse and relapse have postulated a number of coping and preventive strategies. The earlier works of Gorski, Kelley and Havens (1993) and Marlatt and Gordon (1985) are noteworthy in this area. Drawing insights from several years of clinical practice and research, these clinicians and researchers first theorized the relapse phenomenon, explaining the variables and factors involved in the relapse process. Thereafter, a number of behavioral and cognitive interventions have been outlined for substance abuse relapse prevention. Gorski et al. (1993), for instance, have identified a number of principles that are fundamental in relapse prevention therapy. Self-regulation and stabilization, a major principle in their Relapse Prevention Procedure, refers to strategies that increase a client's ability to self-regulate

thinking, judgment, memory, feelings and behavior so to decrease their inclination to relapse. Other principles include integration and self-assessment, understanding and relapse education, self-knowledge and identifying warning signs, coping skills and warning sign management, change and recovery planning, awareness and inventory training, significant others and involvement of others, and maintenance and relapse prevention plan updating.

Marlatt and Gordon (1985) and Parks, Marlatt and Anderson (2004) have also developed cognitive-behavioral strategies geared towards managing high-risk situations and enhancing client's coping skills. Studies have found Relapse Prevention Therapy to be successful in decreasing or quitting substance use and advancing psychosocial adjustment. Using twenty-six studies with a sample of 9,504 respondents, Irvin, Bowers, Dunn, and Wang (1999) conducted a meta-analysis on the effectiveness of Relapse Preventive Strategies. Overall, the researchers found that Relapse Prevention Therapy was efficacious in treating substance use disorders and improving clients' psychosocial adjustment. Some evidence-based programs and practices for substance abuse and relapse include substance abuse counseling, relapse prevention, cognitive-behavioral therapy, 12-step facilitation, motivational interviewing, anger management, brief intervention, brief intervention and rational-emotive behavior therapy (SAMHSA, 2009).

Presently, clinicians combine a variety of techniques and interventions to treat substance use disorders and relapse to substance abuse. Marlatt, Parks and Witkiewitz (2002) have developed clinical guidelines for implementing relapse prevention therapy. In clinical terms, Relapse Prevention Therapy (RPT) starts with the evaluation of a patient's probable

interpersonal, intrapersonal, environmental, and physiological risks for relapse and the distinctive and contextual set of factors and situations that may directly precipitate a lapse. Following this identification, specific cognitive and behavioral interventions are employed to prevent lapses or manage them should they occur. Alongside, global relapse strategies and coping mechanisms are implemented to manage the possible craving and the irrational thinking that usually initiate lapses and exposure to high-risk situations. In all cases, clients are taught important coping skills (Marlatt et al., 2002). Interventions such as the Progressive Muscle Relaxation (PMR), emotional imagery, assertive training, anger management, thoughts and cravings management, refusing requests, intimate relationships, and problem-solving skills (Witkiewitz & Marlatt, 2004) have been used solely or as a compliment to other interventions for relapse prevention.

2.2.5 Rates of Relapse to Substance Abuse

Literature on relapse to substance abuse is replete with studies on the rate of relapse of substance abuse after treatment. Since over three decades ago when a comprehensive study on relapse to substance abuse has started (Marlatt & Gordon, 1985), varying relapse rates have been found for various substances within different time frames. Through the decades, relapse rates after substance abuse treatment are disturbingly high, averaging about 75% within a 3 to 6 month duration after treatment (Brownell et al., 1986; Marlatt & Gordon, 1985). Marlatt and George (1984) documented that high relapse rates exist across the various classes of substances that are commonly abused, with an average time of abstinence ranging from 4 to 32 days after treatment for alcohol, tobacco and opiates.

Exploring the rate of relapse in cocaine users 6 months after treatment in 182 women and 148 men in 26 public outpatient drug abuse treatment program, Fiorentine, Anglin, Gil-Rivas and Taylor (1997) found a rate of 22% for the women and 32% for the men. The findings suggested a significant difference in relapse rates for both men and women. In a related study, Smyth, Barry, Keenan and Ducray (2010) recruited 109 respondents who were being discharged from a rehabilitation center following treatment for opiate use to examine their rate of lapse and relapse. By the end of the first week after discharged, the study showed that 66% of the respondents had lapsed, whereas 59% had relapsed. Conducting a prospective study with 59 young people diagnosed with alcohol and drug dependence disorders that had completed outpatient treatment, Cornelius et al. (2003) found that 66% of the respondents had resumed their drug use within six months after treatment.

Differences in the rate of relapse have been found for adolescents and adults. While most of the studies conducted mainly recruited adults as respondents, significant differences in the rate of relapse have been found among adolescents when the type of drug, frequency of use, and the method and mode of treatment have been controlled. Some studies have reviewed literature on abstinence rates for adolescents following treatment. In one review, Williams and Chang (2000) found that on average, only 38% of adolescents completely stay off drugs from six months after discharge, while 32% continue to remain sober for 12 months after treatment on the average. In a related review, Winters, Stinchfield, Opland, Weller and Latimer (2000) noted that on the average 39% of substance abusers were able

to remain abstinent at six months after treatment, whereas 44% did not return to the substance at 12 months after treatment.

2.3 Rationale for the study

Most studies conducted on substance abuse and relapse among substance abusers have investigated the phenomenon to identify the biological, psychological or social (contextual) factors that precipitate relapse to substance abuse (Marhe et al., 2013; Moos, 2007; Farjad, 2000). Nonetheless, it has been noted that relapse to substance abuse is a complex phenomenon (Marlatt & Gordon, 1985) that implicates psychological and social factors, for the most part. To fully comprehend and be able to develop effective relapse intervention strategies, both psychological and social factors that trigger relapse must be considered. Hence, this study aimed to explore the combine influence of psychological and social factors on relapse, as well as the rate at which these relapses occur after treatment and rehabilitation.

Furthermore, available literature indicate that only a few studies have considered relapsed respondents with their primary care-givers, non-relapsed respondents and mental health professionals in exploring the psychosocial factors precipitating relapse to substance abuse (Tuliao & Liwag, 2011). To thoroughly explore the phenomenon, this study collated data from the relapsed respondents with their primary care-givers, non-relapsed respondents, psychiatrist, psychotherapist and psychiatric nurses. Most studies reviewed have only collated data from relapsed respondents (Chetty, 2011; Cornelius et al., 2003; Moos, 2007; Spurgeon, McCarthy-Tucker & Water, 2000).

The subject of relapse to substance abuse has not been well explored in Ghana. The rate of relapse of substance abusers after treatment is also not well documented (Lamprey, 2005). Studies conducted on substance abuse in Ghana indicate that there is an increase abuse of substances among the youth and adults (Redvers et al., 2006; Lamprey, 2005; Afinnih, 1999a; Danquah, 1979), yet the psychosocial factors that trigger the relapse to substance abuse have not been well researched. This study seeks to explore these factors to help clinicians to predict relapse as well as develop better relapse prevention strategies suitable for clients' issues.

Lastly, most researches on the relapse phenomenon have been predominantly quantitative (Golestan et al., 2010; Ibrahim & Kumar, 2009; Hendershot, Witkiewitz, George & Marlatt, 2011; Mattoo et al., 2009; Moos & Moos, 2006). Quantitative research designs do not permit in-depth examination of a phenomenon. This study employed the qualitative approach to explore in-depth respondents' views on the roles of psychosocial factors in precipitating their relapse. Only a few of the studies also considered the rate of relapse of the respondents (eg. Cornelius et al., 2003; Fiorentine et al., 1997; Marlatt & Gordon, 1985; Smyth et al., 2010; Williams & Chang, 2000).

The factors and process involved in substance abuse relapse have been considered complex, comprising some biopsychosocial factors (Hendershot, Witkiewitz, George & Marlatt, 2011; Marlatt & Gordon, 1985). In addition, other contextual factors such as religion and culture have been found to determine relapse state of former drug addicts (Bickel & Vuchinich, 2000; Moos, 2007; Reece, 2007).

To fully comprehend the substance abuse relapse phenomenon, a multifactorial approach, involving relapsed participants receiving treatment (together with their primary caregivers), non-relapsed participants and mental health personnel are needed to explore this phenomenon in depth. It is in view of this observed gap that this study was conducted.

2.4 Research questions

This study seeks to answer the following questions:

1. What psychosocial factors precipitated respondent's relapse to substance use after treatment?
2. How has other factors such as the family, culture and religion influenced respondents to relapse or to maintain abstinence among non-relapsed respondents?
3. How often do respondents return to pre-treatment levels of substance abuse after treatment?
4. What preventive/coping strategies do clients employ to prevent relapse?
5. What psycho-socioeconomic effects do the relapses bring to respondents, their families and society?

2.5 Operational definitions

For the purpose of this research, the following key terms are used as defined below:

Substance: include alcohol and the illicit psychoactive drugs, specifically tobacco, marijuana, heroin or cocaine. The term 'alcohol and drugs' were used interchangeably with 'substance abuse'.

Substance abuse: a maladaptive pattern of substance use which may be psycho-physiologically damaging to the user. The term ‘Substance use disorder’ is often used with the same meaning as ‘Substance abuse’.

Substance abuser: a person who abuses one or more substances such as marijuana, alcohol, tobacco, heroin, cocaine or other illicit psychoactive drug in a maladaptive manner.

Lapse: a single or few temporal episodes of return to substance use without reaching the pre-treatment levels during the period of abstinence.

Relapse: a return to a maladaptive use (pre-treatment levels) of substances (such as marijuana, alcohol, tobacco, heroin, cocaine or other illicit psychoactive drug) after having been previously treated for the same substance use disorder.

Rate of relapse: how often a respondent returned to previous (pre-treatment) level of substance use after substance abuse treatment or rehabilitation.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter of the study covers comprehensive descriptions of the study setting, the sample size, the research design and materials used in conducting the study and the data analysis. The chapter also elaborates on the reasons for the choice of the study setting, the data collection procedure, the data analysis and ethical considerations.

3.1 Study setting

The data for this study was collated at the Psychiatric Unit of the Regional Hospital, Sunyani. The hospital, established on the 4th of August 2003, is ultra-modern with state-of-the-art medical equipment and diagnostic facilities. The hospital is a referral center for the entire Brong Ahafo region as well as for people from the northern part of the Ashanti region, the southern part of the Northern region and neighboring Cote d'voire justified its choice for the study. The hospital has a 25-bed capacity Psychiatric Unit which is staffed with a Psychiatrist, psychiatric nurses and a part-time Psychotherapist. The Psychiatric Unit also has a hostel for relatives (caregivers) of admitted clients.

3.2 Population

The primary population for the study comprised both male and female substance abused clients who were previously treated for alcohol and drug abuse, but have relapsed (with their primary care-givers) and were on admission or on outpatient treatment at the Psychiatric Unit of the Regional Hospital, Sunyani. The secondary population was made

up of non-relapsed clients who were once treated for substance abuse but have since maintained abstinence for at least 12 months since discharge. In addition, psychiatric nurses who have worked on the Psychiatric Unit for at least four years as well as the psychiatrist and the part-time psychotherapist also formed part of the study population.

3.3 Inclusion and Exclusion Criteria

For the purpose of the study as outlined above, the inclusion and exclusion criteria were:

Inclusion Criteria:

Relapsed Respondents:

1. Male or female client with diagnosis of substance abuse (substance use disorder) according to the DSM-V criteria.
2. Aged between 18 and 60 years
3. Previous history of treatment (at least one psychiatric hospitalization or on OPD base) for substance abuse.
4. Currently receiving treatment for substance abuse
5. Should have no other psychiatric (co-morbid) diagnosis
6. Should be able to understand and communicate in the English language

Care-giver of Relapsed Respondents:

1. Care-giver must be the key (primary) care-giver
2. Care-giver should be aged more than 18 years
3. Care-giver should have lived with the patient in the same household for at least 6 months.

Non-relapsed respondents:

1. Male or female client who had previously been diagnosed and treated for substance abuse (substance use disorder) according to the DSM-V criteria.
2. Aged between 18 and 60 years
3. Had had no relapse since discharged at least 12 months ago
4. Not currently being treated for substance abuse
5. Should have no other psychiatric (co-morbid) diagnosis
6. Should be able to understand and communicate in the English language

Mental Health Staff:

1. Aged between 25 and 60 years
2. Should be working on the Psychiatric Unit as a Psychiatric Nurse, Psychiatrist or Psychotherapist
3. Should have worked on the Psychiatric Unit for at least four (4) years

Exclusion Criteria:

The criteria for exclusion from the study for the various respondents were:

Relapsed Respondents:

1. Respondent has a co-morbid psychiatric diagnosis
2. Respondent is aged below 18 years or above 60 years.

Care-giver of Relapsed Respondents:

1. Care-givers of less than 18 or above 60 years of age
2. Care-giver had lived with the relapsed respondent for less than 6 months

Non-relapsed Respondents:

1. Respondent has a co-morbid psychiatric diagnosis
2. Respondent is aged below 18 years or above 60 years.
3. Respondent had had more than one (1) relapse episode after treatment for substance abuse since 12 months ago.

3.4 Sample/Sample size

Purposive sampling technique was used to select participants for this study. The sampling technique was considered appropriate because the study specifically focused on substance abuse relapsed respondents receiving treatment (with their primary caregivers) and non-relapsed respondents.

A total of 30 respondents were selected for interview for the study with the aid of a Semi-structured Questionnaire to explore in-depth the psychosocial factors that precipitate respondents' relapse and their rate of relapse. Baker and Edwards (2012) argued that to be able to thoroughly explore a phenomenon qualitatively, a sample size of between 12 and 60 is adequate, with 30 being the average.

The staff at the Psychiatric Unit of the Regional Hospital, Sunyani, included six (6) Senior Psychiatric Nursing Officers, and eight (8) Junior Psychiatric Nurses. Four (4) of the six (6) Senior Psychiatric Nursing Officers and five (5) of the eight (8) have worked for over four years with the Unit. There was only one Psychiatrist and one part-time Psychotherapist both of whom have worked with the Unit for over four years.

The sample for this study comprised of fifteen (15) substance abused relapsed respondents (with their primary care-givers), ten (10) non-relapsed substance abuse respondents, three (3) Psychiatric nurses, one (1) Psychotherapist and one (1) Psychiatrist.

3.5 Study design

This study adopted an explorative, descriptive, phenomenological qualitative research design. The reason for the choice of this design was to enable the researcher to explore in-depth the psychosocial factors that precipitate relapse to substance abuse. The descriptive nature of the study provided the researcher a way of discovering new meanings in order to collect accurate domain phenomena to be studied (Burns & Grove, 2007). According to Streubert and Carpenter (2007), phenomenology is a rigorous scientific process whose purpose is to translate human experiences into language. This study employed the phenomenological design type in order to understand and interpret the meaning that subjects give to their everyday lives. Compared with quantitative methodologies, respondents have the luxury to respond, elucidate and describe their experiences surrounding their relapse to substance abuse. In qualitative research particular attention is paid to context, process, and lived experiences (Creswell, 2013). This allows the researcher to get closer to what is being investigated. Besides, qualitative research typically aims for in-depth and holistic understanding of events so as to explore intricate psychological and social factors implicated in the relapse phenomenon (Punch, 2005).

According to Toomela (2007), qualitative research makes it possible to study certain areas that are not viable with quantitative research and it is noted for uncovering issues that are

unexpected and often overlooked by quantitative researchers. Thus to enable the researcher to understand the interplay of the various psychological and social factors precipitating relapse, a qualitative design was employed to elicit the individual's point of view through detailed interviewing and observation (Dawson, 2002). In addition, though not quite a new area the world over, not much literature is available on the substance abuse relapse phenomenon in Ghana. Qualitative design would enable the researcher elicit the needed information which would be relevant to clinicians in understanding and predicting relapse among treated clients. Rich descriptions within a cultural context can only be achieved through qualitative analysis (Barbour, 2008). On the other hand, the rate at which relapse occurred amongst respondents was however collated, computed and presented descriptively.

3.6 Interview instrument/Materials

A Semi-structured Interview Guide (see Appendix A) was used to collate data for this study. The construction of this instrument was guided by: the aims and objectives of the study, the two substance abuse relapse theories selected for this study [Cognitive-Behavioral Model of relapse process (Witkiezie & Marlatt, 2004; Marlatt & Gordon, 1985) and the Relapse Syndrome Model (Gorski, 1982, 1990)], literature reviews of related studies and the responses from respondents during the pilot study. In a Semi-Structured Interview, questions are repeated in each interview while maintaining the flexibility of the interview to make way for other equally important issues to emerge (Dawson, 2002).

A tape recorder was used to record the individual interviews to allow for accurate analysis of the data. Additionally, notes were taken from the observations and informal conversations to add to the recorded interviews (Emerson, Fretz & Shaw, 1995).

3.7 Pilot study

Walliman (2006) states that a critical part of a research is the pilot study, which involves the pre-testing of the instruments to be used for the study. This is to enable the researcher determine whether the questionnaire or the interview guide would elicit the right answers to satisfy the aims and the objectives of the study. During the pilot study, other apparatus such as tape recorders and computers are also tested (Creswell, 2013).

This study was pretested with 6 relapsed and 4 non-relapsed substance abusers and 2 staff selected from the Chosen Rehabilitation Center in Achimota, Accra. After permission was obtained from the Director and the members of the center (respondents), the purposive sampling technique was used to select respondents for the study.

The challenges and observations made during the pilot stage helped in the amendment of the questionnaire and the data collection process for the main study. Firstly, there appeared to be some level of nervousness amongst the respondents. Indeed, recounting events that precipitated substance abuse could be very emotional. Some respondents were unwilling to share their views and experiences initially. The researcher therefore emphasized on the confidentiality and privacy that encompassed the study and the relevance of the study. Following the reassurance and explanations, respondents became

relaxed and thus shared their views without any reservation. Secondly, most of the respondents spoke inaudibly as they answered the questions. Occasionally, the researcher signaled them to speak up loudly so the audio recorder could capture their voices.

Thirdly, sometime after about 30 minutes into the interview, some of the respondents showed some signs of exhaustion. Each respondent was therefore given a five-minute break in the course of the interview. Each interview lasted between 35 and 45 minutes.

Lastly, the researcher also observed that some respondents were responding vaguely to certain questions. For example, when asked about the psychological, social and economic effects of their relapsed to them and others, some responded vaguely as “..... *it's not a good thing*”. The researcher had to repeat, rephrase or clarify such questions before respondents were able to give insightful and comprehensive responses.

These findings and observations were used to improve and modify the data collection approach before carrying out the main study. To a large extent, the pilot study was an invaluable part of the study.

3.8 Procedure/Data collection

Sampling of respondents for the study took place at the Psychiatric Unit of the Regional Hospital, Sunyani. A letter of introduction (see Appendix D) obtained from the Department of Psychology and a copy of the consent form was sent to the hospital's administration for permit. Upon acceptance, the Psychiatric Unit was copied. The Psychiatrist and Psychiatric Nurse-In-Charge of the Out-patient Department (OPD) of

the Psychiatric Unit were informed about the aims and objectives of the study. They assisted the researcher in identifying respondents for the interviews.

With the assistance of the Out-Patient-Department Psychiatric Nurses, respondents were selected by going through the files of clients who reported for appointment, to identify those who met the inclusion criteria for the study. Selection of care-givers was done by identifying care-givers who had accompanied the identified patients to the Out-Patient-Department or caring for them on admission that met the inclusion criteria. Clients and health staffs who met the inclusion criteria were well informed about the study and consent sought before being asked to participate. This was done before they were attended to by the psychiatrist for their follow-up review. Non-relapsed patients who reported to the facility alone were asked to provide phone numbers for contacting their primary care-givers to reschedule a day and time for the interview.

Non-relapsed respondents were identified using their history in their folders. They were informed about the aims and objectives of the study. Those whose review dates were far from the time of data collection were contacted through telephone and informed about the study. Consents were sought and interested clients were recruited to participate in the study. Respondents who consented were asked to provide their contacts such as phone numbers and residential address to book an appointment for a suitable day and time for the interview. Respondents who were ready to be interviewed on the same day, met with the researcher after their review with the psychiatrist.

There were two phases in the data collection. The first phase comprised the main data collection procedure using the Structured Interview Guide. In the second phase, the researcher presented the findings of the data analysis in a meaningful way to the respondents and engaged them in a discussion concerning their responses to the psychosocial precipitants to relapse, relapse coping and preventive strategies and the effects of relapse. The respondents were re-interviewed briefly (30 minutes after the main interview) to confirm the accuracy of the findings and to add details. The second phase of the interview lasted between 10-15 minutes.

3.9 Trustworthiness of interview data

The concepts of credibility, dependability and transferability (Graneheim & Lundman, 2004) and confirmability (Lincoln & Guba, 1985) have been used to describe trustworthiness in qualitative research.

Credibility

According to Graneheim and Lundman (2004), credibility is synonymous with internal validity, which establishes that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described. To ensure credibility for this study, the researcher had prolonged engagement with the respondents; made persistent observations and member-checking of interview data; and had a continuous reflection on the research. In addition, the researcher engaged the services of an independent expert in qualitative study to evaluate the transcription of the interview data and codes/themes, and another as a co-coder to ensure credibility of data.

Dependability

Similar to reliability, dependability pertains to the degree to which data change over time (Graneheim & Lundman, 2004). The researcher's in-depth knowledge of the research setting, the choice of a phenomenological qualitative research design, and supervisory roles by the study supervisors and co-coder all ensured the data outcome was dependable.

Transferability

According to Graneheim and Lundman (2004), transferability refers to showing that the findings from one study have applicability in other contexts. A dense description of qualitative study makes transferability possible. For this study, the researcher conducted a recorded interviews and made field notes to ensure that the data collected was dense. In addition, a complete description of the research design, research strategy and method was well detailed.

Confirmability

Creswell (2013) states that confirmability in qualitative research refers to the degree to which the outcomes could be confirmed or corroborated by others. For this study, the researcher carried out data audit that inspected the data collection procedures and made judgment concerning potential bias and distortion.

3.10 Transcription of interview data

Atkinson (1998) maintains that there are two main approaches in the analysis of interview data. These include transcription and interpretation of interviews in line with already

established objectives. The transcription process could be seen as a painstaking exercise which is time consuming, but also an avenue to get acquainted with the data collected (Creswell, 2013). In fact, Bird (2005) argues that, data transcription is “a key phase of data analysis within interpretative qualitative methodology” (227) and should be seen as an act of interpretation which involves the creation of meaning from interview data rather than as a means of transferring audio sounds on paper.

Transcription of interview data requires a laborious and comprehensive ‘verbatim’ documentation of all verbal and where appropriate nonverbal expressions (Braun & Clarke, 2006). Of particular importance is to ensure that the transcript captures the information that is needed in a genuine and truthful manner from the interview accounts as well as taking cognizance of the purpose of the research analysis (Creswell, 2013). In this vein, audio recordings of the one-on-one interviews were transcribed verbatim as a possible representation of the accounts narrated by the research respondents.

Transcription was done by the researcher. The transcript was thereafter cross-checked with the audio recordings by two independent qualitative research experts from the Department of Linguistics and the Department of Psychology of the University of Ghana for correctness. Differences were resolved in consensus.

3.11 Data analysis technique: Thematic analysis

The collated data was analyzed by means of Thematic Analysis (Braun & Clarke, 2006). Joffe (2012) states that thematic analysis is “...among the most systematic and transparent

forms of such [qualitative] work” (p.210). The process consists of six phases (which are often grouped into three stages) and involves exploring the entire data set in order to differentiate repeated patterns of meaning. Themes are then derived from these specific patterns of meaning embedded in the data (Joffe, 2012). Thematic analysis, similar to content analysis, is a qualitative method of data analysis that seeks to identify, analyze and report themes or patterns within data. It reduces, organizes and describes qualitative research data in a rich detail (Braun & Clarke, 2006). According to Taylor and Ussher (2001), thematic analysis requires the active involvement of the researcher in order to discover the overriding themes inherent in the data since anything short of this could undermine the purpose of the research.

Thematic analysis like other methods of analysis (e.g. Thematic Discourse Analysis and Grounded Theory) seeks to explain the themes within qualitative data. Thematic analysis pays exceptional attention to the manner in which people meaningfully define their experiences as well as how the world at large shapes those meanings, taking into account the focus of the data and the constraints imposed by reality. Braun and Clarke (2006) provide a guideline for thematic analysis of qualitative data. The process comprised six phases that include familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report.

In accordance with the outlined process, the audio recordings of the group interview were independently transcribed by the researcher and by a Master of Philosophy Graduate Student from the Department of Linguistics of the University of Ghana. After the

transcription, the researcher together with the Graduate Student compared and cross checked the interview transcript with the original audio recordings for oversights and errors. The audio recordings and the transcripts were thereafter evaluated by a lecturer and expert (PhD) in qualitative research from the Department of Psychology of the University of Ghana. Where there were inconsistencies, the transcripts were edited to reflect the actual responses of the respondents in the recordings. Following this, the researcher took time to read and re-read the entire interview transcripts on several occasions in order to be well acquainted with all aspects of the data. At every stage of the data analysis, as with the entire work, the researcher was in consensus with both supervisors of the study.

Secondly, following the transcription, the data was independently coded by the researcher and a Master of Philosophy Graduate Student from the Department of Psychology. The double-coding was to ensure reliability (Braun & Clarke, 2006; Miles & Hubberman, 1994). The coding was done by highlighting potential patterns within the data together with some surrounding data in order to keep the context in which the data were presented. Afterwards, all the initial codes generated were collated together with their supporting extracts.

The third phase of the analysis was the search for themes. In doing this, all the different codes were selected out to generate potential themes. Thereafter, the different relevant coded interview extracts were collated within the generated themes. Following this, the relationships between the codes and the themes as well as between different levels of themes were identified under their appropriate names (Braun & Clarke, 2006).

Thus, the texts from the various interviews were organized according to similarity of themes to create main and sub-themes, with the view of indicating shared meanings as well as organizing them into a relational model. The relationship and positioning among the different individual texts were analyzed on a number of issues such as those psychosocial factors precipitating relapse to substance abuse after treatment, and common relapse prevention strategies used by non-relapsed respondents. Having done this, the results were interpreted with reference to theory and literature. All respondents were represented by at least one interview extract to ensure fair representation. The interview extracts are used as instances to indicate and validate the existence of a theme/ sub-theme.

3.12 Ethical considerations

According to Silverman (2006), it is important for the researcher to be mindful of every pertinent ethical issue at each stage of the research process, that is, from the research design stage through to writing of the report. The following ethical issues were addressed.

Ethical Approval: Pursuant to this, ethical approval was sought from the Ethics Committee for Humanities at the University of Ghana, Legon (see Appendix A). Thereafter a letter of introduction was then obtained from the Department of Psychology, University of Ghana, Legon, introducing the researcher and confirming the researcher's identity to the Administration and the Psychiatric Unit of the Regional Hospital, Sunyani. Approval was granted by the hospital's administration and thereafter copied to the Psychiatric Unit.

Informed Consent: Among all the ethical guidelines, informed consent is the most crucial and requires that all respondents in a study are provided with information that would give them a fair idea about the aims and objectives of the research (Silverman, 2006). To achieve this, the nature and purpose of the present study were explained in details to respondents who were selected for the study in the English language. To indicate their consent, respondents were made to sign a consent form (see Appendix A). Boakye-Boaten (2006) argues that any form of agreement that entails signatories carries some level of seriousness, bureaucracy and is oftentimes considered as trustworthiness in the Ghanaian culture. Respondents were all duly informed about the aims, objective and rational of the study.

Confidentiality: This requires that the identity of respondents is held anonymous throughout the phase of data collection to the declaration of findings. A conscious effort was made not to ask respondents about their personal details such as their names and home address so that they could be at ease with the interview process. Considering the sensitive nature of the research topic, it was necessary to assure respondent of confidentiality so as to ensure spontaneous answers to research questions. To be able to identify each respondent by what he or she said and for the purpose of accurate data analysis, alpha-numerical labels were used to designate respondents (e.g. the subjects were labeled, Respondent 1, Respondent 2, Respondent 3 and so on). The recorded interview was safely kept to avoid getting into the public domain. More so, respondents' information about their identity was not involved in the writing of the research report.

Freedom of Participation and Withdrawal: All respondents were informed about their freedom of participation and withdrawal, in that each respondent had the right to voluntarily decide on his or her participation and withdrawal from the study at any time he or she wishes to do so. Respondents were also at liberty to refuse to comment on questions they do not wish to. Ample time was given to respondents for periodic breaks to prevent fatigue during interview session.

Transcription: During this stage, conscious effort was made to ensure that accurate documentation of the narrations was possibly achieved. The recorded data were verified (double-checked) with the respondents to confirm their views and narration to the questions asked before the data was coded. This was done either immediately after the interview or through telephone interview later after the interview for those who could afford the time to stay. The data was transcribed by the researcher and cross-checked by two independent experts and thereafter compared to ensure accuracy and reliability.

3.13 Reflexivity

The researcher has worked as a National Service personnel under a psychiatrist and a psychotherapist for a year in managing a variety of psychiatric cases, including substance abuse. The researcher is currently a final year trainee clinical psychologist. Because the researcher's methodological choices and interpretation of findings could be influenced by his past experiences and present training and practice with substance abuse clients, the researcher had put forth all effort to remain as objective as possible throughout this study.

To decrease subjectivity, the researcher discussed both the research data and potential themes within the data with the thesis supervisors and other experts. Finally, the researcher reflected on his role in the research process, exposed any potential biases, and made this clear in the analysis (Fine, 2002).

CHAPTER FOUR

FINDINGS

4.0 Introduction

The results of the present study are presented in three sections. The first section presents the demographic profiles of the respondents, the units of analyses (see Appendix) that emerged from the interviews for the various respondents on the psychosocial precipitants of relapse, rate of relapse and the effects of relapse to substance abuse to the respondent, family, community and nation. The second section presents the main themes and sub-themes that were generated after critically analyzing and summarizing the respective units of analysis that were developed from each respondent's response and narratives. In this section the results are organized under the main themes and sub-themes. Besides, appropriate extracts from the interview are used to authenticate points made under each theme/sub-theme. In the last section of this chapter, a model of how psychosocial factors interplay to influence relapse to substance abuse is presented.

4.1 The Demographic profile of respondents

Table 1 (see Appendix) illustrates the demographic profiles of relapsed participants, non-relapsed participants and the mental health staff. Only six (6) respondents were females (n=30), two of whom were Mental Health staff. Respondents were aged between 22 and 60 years, with an average age of 34.8 years. Out of the 30 respondents, 14 were married, 12 were single, 3 were co-habiting, and 2 were divorced. With regard to respondents' educational level, 6 had completed Basic level, 13 completed had Senior High School, with the remaining 11 having completed the tertiary level of education. Out of the 30

respondents, 16 were unemployed, 9 were public servants, and the remaining 5 were self-employed.

Among the relapsed respondents, the number of treatment episodes prior to the study ranged from 1 to 5 times, with an average of 3.5 numbers of times. Among the non-relapse respondents, the number of treatment episodes ranged between 1 and 3 times, with an average of 1.5 numbers of times. Additionally, the age range (in years) that the non-relapsed respondents had been drug-free was between 1 to 6 years. Among the relapsed respondents, the time range for substance abuse was between 1 and 8 years, with average years of 3.5. On the other hand, the time range for substance abuse among the non-relapsed respondents was between 2 and 4 years, with an average age of 3.2 years. The most common abused substance was marijuana, followed by alcohol, tobacco, heroin and cocaine. This is true for both relapsed and non-relapsed respondents.

4.2 Themes generated by relapsed respondents

Table 2 (see Appendix) presents the various codes that emerged from the Relapsed Participants' responses that underlined the psychosocial precipitants of relapse to substance abuse, the influence of the family, culture and religion on their relapse, and the personal, family and social effects of their relapse thereof. Three major themes emerged from the analysis of data from the Relapsed Respondents. They were: *Psychosocial Precipitants*, *Cultural-contextual Factors*, and *Consequences of Relapse*. There were generally ten (10) sub-themes that emerged from the relapsed respondents' responses under these three major themes. Under Psychosocial Precipitants, the sub-themes were:

Positive and Negative Affect, Sense of Loss, Peer Pressure, Interpersonal Conflicts, and Occupational and Environmental Factors. Under the Cultural-contextual Factors, the sub-themes were: *Family-Culture Issues*, and *Religious/Spiritual Issues*. Under the Effects of Relapse, the sub-themes were: *Unemployment, Loss of Valued Relationships and Respect, and Medical Illnesses and Psychosocial Problems*.

4.2.1 Psychosocial precipitants

Psychosocial factors precipitating relapse refer to thoughts, feelings, attitudes, or other cognitive or affective characteristics of an individual as well as environmental and intrapersonal factors that play a direct or indirect role in a respondent's return to substance use after a period of abstinence. These characteristics or factors could be personal or non-personal to the individual, occurring in diverse ways and time. One respondent, a 28 year old male recounted:

...after discharge, I promised myself that was the end. For a year and half, I stayed out of drugs...and I started 'picking up my life'. But one day...I became very frustrated and angry with myself because I felt I was 'far behind in life'. Life seems to be at a standstill for me. I couldn't withstand the self-hatred...I passed by a bar near my home and bought myself a glass of alcohol...and that was all...(Respondent 5).

This respondent certainly had the volition to abstain from drugs, having stayed off for such a time. However, he could not bear up the frustration and anger that followed his feeling of self-worthlessness leading to his lapse and relapse thereafter. The perception of being 'far behind in life' is psychosocially traumatic enough to enable a former drug addict return to substance abuse.

Another respondent, a 41 year old male, validates this interpretation when in another dimension he discussed how he resumed to tobacco and alcohol use after he had his left arm amputated following a road traffic accident:

...so for over 9 months I hadn't taken alcohol or tobacco. I knew it was over. But soon after I had my hand amputated, I lost my job and other family issues also cropped up. I felt as if 'I wasn't a human anymore'...I felt worthless and helpless...I even thought about killing myself. And before I realized I had started drinking and smoking again (Respondent 7).

Undoubtedly, losing a hand and a job compounded by other familial issues could be very distressing. The degree of this psychosocial impact ('*I wasn't a human anymore*') could clearly precipitate a relapse. Former alcohol and drug addicts easily become entrapped and relapse when faced with such psychosocial factors, in the mist of poor coping strategies. To explore this main theme further, a detailed examination is presented below.

Positive and Negative Affects

Affects are emotional experiences – be it positive such as happiness, or negative such as sadness or anger. The majority of the relapsed respondents stated a number of positive and negative affect as factors that have contributed to their relapse. These include feeling sad and/or depressed, being frustrated, feeling lonely, feeling angry, being bored, feeling good and/or happy, being stressed, feeling worthless, guilt and a strong unflinching craving. Feeling good and/or happy were the two most cited positive affects for relapse to substance abuse. However, negative affects were mentioned more often, with the two most mentioned being feelings of boredom and frustration. Other reported negative affects, such

as persistent headaches and tremors, were clear withdrawal symptoms that tend to function as triggers of relapse.

Some respondents mentioned that symptoms of depression resulted in strong urges to return to substance use. Respondents reported feeling “very down” and “worthless” and that these feelings often precede crave for alcohol or drugs. A 34 year old male described his return to marijuana and alcohol use to help cope with his depressive symptoms:

...often times I feel ‘down’, and it appears no one even cares about me. My elder brother wouldn’t even want to see my face. I know I needed to change...and I was prepared to change, but no one wants to give me a chance. So...when I feel I have no one in the world...then my only thought is to get myself ‘high’ ...after all...(Respondent 13).

Majority of the respondents remain unemployed, in addition to feelings of rejection from family and friends as illustrated in the extract above. Indeed there is some level of stigmatization attached to alcohol and drug abuse. Certainly one’s reflection and evaluation of life, which is part of humankind, could result in a negative self-assessment and therefore worsen the depressive state. The obvious consequences will be a cycle of relapse episodes.

Another respondent, a 24 year old male narrated that his feelings and reactions towards stress which emanates from conflictual family relationships, unemployment, and legal problems often becomes the reason accounting for his return to his alcohol abuse. He narrated:

...my father and elder sister always make the home a hell for me. Maybe they think they are trying to help me, but ...not through quarrels. I have been jobless for almost two years now...and living every day without

working...you know...people think you are lazy and 'useless' (Respondent 2).

The influence of, and level of stress was reflected in this respondent's response: "...*the home a hell for me,*" and relatives considering the client 'useless', clearly shows the psychological distress and challenges in his quest to prevent relapse. Whereas ordinary persons who go through similar stress are likely to find better and healthier coping mechanisms and strategies to such overwhelming stress, the return to alcohol and drug abuse tends to become the most likely and appealing alternative to rehabilitated substance abusers, hence their relapse.

Some respondent also narrated the influence of positive affects on their relapse. In particular, periods of celebration and pleasure became the turn-over to their sobriety. One respondent, a 34 year old male, validated this assertion:

...now and then I get some contracts that come with some big bonuses. Sometimes my boss even doubles my bonus when we hit big. I always have some money on...and always happy. When I hit big, I go to Tyco relax...

Similar to non-drug addicts, former drug addicts use substances, during periods of pleasure and joy. However, unlike non-drug users, such moments could spark up desirable memories associated with the substance use in former drug addicts, and becomes an impetus to relapse.

Sense of Loss

Sense of loss refers to a feeling of sadness associated with the death or loss of something valuable. Several respondents recounted having felt some sense of loss, and the experience of actual personal loss often led them to drug and alcohol abuse, even in the midst of

frantic efforts to abstain. Again, receiving negative feedback from others about how one has mismanaged his life through drugs, as well as the feeling of, or actual experience of great personal loss, such as the death of a loved one, divorce or termination of other valued relationships or becoming physically disabled following a disease or accident, or through the loss of property such as by robbery or fire have all been cited by respondents as factors that triggered their relapse. One respondent, a 49 year old male stated how the delivery of a still-born baby by his wife affected his efforts to remain sober:

...I wish that day never came...I rushed my wife to the hospital to deliver. Hours later, I was told the baby had died. For a few days I was able to control myself and comforted my wife. But about 2 weeks later...I don't know...I was too disturbed. One day I just found myself drinking and smoking again (Respondent 8).

With a similar despondency, another respondent narrated:

...our elder sister in the US wanted me to join her. My mother told her I was drinking and smoking so they asked my junior brother to go instead. I became mad at my mother and left the house for about a month to stay with a friend. I can say that ...that period actually sent me back to the drugs...though I had stopped for about 8 months before that time (Respondent 5).

The agony of experiencing loss and failing to utilize an opportunity and other such negative experiences tend to push recovered substance abusers to their extreme limits. Most non-drug users cannot cope with the pain of disappointment, nonetheless former substance abusers. The anxiety that results from such feelings of sense of failure and loss are managed by returning to substance use from which they expect to derive a desirable psycho-physiological stimulation to take their minds off the situation, although temporarily. This obviously indicates their probable lack of will-power and coping strategies in relapse prevention, and hence an easy yield to relapse.

Peer Pressure

To a larger extent, the role of peer influence in the relapse process was noteworthy, cutting across the various age groups. Peer pressure refers to the influence that one's peer group has on the person's behavior. Most respondents recounted how they were influenced to commence, sustain or resume alcohol and drug use through the influence of school or work colleagues. One respondent, a 29 year old man, narrated:

...I started smoking marijuana when I went to Form Two. My friends said I could learn and play football well when I smoke. I had many problems and I stopped for about...emmm...almost a year. I promised myself I won't use it. But...one day I just told them to pass me a piece...and so that was how I went back. Later, I was introduced again to "laka" (bitters made from marijuana and locally prepared alcohol) by the same friends...(Respondent 9).

Another respondent, a 51 year old man also recounted how his work co-workers influenced his relapse to alcohol abuse:

...I was working with a construction company. We had a new boss who would sometimes take us out to take a drink on Fridays. I told them I don't take alcoholic beverages. But one day they insisted that I was not going to drink any other drink than beer. I protested, but they won't listen. So from that day onwards I took beer...so by and by I returned to the alcoholic behavior (Respondent 12).

To the rehabilitated alcohol and drug abuser, the negative influence of friends remains one of the greatest challenges. The need to belong (which is part of humankind) and to satisfy the wishes of one's friends and colleagues appears to carry such a persuasive power. Some respondents relapsed because to them the fear of rejection is greater than that of relapsing.

It has long been documented that the influence of one's friends and colleagues on the relapse status of a rehabilitated substance abuser is one of two ways: positive or negative.

However, as much as one's peers could offer positive and healthier influence to maintain sobriety, they could equally offer some negative influence and misdirect others into bad behavior. This is so because clients, upon discharge from treatment, oftentimes continue to maintain their relationships with people who led them into the substance use and who still abuse substances.

Interpersonal Conflicts

Interpersonal conflict refers to disagreement that occurs between two people. Most respondents reported having had interpersonal problems both at home or at work which is in one way or the other connected to their history of, or their current state of drug abuse. The frustration resulting from unemployment, loss of respect from relatives and others, shirking off responsibilities, and the associated loss of reality and judgment from the alcohol and drug use serves as reasons responsible for conflicts at home and at work that often precipitate clients' relapse. The extract below, from a 29 year old man, gives credence to this assertion:

...I think it was how my people were behaving at home. Because after I was discharged from here...I didn't smoke or drink for almost 4 months. But everyday my father would pick up an issue against me...because he thought I was still smoking. I even fought with my sister on two occasions and she got hurt. Apart from my mother, it was as if everyone was against me...(Respondent 1).

This respondent, a 34 year old man also recounted how he always returns to alcohol after a quarrel with his wife:

...hmmm...I started moving on well. But my wife...she said I was having an affair and was always quarrelling with me. She went to report this to our pastor and the elders in our church. That really annoyed me. That night I slapped her. Later I regretted when she continued crying. I left the house

*and went to drink. I did that throughout the week and continued since...
(Respondent 3).*

It could be said that disagreement and conflicts with others pose a major threat to relapse prevention among former drug addicts. Relationship tensions, for instance, could lead to emotional instability and frustrations and become impetus for former substance abusers to return to drug use in their quest to ease these tensions. When interpersonal conflicts replace social support, not much is left for the client than to find solace in the very substance which he or she is battling with.

Occupational and Environmental Factors

Analysis of the data indicated that the majority of the respondents attributed their relapse to the environment and context in which they found themselves. In the sense of this study, occupational and environmental factors are all job-related and locational factors that can potentially trigger relapse. Unfavorable home and work environment tend to work against the efforts of the client in preventing relapse. Respondents narrated that the availability of alcohol and drugs at home (especially where a relative is also an abuser), or residing around a ghetto or a drinking spot, or working in an alcoholic beverage producing or distribution company were some factors that triggered their relapse. One respondent narrated how his job as a sales-person in a drinking spot sustained his substance use:

I was the one in charge of the spot. I had free access to any drink at any time. Most often, I carry the alcoholic drinks home and share with my girlfriend who also drink. I knew I was suffering, but I couldn't stop...(Respondent 15)

Another respondent, a 29 year old man recounted how his tenant who used and sold marijuana greatly influenced him to continue to use:

...when I got my new job with Newmont, I relocated to Sunyani. I later found that my landlord's son deals in marijuana. Over the weekends, you see so many guys coming around to buy. I told myself I was never going to smoke marijuana again. One Saturday night, I felt so down and decided to just get a roll. When he found out that I smoke marijuana, he offered them to me for free. And when he travels, he keeps them with me to sell for him...and so it became very difficult for me to stop...(Respondent 4).

To say that unfavorable environmental and contextual factors do thwart the efforts made by former alcohol and drug abusers to maintain sobriety is the least. The ease of accessing the substance, as well as the continuous contact with the substance makes it irresistible to these former addicts to abstain. A change of job or residence could be one relapse preventive approach for such group of people who cannot stand the continuous temptation.

4.2.2 Cultural-contextual factors

In September 2012, the *WIN-Gallup International Association*, an internationally reputable polling agency based in Zurich, in its Quarterly World Religiosity Index, voted Ghana as the most religious country in the world. Certainly, most Ghanaians are religious and culturally inclined. The analysis showed some respondents implicating various familial, cultural and religious factors as relapse triggers. Except for religion which has served as a protective factor against relapse – for the most part, the familial and cultural factors have received both praise and condemnation with respect to the relapse process. One respondent, a 32 year old man, recounted how familial and cultural factors influenced his relapse:

...when I completed Kumasi Polytechnic, my family didn't know that I drink alcohol...and I was making every effort to quit. However, my grandfather had several bottles of alcoholic drinks kept to serve visitors and also from 'left-overs' after he had settled disputes and conflicts brought to him.

Alcohol was always available and it was difficult for me to stay off...(Respondent 7).

The Family-Sociocultural Issues

The roles of familial and sociocultural influence in alcohol and drug relapse also emerged as some respondents recounted various ways in which these two factors aided their relapse. Notably, the family and sociocultural factors have both served as protective and precipitating factors to relapse. The protective aspect of these factors has been discussed under the coping strategies for non-relapsed respondents.

In no small way, the family is one important institution that serves as an avenue for treated and rehabilitated substance abusers to continue their recovering process. Unfortunately, this has not always been the case. Respondents reported of instances of hostility from loved ones as to help them stay off the substance. The withdrawal of certain privileges such as financial, educational, job and other supportive interventions, as well as the lack of demonstration of love play an invaluable role in the relapse status of clients after discharge from treatment. One respondent, a 27 year old woman recounted of how she continuously relapsed because of the lack of support and rejection by her family:

...after my discharge, I thought my mother and younger siblings will 'be there' for me...because already I had lost most of my friends. My mother kept ignoring me...and telling people how a female like me has been drinking and smoking. Sometimes no one will even speak to me or give me anything at home. Sometimes I feel I am a tenant in my own home. Often I go to my boyfriend who always has alcohol and marijuana at home (Respondent 5).

In a patriarchal context, such as Ghana, where masculinity is an important factor, female substance abusers may encounter overwhelming neglect, rebuke and despise more than a male counterpart. In one sense, this negative expectation could serve as substance abuse and relapse prevention strategy. In the other sense such continuous ordeal, especially from relatives could also become a precursor for relapse.

Another respondent, a 34 year old man describes how familial factors thwarted his efforts to quit cocaine and marijuana use:

...my dad said if I don't stop he will disown me and drive me from home. I wanted to stop, but I needed help to do that...so we were always fighting at home. He said my behavior could affect his political career as an MCE. So it was difficult to even stay at home. I go out, meet my friends and go and do it again...almost all the time (Respondent 11).

In the traditional Ghanaian society, individuals become concerned and mindful of the behavior and actions of others that has the potential to dent their reputation.. A relative could go to a great length to employ all available strategies, most often non-therapeutic, in an effort to prevent the client from bringing the family's name into disrepute. Instead, it would be therapeutic when family members remain 'there' for a person recovering from substance abuse. When the family comes to terms with the fact that substance abuse is a behavioral problem which can be unlearned or treated with behavioral and cognitive interventions, through family support, relapse rates could be minimized. Furthermore, and as recounted in the earlier abstract, relatives and friends may find it difficult to understand that both males and 'females' stand the chance of abusing alcohol and drugs. Clearly, when relatives do not receive such insights, they may be unable to offer the needed support.

Certain cultural and societal elements were also at play in the relapse phenomenon. In the Ghanaian traditional society, alcohol (usually the locally brewed “akpeteshie” containing a high percentage of ethanol) is served during traditional social events such as funerals, engagements and weddings, naming ceremonies, festivals and a host of other occasions. To some degree, it is socioculturally expected to consume all drinks served. The Ghanaian society is largely patriarchal, where masculinity is displayed through various means by men. In traditional gatherings and family meetings, men are served with alcoholic drinks. Others may abuse substances for sexual enhancement to prove their masculinity or as appetizer.

Some respondents have stated that they could not help, but to join others to drink when they found themselves under such circumstance. When this drinking behavior was established, respondents reported resorting to other substances such as tobacco, marijuana or heroin in the course of time. One respondent, a 41 year old man told of how cultural expectations and traditions fueled his relapse:

...ok...for about 11 months I hadn't had a drink or smoked. I knew I was free. So when I was offered a beer at a friend's wedding, I refused. My friends asked whether I thought they wanted to poison me. I took it to exonerate myself. The following week I went to a funeral where I was served with alcohol again. Within 3 weeks I returned to heavy drinking again (Respondent 12).

Another respondent, a 29 year old man also recounted his ordeal during a traditional family meeting when he was made the chair of the meeting and had to drink alcohol as tradition demanded:

... one day, my family...the extended family met and settled some land disputes and other family issues. I was made the “Okyeame” (linguist). I

had to share the alcoholic drinks. I needed to drink first before sharing and also drink the last shot. The last bottle was half-full...and I was told to keep it...(Respondent 7).

Religious/Spiritual Factors

By and large, religion has served as a protective factor against relapse to substance abuse. Nonetheless, religion and religious elements have been implicated as mediating relapse. Respondents' implication of religious factors could be considered under one of two dimensions: those due to their non-involvement in religious activities and those who consider their relapse as a spiritual manipulation and thus beyond their control. When asked to tell how religion may have influenced his relapse, one respondent, a 28 year old male narrated:

...hmmmm...for my problem, I believe it is spiritual. I have done everything...but it is still there. Last two years, I even went to Nigeria with my junior brother (who also drinks and smoke) to see a Pastor...but about 4 months later, I started again. Even what I see in my dreams...I know it is not a normal thing...(Respondent 3).

Certainly this respondent has explained off the cause of his substance abuse behavior to be spirituality. To him a spiritual causation demands a spiritual intervention. He would not consider his drinking behavior as problematic since he '*believes it is spiritual*'. When a relapsed behavior is spiritualized, it affects personal responsibility of the behavior by attributing to external force.

Another respondent, a 32 year old man also correlated his relapse with his religious or spiritual standing:

...I can see that anytime I don't do things right or I sin, then I find myself smoking. I believe my continuous relapse is a punishment from God...I know I have to be serious with church...then I can stop forever...(Respondent 10).

Considered a religious nation, the influence of, or the perception of religious influence in people's lives cannot be underestimated. Indeed, religion plays a major role in the lives of most Ghanaians – and most phenomena *would* easily be explained in terms of religion. Religion itself could be used to help clients who carry lots of religious sentiments into therapy. However, should the problem be purely behavioral (which appears to be the case most often), religious based intervention alone may not be helpful.

Lastly, one respondent, a 32 year old male, a Catholic, stated that the laissez-faire use or tolerance of some drinks containing some amount of alcohol even among the Catholic clergy justified his initiation and continuous relapse to alcohol abuse. To his understanding, it is permitted for one to use alcohol in a regulated quantity, recounting the Biblical passage of Jesus turning water into wine for use at a wedding, He stated:

...well, I am a Catholic and I know we can use alcohol provided it is not too much. So sometimes I even tell myself that even the Pope drinks so it isn't a problem. But I know I have to stop because I can't continue like this...(Respondent 14).

4.2.3 Consequences of relapse

A host of negative effects following respondents' continuous relapse were shared. Most respondents indicated that they started using and abusing alcohol and drugs in their quest to enhance their performance and output. However, the adverse psychosocial and economic effects are incomparable to the anticipated benefits – which are often erroneous.

Sub-themes that emerged under the Effects of Relapse following the analysis include: *Unemployment, Loss of Valued Relationships and Respect, and Health Problems*. These are elaborated below.

Unemployment

Majority of the respondents were unemployed as a consequence of their relapse. Several reasons, including difficulty in adhering to work rules, regulations and ethics, conflicts with other colleagues, neglecting one's post and responsibilities, and inefficiency at work were cited for their inability to remain employed. Others who were once self-employed also lost their capital and other resources and as a result had their ventures become malfunctioned. A 43 year old male respondent narrated his experience of how he lost his job through heroin use:

...I was the second in command (supervisor) at Afriko Ghana Limited. I was earning a good salary. But when I started drinking and later doing heroin, I could not work as before. My boss cautioned me several times...but I couldn't stop. Later in the year, I was asked to go on an indefinite leave...and I was never called back (Respondent 11).

Another respondent, a 39 year old man who has been unemployed for 6 years recounted:

...my elder brother in the UK came to establish a construction (hardware) shops...two of them in Sunyani and one in Techiman...and I was the manager. When I started using cocaine and marijuana, I started misusing the money to buy the drugs until all the shops collapsed...as of now I don't have a Cedi in my account...(Respondent 6).

Other respondents described how they have remained unemployed, or under-employed as a result of their alcohol and drug abuse. It is also worth mentioning that the frustration and stress that comes with the persistent unemployment and the aftermath negative self-

evaluation could trigger the person's relapse, and therefore becomes a cycle. Yet another challenge is that people who have been rehabilitated from alcohol and drug abuse find it difficult to be accepted back to their post at work. What could be helpful is for clinicians to involve employers in the treatment model and advocate for their reinstatement after treatment.

Loss of Valued Relationships and Respect

When a person becomes irresponsible, quarrelsome and violent, poor, and brings disgrace to themselves and others, there is a high proclivity that the person would lose some valuable relationships and respect. Most respondents reported that following their continuous battle with alcohol and drugs, they have lost the respect and dignity formerly bestowed on them. Likewise, others reported of having been separated or divorced. The sense of losing such esteem, as well as having to continue life without a significant person such as a spouse or child could in itself precipitate relapse, as much as it is a consequence. This was a 34 year old female respondent's answer in response to the consequences of her relapse:

...yea...hmmm. My husband left with my only child because he could no longer tolerate my alcohol use. It's a big blow losing these two important persons in my life...(Respondent 14).

Another respondent, a 38 year old man, also narrated:

...because of my father's status as a sub-chief, I used to be respected a lot. Everywhere I went they accorded me the royal respect. But now...the way people even look at me...I know they insult me in their heads...and some of good friends too don't want to be close again... (Respondent 10).

The agony and regret that respondents had gone through could be felt in their tone of voice and mannerism as they recount the loss of their once fruitful and enchanting relationship and respect they had enjoyed.

Health Problems

Almost all respondents narrated that they also suffer from one medical problem or the other as a result of their alcohol and drug abuse. Some have stated that they had had their fair share of psychological distresses, including depression, hallucinations and suicidal thoughts and attempts. Some respondents complained of periodic migraine, severe pain around the eyeballs and chest and palpitations soon after they had abused substances. A 41 year old male respondent shared how he once attempted suicide:

...for three years I have been unemployed. I have sold most of the things I owned. I knew I can't stop the cocaine...and it was not worth continuing to live. I decided to end it all using some chemicals (pesticides)...I think God gave me a second chance to live...(Respondent 11).

Another respondent, a 39 year old man also narrated how he developed a medical problem after years of marijuana and alcohol abuse:

...first my foot and eyelids became swollen. I didn't bother so much... but 4 weeks later it was still there and even worsening. I went to the hospital and I was told I had a kidney problem. They also said some of my labs were very bad. They told me if I don't stop the drinking and smoking I'd die from kidney and liver damage (Respondent 9).

The penalties for drug abuse are very detrimental – the consequences are not only borne by the individual but also by the family, loved ones and the society as a whole. Yet more critical are the psychological consequences associated with drug use. Suffering depression, hallucination or suicide attempts and organ damages and diseases should in

itself serve as a deterrent to respondents to quit alcohol and drug use. However, following the addictive nature of these substances, and coupled with the interplay of various psychosocial and biological factors, clients find themselves continually abusing substances.

4.3 Themes generated by non-relapsed respondents

In this section of the study, the researcher sought to explore the various coping strategies and mechanisms that aided the non-relapsed respondents from relapsing. Ten (10) clients who were once treated and/or rehabilitated for substance abuse but had since remained abstinent for a minimum of one year were contacted and included in the study. Several codes emanated from the text from the non-relapsed respondents (see Table 3 in Appendix). Two major themes emerged from the analysis of data from the Non-relapsed Respondents. They were: *General Relapse Prevention Strategies* and *The Contextual Relapse Prevention Strategies*. There were generally five (5) sub-themes that emerged from the Non-Relapsed Respondents' responses. Under General Relapse Prevention Strategies, the sub-themes were: *Personal Preventive Strategies* and *Clinical Preventive Strategies*. Under the Contextual Relapse Prevention Strategies, the sub-themes were: *Family-aided Relapse Prevention Strategies*, *Culturally-aided Relapse Prevention Strategies*, and *Religiously-aided Relapse Prevention Strategies*.

4.3.1 General relapse prevention strategies

Substance abuse relapse preventive strategies include various methods and interventions which substance abusers employ to reduce the use and abuse of a substance or to quit

entirely. Non-relapsed respondents shared various coping strategies they had used to help themselves stay off the substances. Respondents cited a number of *Personal* and *Clinical Coping/Preventive Strategies* which they have instituted to keep them from relapsing. Some respondents stated that they have experienced lapses, especially when a mechanism or preventive strategy was not effective. Some commonly cited strategies included quitting their jobs and friendships, relocating to a different area/town, destroying available substances and informing family, friends and suppliers about their decisions to quit, running or rushing out to public places when there was a strong urge to use a substance, talking or shouting out to self, giving out or destroying a valuable item when there was a lapse, shaming self and using other strategies such as holding one's breathe or performing deep/diaphragmatic breathing, engaging in muscle relaxation, attending Alcoholic Anonymous meetings, exercising or engaging in an outdoor activity and calling up the psychotherapist or a friend for a conversation when there ensued a strong feeling to abuse a substance. A 38 year old male respondent who resorted to outdoor activity for relapse prevention recounted:

...I realized that I become tempted to use the substance when I was lonely. So what I did was whenever I begin to have the feeling to smoke or take alcohol, I will leave the house and hurry to town...just walking or go to the stadium area and watch people play football...(Respondent 6).

Personal Preventive Strategies

After years of abusing substances, and experiencing some negative effects, most respondents have employed some personal preventive measures to help them quit. The intolerable psychological, social and physical effects of substance abuse have served as an impetus for abusers to find all possible means to quit – often employing crude methods.

One respondent, a 43 year old man shared how he was able to quit marijuana and alcohol abuse by relocating from his community:

...I did so many things to stop...but I was still smoking and drinking. One day I told myself I have to move from New Dormaa. I had some Newmont co-workers in the area that always influenced me to drink and smoke. I found a guy to rent my room, got a different room at Abisim – all in one day... For me, I think that really helped me to stop (Respondent 8).

One of the toughest decisions to take is to relocate suddenly in order to help one to dissociate from bad influences. This approach, although could be suggested by a clinician, may not have been as sudden as narrated above. This drastic action shows the seriousness of the respondent to use all possible means to quit.

Another respondent also recounted how he was able to quit by telling everybody about his decision and destroying his supplies:

...one day I had a dream I was smoking and my shirt caught fire and got burnt and I died. When I woke up...I went to my uncle and told him to help me stop the alcohol and “wee”. He came with me, collected all the “wee” and burnt them in the house. He told everyone in the house that I have stopped smoking and drinking...and yea...that was all. It was very embarrassing though (Respondent 10).

The expressions of joy following respondents’ ability to quit substances were obvious as respondents recounted the means by which they became abstinent. This joy and feelings of liberation outweighs the ‘embarrassment’ that could be associated with the quitting process. In all cases, one critical aspect of the process includes being able to identify the high-risk situations and work to prevent them.

Clinical Preventive Strategies

The Psychiatric Unit of the hospital is staffed with a psychiatrist, psychiatric nurses and a part-time psychotherapist who comes often for counseling and psychotherapy sessions for clients. Almost all of the respondents had had some psychotherapy sessions with the psychotherapist. In addition to receiving psycho-education and insight therapy on their condition, clients were taught some relapse preventive strategies to help prevent relapse. Relapse prevention techniques such as time-outs, thought stopping, positive self-talk, motivational enhancement therapy, cognitive-behavioral therapy, rational emotive behavior therapy, building new positive friendship and activities, and assertive training to say “NO” when being offered drugs and alcohol were mentioned by the non-relapsed respondents relapse prevention skills and strategies they acquired through counseling. One respondent, a 40 year old male respondent narrated how he applied the positive-self talk strategy which was taught during a therapy which helped him to abstain:

... he taught me how I can say certain positive things about myself when I find myself when I have a strong temptation to use the substance. So for me...I say, “I’m wiser...I have self-control. I won’t yield to my fleshly demands because it’ll destroy me. I have a better future”. It was like rebuking myself...but it work...it was helpful...(Respondent 4).

Another respondent, a 34 year old man recounted how his use of relaxation helped him to control his anxiety and thus relapse:

...when I have the strong urge, I do the relaxation and the deep breathing ‘Father’ (the psychotherapist – a Catholic priest) taught me. It relieves me from the tension and anxiety that comes along with it. When I experience the feeling when I am at the work place, I take a short break and go to dosome relaxation exercises. At the same time I send my mind to imagine some positive things. It has helped a lot (Respondent 1).

Indeed, there are some level of anxiety and tension associated with suppressing the urge to use substance. These ‘*strong urge*’ or crave significantly work against clients’ effort in maintaining their sobriety. Employing such clinical methods as relaxation and other Cognitive and Behavioral techniques could reward their relapse prevention process. The commitment and readiness of the client to quit, for instance, is a very valuable factor in substance abuse relapse prevention. Other important factors such as the rapport between therapist and client, the techniques being used, the persona and experience of the therapist as well as the severity and type of diagnosis could all affect therapy outcomes. Indeed both client and therapist’s factors are critical and determines treatment outcomes. The non-relapsed respondents showed a great level of adherence to therapy, resulting in their eventual recovery.

4.3.2 Contextual relapse prevention strategies

To most non-relapsed respondents, familial, cultural and religious factors have served as relapse prevention institutions and agents. Humans derive their sense of belonging, feelings of attachment, and social support from the family. Furthermore, during times of psychological and behavioral problems, such as drug addiction, the family could play an invaluable role in the behavioral change process. Respondents recounted having received financial, psychological and other social supports from their family which they considered as critical to their recovery from alcohol and drug abuse.

The traditional Ghanaian cultural values and norms, in various capacities have also played remarkable roles in preventing relapse among respondents. Being continually rebuked

(and insulted) by town elders and other adults, or denied of certain privileges (such as refusal by a family to accept marriage proposal from a substance abuser), receiving little or no share in family properties, and being sidelined in a decision making process are but a few ways respondents reported as some consequences which had strengthened their efforts to quit.

An equally important factor that was cited as having prevented relapse to substance abuse is religion. In no doubt, Ghana is largely a religious state, and highly religious parents bring up their children and wards to adhere to the tenets, principles and commands of the religion they profess. Respondents have recounted how these three factors: the family, culture and religion played critical parts in their relapse prevention process.

Family-aided Relapse Prevention Strategies

To many respondents, the family was the most valuable source of assistance in their relapse prevention process. Respondents stated that their families accepted them even during that difficult moment in their lives as substance abusers. The sense of being accepted and the consideration of the substance abuse as a behavioral problem rather than defining the individual as the problem was an important insight that guided the families to offer the needed assistance. In addition, the words of encouragement from family members, as well as the physical and financial support offered to respondents were seen as an invaluable contribution to the prevention process. One respondent, a 51 year old man told of how the family helped him to quit marijuana and alcohol abuse:

... I think my wife is an angel. I can't count the numerous times she took me from the floor, gave me a bath and fed me. Although she was unhappy with

my behavior, her words were always kind and encouraging...and I know she was praying for me too. One day I just cried and prayed the whole night...and I never went back to drugs...(Respondent 3).

Certainly this warm and humane approach used by this family through the “*the numerous times*” the respondent was shown love could have reinforced the client positively to continue to abuse substance. However, in its right measure and expression, love and support is powerful enough to challenge the client to take a deeper reflection and commitment to quit the abuse of the substance.

Another respondent, a 29 year old woman narrated how her family’s continuous support prevented her from relapsing to alcohol:

.... Many people only rebuked and insulted me. But it was my family who actually cared...and I was surprised. I expected them to also act as the others. Mum in particular was comforting. She was always there for me...and my siblings too. They all encouraged me to pray, go to church...and go for review at the hospital...(Respondent 9).

Unquestionably the sense of one’s family always been ‘there for them’ provides some motivation and strength to pull through the difficult challenge of overcoming cravings and contextual situations that precipitate one’s relapse to substance abuse. It is therefore necessary that the family is given the needed psych-education on the complexities of addictive behaviors and their invaluable roles in the treatment and relapse prevention process

Culturally-aided Relapse Prevention Strategies

It emerged from the collated data that cultural factors played important role in aiding respondents to remain abstinent from substance abuse. Inherent in the Ghanaian culture is

respect and obedience for the elders. In the cultural context, one must live a life void of debauch and deviancy in order to earn respect and be in good repute. Where one fails to live to the standards of the communal tenets, punitive measures, such as being rebuked and shamed, prevention from leading or contributing to family or communal discussions, forfeiting certain privileges (such as marriage offers) and other negative reinforcement meant to decrease the particular behavior are employed. Respondents cited some of these culturally inherent punitive measures as having informed and strengthened their decision to quit substance abuse.

One respondent, a 32 year old man narrated how the concerns and reactions from people in his community informed his decision to quit:

...I realized that I had lost all my respect...and I was tired of relatives and the elderly calling me to their homes just to rebuke...or advise me. It was as if I can't do anything for myself! One day I decided that I was going to prove these people wrong...and I have since not touch alcohol or marijuana again...I realized that these people were my savior...(Respondent 10).

Another respondent, a 38 year old man, also recounted:

...after a small misunderstanding with my fiancée, my would-be father-in-law said he won't give his daughter to a "wee" smoker to beat her to death. That was a very big blow for me...because I loved Jane and she also loved me...I know. After that I realized that I was losing a lot...because of the marijuana. I pulled all my strength together and stopped. It was not easy though (Respondent 4).

The frustrations and sense of loss one experiences as loved ones and other people in the community continue to rebuke and show repulse to one's behavior becomes an impetus to quit substance abuse, to some significant degree. Human beings have a need to belong and to be accorded the right respect and privileges. When becomes "tired of relatives and the

elderly calling...to their homes just to rebuke...or advise” or when the “*would-be father-in-law said he won’t give his daughter to a “wee” smoker”* then certainly a second reflection is needed and a drastic change of behavior is equally required.

Religiously-aided Relapse Prevention Strategies.

Statistics from the population census through the centuries indicate that most Ghanaians are religious and either professes the Christian, Islamic or the Traditional African religion. Fortunately, for the most part, such religiosity continues to reshape society in a positive and desirable way. To many respondents who have remained abstinent to substance use and abuse, religion has been a major contributor. Religious elements, from prayer and fast through taking up an active religious role, to building up one’s faith and the reliance on God, Allah or the gods for assistance have all been cited as factors that have influenced their ability to stay off alcohol and drugs.

One respondent, a 54 year old man told of how he quit cocaine and alcohol abuse after engaging in prayer and fast and other spiritual matters:

...I had used cocaine and alcohol for 8 years. I have seen the psychiatrist and psychologist for several times. My auntie took me to a prayer camp where we spent two weeks fasting and praying. A lot of issues and revelations came up. It was difficult though...I had to fast and pray all the time. After a series of deliverances, the prophet told me I was free...and that was it (Respondent 6??).

Another respondent, a 32 year old woman narrated how she was able to quit alcohol abuse after she took up a role as a chorister in church:

...after 6 years of abusing alcohol, my sister encouraged me to go to church...and I became an usher and later joined the church choir. Initially, it wasn’t easy because some people knew me and were looking at me with

different eyes. But now I have settled well and have since not even thought about alcohol again (Respondent 8).

A 51 year old man also narrated how he overcame his marijuana and alcohol addiction when he became part of a church group:

...my neighbor kept inviting me and my wife to church. One day we followed them...and as we continue to hear the word of God and praying with them, I saw that I was changing. As we fast and prayed, and kept reading the word of God, I realized that I was not having the desire to smoke or drink again. So for about two years after we joined the church, I was able to stop the alcohol and drugs (Respondent 2).

That religion has played an enormous role in relapse prevention is an understatement. Whether through several days of fasting and prayers or taking up of a religious role in church or study the Bible or Quran, these respondents gradually became aware of the need to quit substance use for a more fulfilled life as promised in the religious doctrine they profess. As this conviction became stronger, respondents became less concerned about people's reactions, as well as the likely prejudice – such as people “*looking at me with different eyes*”.

4. 4 Themes generated by mental health staff

In this section of the study, the researcher sought to explore from mental health staff about the various psychosocial factors that relapsed clients cite as having precipitated their relapse to substance abuse, as well as their coping strategies and protective factors that have aided non-relapsed respondents from relapsing, and the roles of the family, culture and religion in the relapse prevention process. Several codes emanated from the text from Mental Health Staff (see Table 4 in Appendix). Five (5) mental health staff made up of three (3) psychiatric nurses, one (1) part-time psychotherapist and one (1) psychiatrist

were recruited for the interview. All staff had worked on the Psychiatric Unit for at least four (4) years.

Two major themes emerged from the analysis of data from the mental health staff. They were: *Psychosocial Precipitants to Relapse*, and *Relapse Prevention/Coping Strategies*. There were generally six (6) sub-themes that emerged from the respondents' responses. Under Psychosocial Precipitants to Relapse, the sub-themes were: *Affective/Mood Factors*, *Interpersonal Factors*, *Environmental and Contextual Factors* and *Treatment-based Factors*. Under the Relapse Prevention/Coping Strategies, the sub-themes were: *Personal Preventive/ Coping Factors*, *Clinical Preventive Factors*, and *Family-Cultural-Religious Factors*.

4.4.1 Psychosocial precipitants to relapse

A number of psychosocial factors were recounted by the mental health staff as the commonly cited factors that influenced clients use and abuse of substances. From the analysis, mental health staff recounted several factors that are affective, interpersonal and environmental (contextual) that clients usually state as reasons for the commencement or continuous abuse of drugs.

Affective/Mood Factors

Similar to most factors stated by the relapsed respondents, the staff mentioned several negative and positive affective or mood states that clients have, along the years implicated as reasons for their alcohol or drug use and abuse. One respondent, a 32 year old female

respondent expressed how clients often cite anger as a very strong trigger for substance abuse:

...most of the clients report that they started to abuse alcohol and drugs when they became angry with either themselves or others. They feel they need to calm their nerves down. Because they lack proper coping skills and mechanisms, they end up going to drink or smoke to feel “high”. Sometimes too they abuse substances just to pick an argument with people...you know...(Respondent 3).

Another respondent, a 54 year old male respondent also recounted how clients resort to substance abuse when they become depressed:

...when you interact with some of these clients, they tell you depression was what precipitated their relapse. They usually face certain overwhelming challenges, such as when a relative dies or when they lose their job. And instead of planning to solve the problem they rather think they can drink or smoke the problem away (Respondent 1).

On the contrary, a 60 year old male respondent expressed how some clients also use and abuse drugs when they were in a happy and celebratory mood:

...for some too...it’s when they become happy or in a celebrative mood. For instance, there is one client who abuses alcohol in weeks after he’s been paid at the end of the month. One lady too, when her siblings send her money from abroad every month, she spends a good part on alcohol and cannabis (Respondent 4).

Similar to earlier narrations by some relapsed respondents, the extremes of both positive and negative emotions have served as factors precipitating alcohol and drug abuse. Respondents almost always relapsed when they encountered situations that made them glad or happy, or on the contrary, sad, distressed or poignant. Similar to non-drug users, substance abusers equally become overwhelmed during times of extreme emotional experiences, such as “when a relative dies or when they lose their job” but instead resort to alcohol and drugs either to seek for comfort or to “calm their nerves down”.

Interpersonal Factors

Interpersonal discourse that becomes confrontational, argumentative or quarrelsome could become a main factor in influencing clients to return to substance abuse. The tension that results from dissentious and contemptible relationships, such as living with a quarrelsome spouse or relative, or working under a superior who always appear hostile are but a few interpersonal relapse precipitants that clients report as having played a key influence in their relapse. In particular, mention has been made of sour relationships with relatives, friends and colleagues at home and the workplace that later develops into conflicts and animosities. During such periods, clients resort to substances either in order to be able to confront the situation or person, or to forget about the incident or person, albeit momentarily. Furthermore, others also relapse because they go back to associate with friends who still abuse alcohol and drugs.

One respondent, a 43 year old female respondent told of how she witnessed several clients return to the facility due to persistent interpersonal factors:

...oh yes. Several of them who come back here because they go through some relationship problems at home or work. Some report that they had had difficult times with their family or with colleagues and supervisors at the work place. So yes...continuous conflicts, quarrels and disagreements turn the world into an uncomfortable place for them. At the end of the day, they go and use their alcohol or marijuana again...to wash away their predicament (Respondent 5).

Another respondent, 41 year old male also added:

...for me I'd say one of the reasons why they relapse is relationship issues. These clients usually associate with other friends who continue to abuse substances. After discharge, they return to these same friends who influence them at the end of the day to start abusing drugs. The problem is it's so difficult for them to dissociate with such people... (Respondent 2.)

Conflictual relationships with relatives and co-workers leaves former drug addicts tensed and frustrated and thus end up taking solace in the very substances they have struggled to refrain.

Returning to '*these same friends who influence them*' after treatment has been reported as one major precipitating factor. As much as they desire to quit completely, some clients end up returning to these friends who continue to abuse substances. These trends were congruous to the narrations given by some of the relapsed respondents themselves.

Environmental and Contextual Factors.

Almost all respondents narrated that clients mention some environmental and contextual factors such as easy access to alcohol and drugs at home and in the community, low cost of substances and being in constant contact with the substance or with peers who still abuse substances, and continuous exposure to substances such as working with a brewery company as some triggers to relapse.

Almost all respondents stated that clients implicate environmental and contextual factors that triggered their relapse. These include staying with relatives who abuse alcohol and drugs, living in an environment with easy access to alcohol and drugs, offers at social events, working as an attendant in a drinking spot, or managing a night club. The exposure to alcohol and drugs under these circumstances after receiving treatment or rehabilitation becomes a challenge for clients to maintain their sobriety. A 60 year old male respondent expressed his view on how clients implicate these environmental and contextual factors in their relapse:

...you see...after clients are discharged, we try to educate them about abstinence and how to prevent relapse. But some stay with relatives who are also abusing the substance...and they know where the relatives keep the alcohol and the cannabis at home. Before long, you see them coming back. It's a big problem (Respondent 4).

A 43 year old female respondent also added her view on the phenomenon:

...I have seen several clients who continue to relapse because they have easy access to alcohol and drugs in their community. After discharge, when they crave for it, they just walk to the agents and purchase them...just GH 50p and GH \square 1.00. For some others too, it's where they work. One client kept relapsing until we discovered he was working with a truck that distributes and supplies alcoholic beverages (Respondent 5).

Admittedly, environmental and contextual factors are some of the most common reasons for relapse. Easy and cheap accesses to alcohol and drugs, similar to the narrations by relapsed respondents, have a great impact on relapse management. The will-power and efforts of the client are challenged under these circumstances. Free offers of substances and the type of one's occupation are undeniably real time tests of sobriety.

Treatment-based Factors

A number of facility-based factors such as non-adherence to treatment regimen, unavailability of medication and health personnel, cost of travel to facility and staff-client relationship issues have been stated by respondents as precipitants to their relapse to substance abuse. One respondent, a 32 year old female told of how non-adherence to treatment protocols by most clients continues to be a bane to their sobriety:

...for most of those who relapse, it's mostly due to non-adherence. They usually default. When they are asked to take certain medications or acquire certain coping skills to manage their withdrawal symptoms, they often default...and we do not have the means to contact them...say through telephone. At the end of the day, they end up relapsing and returning to this place (Respondent 5).

Most clients who have abused alcohol and drugs for longer time periods are known to experience certain withdrawal symptoms when they suddenly quit. Clients who do not yield to treatment protocols often relapse in their quest to manage out these symptoms in the course of their recovery.

In furtherance, the occasional shortage of medication for clients and other staff-related issues were indicated as contributory factors to relapse. One respondent, a 60 year old male narrated how the medication-personnel issues are critical in relapse prevention:

...you see...the medications are not always available. Sometimes for about a month we'd be short of supply of drugs. And it's expensive at the pharmacy shops. So even when you write a prescription, they do not go to purchase them. Again, the psychotherapist comes here once in a week. And he is only able to see few clients...(Respondent 2).

Concerning the accessibility to the facility and the staff-client relationship, one male respondent stated:

...this hospital serves a whole lot of people...from upper Ashanti through the entire Brong Ahafo region to the Northern and even neighboring Cote d'Ivoire. Some travel the whole day to get here. Again...sometimes...clients complain about the behavior of some particular staff and may not return again (Respondent 4).

The extent of the influence of factors regarding treatment on relapse state of a client is noteworthy. The unavailability of a permanent clinical or health psychologist, for instance, in a facility that serves such a large population with myriad psychosocial issues very well contribute largely to the relapse phenomenon.

4.4.2 Relapse prevention/Coping strategies

Much as there are psychosocial factors precipitating relapse, there are also several relapse preventive and coping strategies available to, and used by clients. The analysis revealed a number of coping and prevention strategies which clients usually mention as having protected them from relapsing. Spanning from personal preventive or coping factors through clinical preventive factors to contextual strategies, these strategies have been used in varied degrees to either manage the crave to use substances or coped with high-risk situations. Three sub-themes emerged: *Personal coping/preventive Strategies*, *Clinical coping/preventive strategies* and *Contextual strategies*.

Personal Preventive/Coping Factors

When inquired, most respondents narrated that clients reported employing certain preventive factors to help them cope with the urges and temptations to abuse substances. Respondents reported that some clients, most of whom have been able to quit alcohol and drug abuse, have stated that they have made use of strategies such as singing aloud, pinching or piercing a part of their body with a sharp object, hitting a limb against an object, holding their breath for a time, throwing objects around and re-arranging them up and a host of other strategies. Although these mechanisms and coping strategies may appear non-clinical and to some extent, unhealthy, a number of respondents indicated that it has been of use to them.

A 54 year old male respondent expressed how some non-relapsed clients claimed to have benefited from these personal coping and prevention strategies:

...ooh yes...some will actually tell you some funny stories...but it has worked for them. Some mention screaming or singing aloud when they crave for the substance, especially when they are alone. Others too will tell you that they hit their hand or feet against a wall or object to a quest to inflict pain on themselves so to fight the urge off (Respondent 1).

One other respondent narrated how some clients reportedly employed “breathe holding” and “object throwing” strategies to help them stay off alcohol and drugs:

...I know some few clients who said when they felt for drugs, they held their breath for about a minute or two. The ensuing discomfort takes their minds off. One other client said that he would “scatter” or mess up things in his room and spend some time to rearrange them up. Sometimes he’d mix up files and folders on his laptop and sit to put things in order. Before long the urge is gone (Respondent 5).

Similar to the narrations by non-relapsed respondents, engaging in such personally-initiated strategies can be as rewarding as those learnt in psychotherapy sessions. As much as they may cause some discomfort, they serve their intended purpose – to keep one away from relapsing. Aside teaching clients about various scientifically proven methods and relapse prevention techniques, they should be guided to explore what they think will work out for them as long as it does not impose any health risk.

Clinical Preventive Factors

Similar to relapsed clients, respondents reported that clients who have received treatment at the Unit were seen by the psychotherapist for counseling and psychotherapy depending on their condition and the availability of the psychotherapist. Clinical interventions such as the Progressive Muscle Relaxation (PMR), Emotional Imagery, Motivational Enhancement Therapy, Assertive Training, Anger Management, Managing thoughts and cravings for use, Refusing requests, and Problem-Solving Skills using the functional analysis approach have been used by clients to prevent relapse.

One respondent described how a client made good use of PMR to help control anxiety and tension experienced during his rehabilitation stage:

...yea...one client who was able to quit marijuana stated that he was taught how to relax his muscles and take deep breaths when he had strong urges to go and smoke. He testified how that method alone had been a critical factor to his eventual recovery (Respondent 3).

Another respondent, a 32 year old female also told of how several clients narrated about how they used negative thought, crave and anger managements to help them stay off the drugs:

...yes I know many clients who were able to quit substance abuse by using the techniques they were taught here. Particularly, some mention that 'Father' taught them how to manage their thoughts and cravings and control their emotions. Those who took it serious were able to quit (Respondent 2).

Unquestionably, one reason for relapse is clients' inability to rationally solve the social problems they encounter. Among other strategies, respondents stated that some clients use problem-solving skills, assertive training and better communication skills to manage their way through the rehabilitation process.

Concerning the clinical preventive strategies, another respondent added:

...I can say that majority of those who have managed to stay off drugs are those who have been able to develop problem-solving skills and good communication or assertive skills. Substance abusers face similar, if not much more problems in life than the non-drug user. They only need to learn how to say no to free offers (Respondent 1).

The list of clinical interventions for relapse prevention has been of much importance to many clients. Relational conflict was found as one major precipitant to relapse. Unquestionably, acquiring *'problem-solving skills and good communication or assertive*

skills' was one effective way of overcoming the relational and situational challenges that are often associated with the relapse prevention process.

Contextual Strategies

It has long been known that family, culture and religion are critical factors in the substance abuse relapse phenomenon. Social support, for instance, was found to be a critical determinant of whether a client will relapse or remain abstinent. Respondents posit that most clients who receive family and social support were able to quit substance use. To a significant degree, cultural elements also played critical roles in respondents' coping strategies. Cultural norms forbid children and adolescents from alcohol and drug use in the traditional Ghanaian society. Besides, older adults have the mandate and authority to reprimand younger ones who abuse substances or live a debauched lifestyle, especially in the small towns and rural areas where there is communal-type of living. Religion has also been a key factor in the relapse prevention process. Most Ghanaians profess to the Christian religion, traditional African religion, or the Islamic religion. Such a belief in a Supreme Being facilitated the recovery and rehabilitation process.

One respondent, a 43 year old female recounted how the family had been crucial in clients' ability to quit substance:

...well...I can say that the family plays a critical factor. Almost all the clients who were able to stop alcohol and drug use had their family by their side. For some other families, instead of helping the relative to fight the drug abuse behavior, they tend to fight the person himself. It doesn't work that way. The family must love the person but hate the behavior...and work to help them change the behavior (Respondent 4).

The above extract is a summary of the family's role in relation to relapse prevention. When the family understands the difference between the person as an entity and his or her behavior as a problem, they would be more prepared to assist with the recovery process.

Cultural factors hold an invaluable part in the relapse process. Norms and values are often set to regulate deviant behaviors. Adults have the obligation to correct and check the behavior of younger people. One respondent recounted how some clients have mentioned the positive influence of cultural factors in their rehabilitation process. One respondent, a 60 year old stated:

...certainly...to some extent cultural norms and values have been helpful to some clients. Some clients have said that continuously they have been advised and encouraged by the elderly and respectable people in the community to stop drug abuse. This puts some 'sense' into their heads...(Respondent 5).

To have community members put 'sense' into one's head can be both daunting and therapeutic. In spite of the accompanied frustration and shame, receiving advice and encouragement from the elderly with regard to a deviant behavior is in itself therapeutic and helpful for their recovery.

Similar to familial and cultural factors, religion has also played an invaluable role in substance abuse relapse prevention among former alcohol and drug addicts. From the analysis, respondents have indicated that most clients carried religious sentiments and religion greatly influences their decision making. Clients have attributed their ability to quit alcohol and drug abuse partly to the activities and tenets of religion they profess. Factors such as prayer and fasting, taking up an active role in church and seeking for

church counseling have been a significant contributory factor in their relapse prevention phenomenon.

A 54 year old male respondent recounted what non-relapsed clients usually say about religion concerning their recovery:

...yea...most clients state that it (religion) has been very influential in their eventual decision to quit substance abuse. In one way or the other, they would state how through prayer and fasting, deliverance or through church counseling they gave up the old habit. I think religion is an avenue mental health personnel can use to cause recovery amongst substance abusers...(Respondent 3).

High religiosity and adherence to religious beliefs enormously impacts on a person's decision making. Many religious activities such as fasting and prayer and spiritual deliverances have been associated with a drastic change of behavior as reflected in the narration above in 'giving up old habits'.

4.5 Rate of relapse

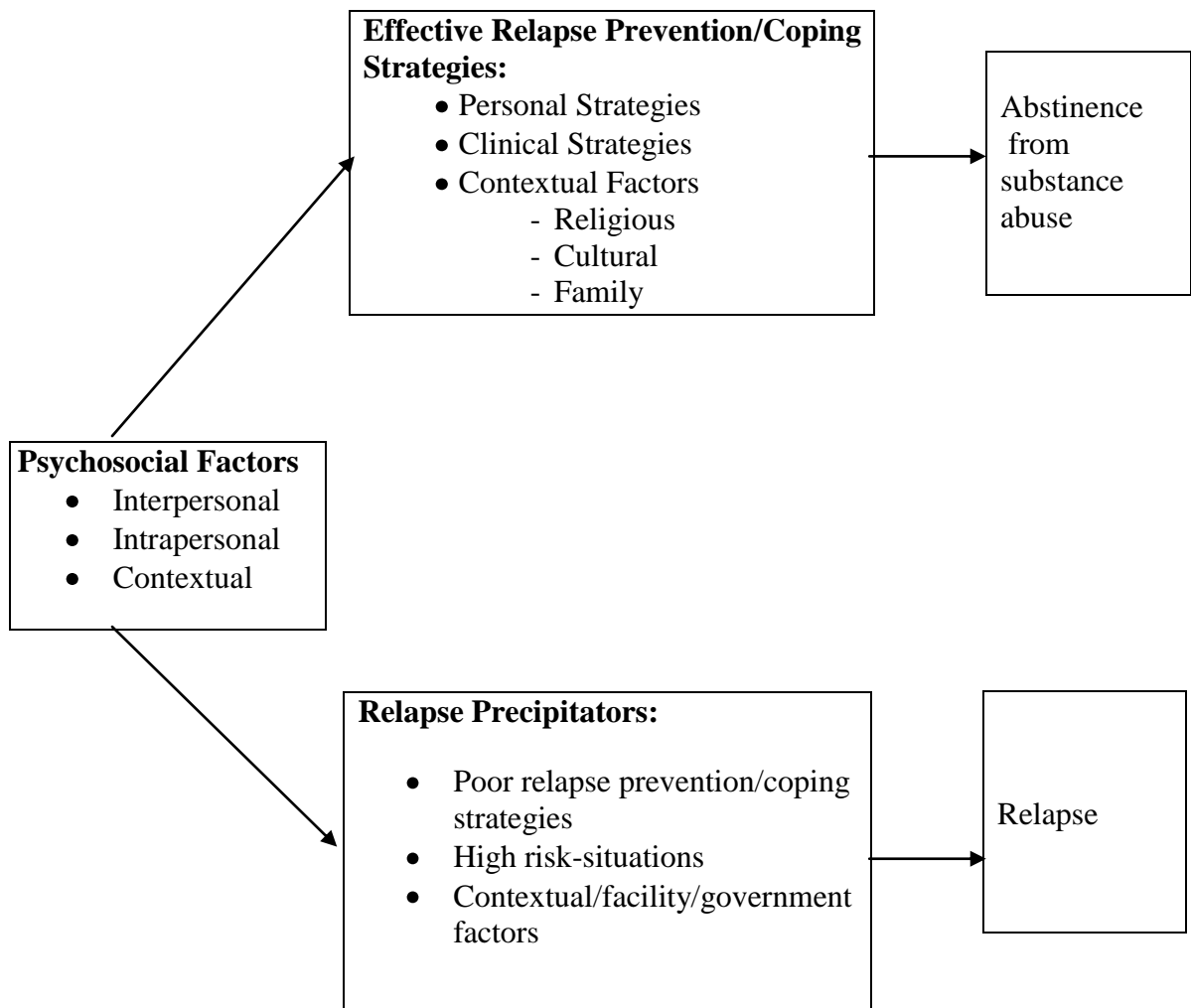
The rate of relapse – how often respondents returned to substance use after they were rehabilitated, varies among respondents. Over all, the rate of relapse depends on a number of factors including the type and number of the substance abused, number of years of abuse, individual susceptibility (biological predisposition), the post-treatment environment, family or social support and the availability of treatment options (Brownell et al., 1986; Smyth, Barry, Keenan & Ducray, 2010). The rate of relapse for the relapsed respondents was estimated descriptively using a 12-month retrospective data.

From the descriptive analysis, the findings showed that for the fifteen (15) relapsed respondents, the number of relapses for each individuals ranges from two (2) to four (4)

times within the one year period (see Table 4 in Appendix). Altogether, there were 42 relapses among the respondents for the time period, yielding an average relapse of 2.8. The average rate of relapse among respondents for the time period (12 months) was therefore 23.33%, ranging between 16.67% and 41.67%.

4.6 Model for substance abuse relapse process

The model depicted in Figure 4.1 below shows the interplay of various psychosocial factors implicated in relapse to substance abuse. It explains the relapse process, by indicating how these psychosocial factors (interpersonal, intrapersonal and contextual factors) influence relapse to substance abuse in the presence of such precipitants as poor relapse prevention/coping strategies, high risk-situations, and unfavorable family-health facility-government factors. On the contrary, the model proposes that personal, clinical and contextual (religious, cultural and family) relapse prevention and coping strategies work together to prevent relapse to substance abuse. For instance, an individual who acquires little or no coping strategies after substance abuse treatment, who lives in a community with no treatment facility, with an unsupportive family has a high proclivity to relapse to substance abuse after treatment. However, a former drug addict who developed effective personal and clinical strategies, with favorable contextual factors, is more likely to abstain and maintain sobriety.

Figure 4.1: Model for the Relapse to Substance Abuse Process

CHAPTER FIVE

DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.0 Introduction

The high incidence of substance abuse and rates of relapse to substance abuse among clients who have been treated and/or rehabilitated continue to be a major challenge for clients, relatives, clinicians, society and governments the world over. In addition to clients being confronted with physical, psychological, social and economic problems, they also become dependent on primary care-givers who themselves become non-productive having to spend all their time and resources in caring for the substance abuser. Society suffers the horrendous crimes and violence that are often associated with substance abuse whereas governments continue to spend a good quantum of resources in the treatment and rehabilitation of alcohol and drug addicts.

The present study explored the psychosocial factors precipitating relapse to substance abuse and the rate of relapse to substance abuse. Thematic content analysis was used to analyze the qualitative interviews to produce themes that were significant to the relapse phenomenon whilst quantitative means was employed to estimate the rate of relapse using a retrospective data from relapsed respondents. Using a Semi-Structured Interview Guide, respondents were interviewed to recount and share on the various psychosocial factors which have precipitated their relapse. Non-relapsed respondents also discussed their coping mechanisms and other relapse preventive strategies being used. Thematic content analysis was used to analyze the qualitative interviews to produce themes that were both emerging and a priori. Findings revealed several psychosocial factors which were both

similar and contrary to those found in other studies. The findings and implications are discussed below.

5.1 Discussion

Psychosocial precipitants to relapse

The result of the present study showed that certain psychosocial factors were consistently associated with relapse to substance abuse among previously treated substance abusers. In particular, respondents have cited variables such as positive and negative affect, sense of failure and loss, peer pressure, interpersonal conflicts, environmental and contextual factors and facility-based factors as major relapse precipitators that have influenced their relapse in varied degrees.

To a large extent, both positive and negative affects have been implicated as major factors that have contributed to the return to substance abuse after treatment. In particular, the analysis has revealed affects such as anger, frustration, sadness, boredom, stressed, worthlessness, guilty, and depressed indicators associated with respondents' relapse episodes. In their quest to resist, cope, deny or confront a problem, respondents have sought for solace in alcohol and drugs which they know would provide some comfort and desired effects. On the other hand, respondents have resorted to alcohol and drugs use to produce or increase their euphoria in times of merrymaking and at social occasions. These lapses, when not controlled, eventually lead to their relapse. This finding is consistent with the Self-medication Hypothesis (Khantzian et al., 1974; Duncan, 1974) which associates substance use and abuse to periods of negative emotional stress. The finding is similar to

the work by Hammerbacher and Lyvers (2005) which provide evidence that negative emotional states predict relapse to substance abuse. Earlier studies (McKay, 1999; McLellan et al., 1994) provide a number of positive and negative psychosocial factors that associate relapse to substance abuse among rehabilitated addicts. This influence of positive and negative affects in relapse, as found in this study, is consistent with earlier works by Chetty (2011) in South Africa and Lawal et al. (2004) in Nigeria.

Furthermore, following the analysis of the data, respondents have attributed the sense of failure or major personal loss as one major factor that had contributed to their relapse to substance abuse. Sudden, traumatic and devastating life events that affect the individual or close relatives tend to facilitate relapse among former drug addicts. The pain and sorrow that accompany the loss of a loved one, the loss of property or being diagnosed with a chronic or terminal disease becomes enough reasons to return substance abuse, especially in the absence of adequate coping strategies. This finding is similar to those by Wills et al. (1992) who found that negative life events, as well as contemporary psychological distress precipitated the use of hard drugs such as cannabis, alcohol and nicotine among the respondents. More recent research also identified the role of negative life events as a predictor of substance use and relapse (Tate et al., 2006; Kostecky, 2005). The roles of sense of failure and major personal loss as a major precipitant to relapse were not found in some of the African studies reviewed in this study (Chetty, 2011; Kuria, 2013; Lawal et al., 2004; Mahamba, 2009; Okasha et al., 1990).

From the analysis, respondents indicated the significant role that friends and other colleagues have played in their return to substance abuse. Reuniting with peers who continue to abuse drugs after treatment, or using and abusing substances in a quest to belong or to fulfil group demands are ways respondents recounted as having led them to relapse, as revealed from the analysis. A major human basic need is for acceptance and to belong. In spite of their desire to maintain sobriety and stay off alcohol and drugs, clients are faced with the challenge of associating with friends who abuse substances or joining a group who do drugs. Lawal et al. (2004) also identified pressure from peers as a critical relapse determinants in their study conducted in Nigeria. An earlier study by Hundleby and Mercer (1987) also found that peer substance use plays a significant role in predicting adolescent drug use and relapse. Similarly the work by McDonald and Towberman (1993) showed that immature adolescents who wish to belong to a gang or group, are required to experiment with drugs. Furthermore, this finding is also consistent with a recent study which found that some individuals abuse substances to be accepted into a specific social group (Nordfjærn, 2011).

It emerged from the analysis that interpersonal conflicts equally accounts for another main reason for relapse among the respondents. Continuous quarrels with loved ones at home, colleagues at the workplace or community members increase the proclivity to relapse. The analysis showed that respondents relapse to alcohol or drug abuse either to help suppress anger and frustration following an interpersonal conflicts or to enable them confront the persons whom they have issues with. In a related study, Lian and Chu (2013) found that the third most cited reason by their twenty respondents was interpersonal conflicts with

their family and others. The study by Connors et al. (2001) and Donovan and Marlatt (2005) are noteworthy as their findings, similar to that of this study showed that variables such as anger and resentment, resulting from interpersonal conflicts largely contribute to relapse. It is noteworthy that among the studies from Africa reviewed in this study, only the work by Okasha et al. (1990) identified interpersonal conflict as a significant substance abuse relapse precipitant.

Additionally, analysis of data also uncovered the fact that environmental and contextual factors were very relevant in the relapse episodes of respondents. Many factors including the work environment of the individual, living with a relative who abuses drugs, and living in a community or ghetto where alcohol and drugs are easily and cheaply available were common contextual and environmental factors that have aided relapse among the respondents. This finding is similar to an earlier one by Glynn (1981) who suggested that among adolescents, those whose parents abuse substances stand a greater risk of relapsing after discharge from drug rehabilitation as parents serve as models. This is especially true when there is a strong parent-child relationship. Another finding in the work of Andrews, Hops, and Duncan (1997) correlates to that of this study, suggests the influence of parents' alcohol and drug use state on children's alcohol and drug use behaviour, as well as the work environment of the individual in precipitating relapse.

In addition, the analysis of the present study has shown that treatment-based factors, including unavailability of medication and health personnel, non-adherence to treatment regimen, cost of travel to treatment facility and staff-client relationship issues have been

stated as variables that have contributed in various ways to influence the relapse process. In times of short of supply of medication, some respondents are unable to afford the cost of the medications from the pharmacy shop. Likewise, the cost involved in travelling from long distances to the treatment facility has been a challenge to many clients, thus resulting in their eventual relapse. This finding is congruent with the work by McLellan et al. (2000) and Nestler (2002) who also found that inadequate health personnel, unavailability of treatment facilities and shortage of medications, as well as the use of ineffective traditional treatment and rehabilitation models contribute to the relapse of former drug addicts. This finding is consistent with the work by Mahamba (2009) who also found poor referral system, non-compliance and lack of home visits as critical relapse determinant.

Contextual factors in substance abuse relapse

That familial, cultural and religious factors play critical roles in substance abuse relapse is an understatement. In various instances and degree, respondents stated the circumstances under which they relapsed or maintained sobriety following familial, cultural and religious influences. For the most part, respondents have stated that religious factors served as relapse protectors than as relapse precipitants.

In particular, from the analysis, some relapsed respondents reported attitudes such as hostility, withdrawal of assistance such as financial, educational, job placements and the lack of demonstration of love from relatives as some means by which their families' actions and inactions have contributed to their relapse. When relatives become hostile and thus provide no psychological and other social support to people rehabilitated from

substance abuse, the inclination to relapse becomes higher and oftentimes imminent. Some respondents noted that several months after their rehabilitation, some relatives still consider them as ‘mentally sick’ and thus offer little or no support to them. Instead, they tend to develop poor and hostile relationships with them. When this attitude continues for a long period, clients may become incapable of bearing the frustration and thus return to substance use for the accompanied desirable effects. This finding corresponds with the work of Ibrahim and Kumar (2009) who, exploring factors influencing relapse among rehabilitated drug addicts, noted that relapse becomes imminent when family and social supports are unavailable. Mahamba (2009) also reported similar finding.

Furthermore, the various means by which cultural elements influenced respondents to relapse to substance use were also well recounted. The analysis revealed high-risk situations such as being offered strong alcoholic drinks at traditional social events including funerals, engagements and weddings, naming ceremonies, festivals and a host of other events. During these instances, it is socially expected to accept and consume the offered drinks. In particular, the analysis indicated that the lack of social and financial support, rejection by family, and the practice of certain cultural tenets all encumber the client’s efforts to abstain from alcohol and drug abuse. This finding is congruent with those in other studies, such as the work of Chen et al. (2004), who reported that ethno-cultural identity and religiosity have been found to be protective of substance use and relapse to substance abuse. Their study indicates that there was a reduction or non-initiation of alcohol consumption in people with high levels of religious practice and

religious devotion. In a related work, Blum et al. (2003) had found that people who become highly religious are more unlikely to relapse to substance abuse after treatment.

Consequences of relapse to substance abuse

The negative effects and other consequences of continuous substance abuse and relapse on the individual, family, society and the nation remain incontestable. Certainly there are biological (physical), psychological, social and economic consequences. Analysis from this study showed that respondents suffer unemployment, loss of a cherished relationship and respect, medical illnesses and psychological effects including hallucinations and suicidal thoughts.

The difficulty to maintain sobriety, following alcohol and drug dependence, makes it very challenging for clients to maintain a job or perform effectively at work as required. Lateness and inability to meet deadlines, conflicts with clients and colleagues as well as errors and inaccuracies with information and inconsistencies with work are but a few reasons for respondents' inability to maintain their jobs. A number of studies on the social and economic effects of substance abuse have also stated similar findings. The work by Pressley and McCormick (2007) and Burger (2008) are noteworthy. Among other effects, their studies listed poor job performance and inability to remain employed as major consequences suffered by substance abusers.

Findings from this study have also revealed that respondents reported some physical symptoms which they associate with the substance use and abuse. Insomnia, migraine,

pain around the eyeballs, memory loss and hallucinations were reported by some respondents soon after or a while after substance use. The works by Davison et al. (2004) and Kring et al. (2007) both provide a listing of several physical effects in individuals who abuse substances. While researching with respondents who had abused substances for several decades, their findings provide similar but a more comprehensive and advanced consequences, including cancer, stroke, suicidal ideations and heart failure which were not reported by the respondents in this study.

From the analysis, some other respondents had indicated that they had had problems with the law as a result of their substance use. Respondents reported being involved in conflicts, fights and other crimes which put them into trouble with the law. Alcohol and drugs are psychoactive stimulants that work to alter the perception and the realities of the abuser. The actions and consequences that occur following the ingestion of a substance are often without a thorough and objective evaluation and thus resulting in deviant behaviours which often contradicts with communal and state law. Asbridge, Hayden and Cartwright (2012) have found that the continuous abuse of marijuana, for instance, is accompanied with several biopsychosocial consequences including double risk of car crashes and problems with state laws.

Coping/Relapse preventive strategies

A number of coping and relapse prevention strategies have emerged from the analysis of the data. Respondents (non-relapsed clients and mental health staff) have shared on various coping skills and other relapsed prevention strategies they employed (or clients

reported employing) to help them remain off the substances. Largely, these are classified at the individual level and clinical interventional levels. In their quest to prevent themselves from relapsing, respondents reported having employed certain personal strategies they considered helpful. In particular, some recounted singing or screaming aloud, pinching a part of their body, hitting a limb against an object, or holding their breath for a time when they felt a strong urge – crave to use the substance for which they have been rehabilitated. In furtherance, others resorted to throwing objects, such as playing cards or a set of items at home around and re-arranging them up, rushing to take a bath, and playing games on their phone or computer and a host of other strategies. These strategies, although not a long term panacea to relapse, helps clients to temporarily fight off the sudden, strong urge (crave) by diverting their attention and energy. Similar personal coping strategies have been discussed by (Marlatt, Parks & Witkiewitz, 2002; Witkiewitz & Marlatt, 2004).

In addition, the analysis revealed that respondents employed several clinical, evidenced-based therapeutic interventions to help prevent them from relapsing. In particular, respondents who had had counselling and therapy sessions with the psychotherapist reported having employed, aside some personal coping strategies, a wide range of clinical relapse prevention strategies. Amongst other interventions, respondents recounted engaging in Progressive Muscle Relaxation (PMR), deep breathing exercises, emotional imagery, motivational enhancement therapy (MET), assertive training, anger management, negative thought restructuring and cravings for use, refusing requests, and problem-solving skills (Baker, et al., 2006; Vaughn & Howard, 2004).

The success of the intervention, however, depended on the individual's mastery of the specific strategy as well as its application at the right time under the right circumstance. In part, this could account for some respondents' continuous relapse in spite of receiving similar substance abuse therapy as others – a perspective consistent with the Cognitive-behavioral Model of Relapse Process (Marlatt & Gordon, 1985; Witkiewitz & Marlatt, 2004).

Rate of relapse

Altogether, there were 42 relapses among the 15 relapsed respondents within the 12 month period the rate was estimated, yielding an average relapse of 2.8. The average rate of relapse among respondents for the time period (12 months) was therefore 23.33%, ranging between 16.67% and 41.67%.

The average rate of relapse found from this study is comparatively lower than the 66% rate of relapse found among the 109 recruits by Barry, Keenan and Ducray (2010) within the first week after discharge from treatment. Furthermore, the resultant rate is also lower than the 68% found by Williams and Chang (2000) in rehabilitated addicts a year after discharged. It is also lower than the 56% found by Winters et al. (2000) in alcohol and cannabis abusers a year after they had received treatment. Nonetheless, in spite of the small sample size, the 23.33% average rate of relapse found in this study is comparatively similar to the 22% rate of relapse for the women and 32% for the men that Fiorentine et al. (1997) found as they explored the rate of relapse in cocaine users 6 months after treatment in 182 women and 148 men in 26 public outpatient drug abuse treatment program.

Undoubtedly, the differences in the rate of relapse found in this study as compared to those found in other studies was influenced by the type of substance(s) in question, the duration of abuse, the duration of the study and the number of respondents recruited for the study. It is worth stating that, similar to other studies, majority of the respondents were males. Out of the total of twenty-five (25) relapsed and non-relapsed respondents, only four (4) were females (see Table 1 in Appendix). Although increasing number of females may be abusing alcohol and drugs, substance abuse among males remain high. Ghana, been largely a patriarchal society, masculinity is desired and upheld. For instance, males serve and are served with alcoholic drinks in traditional gatherings and family meetings. Alcohol and drugs may be abused as appetizer and for sexual enhancement, exposing more males to substances than females.

On the average, from Figure 4.1 (see Appendix), most respondents (n=15) returned to substance use during the third and fourth months after discharged from treatment and rehabilitation, with first and twelve months recording the least number of relapse. This finding is similar to the works by (Brownell et al., 1986; Cornelius et al., 2003; Kuria, 2013; Marlatt & Gordon, 1985; Winters et al., 2000) who found most participants relapsed by the third to sixth months after receiving treatment. However, this finding contrasts the work by Brandon, Vidrine and Litvin (2007) that found relapse rate of 80 – 90% among clients one year after discharge.

Limitations of the study

The procedure followed in this study was useful in exploring the psychosocial precipitants and rate of relapse among the respondents. Nevertheless, there were some limitations which include generalizability and the inclusion of all substances of abuse in the study.

Generalizability refers to the ability to apply the theory or result of the study to them population of interest (Auerbach & Silverman, 2003, Maxwell, 1992). The findings from the study lack external validity, which is problematic of qualitative research (Creswell, 2013). However, the study demonstrates internal generalizability in that the resultant findings which are developed from repetitive themes and patterns of relapse precipitants among substance abusers in the Sunyani Metropolis may be applicable to rehabilitated substance abusers in other health facilities in the country. However, the unique characteristics of each setting and the purposive sampling method may affect the applicability of the findings (Reece, 2007).

Furthermore, the findings from this study are not specific to a particular substance of abuse. Both single and multiple substance abusers were included in the study. The findings therefore do not reflect on a particular substance of interest, but for all substances operationalized to include alcohol, tobacco, heroin and cocaine.

5.2 Recommendations and implications for clinical practice

In light of the findings, it is recommended that further studies be conducted using the quantitative research design with larger sample size to further expand on the themes that have emerged from this study. It will also be necessary to carry further studies using

samples of respondents from across the various hospitals and rehabilitation centers in the country. Such triangulation will enable the researchers and clinicians identify key relapse precipitants that are contextual to this country so as to develop a more effective relapse coping and preventive strategies.

It is further recommended that whilst this study has included all the substances of abuse, further studies can be carried out to explore the relapse precipitants, process and the rate of relapse of a particular substance among particular age groups.

Furthermore, it is recommended also that government, the Ministry of Health, the Ghana Psychological Association, individual Clinical Psychologists and primary care-givers of substance abusers become familiarized with the findings from this study in order to advocate for appropriate psychotherapeutic interventions as well as be guided in the selection and application of more appropriate relapse prevention strategies for clients.

In addition, working through Community Psychiatric Nurses, the Ministry of Health and all Psychiatric Hospitals and Units should institute an effective and workable follow-up system to reach discharged clients to enforce treatment adherence and review. In particular, using the findings of this study, the Ghana Psychological Association could liaise with some telecommunication networks to provide practicing clinicians with toll free telephone numbers to serve as a platform for both clients and clinicians to reach each other.

On a theoretical basis, the implications of this study, consistent with other studies and theories, suggest that there is interplay of a number of psychological and social factors that precipitates relapse to substance abuse. Often times, intricately intertwined, these factors initiates, maintains or progresses a lapse to full blown relapse to substance abuse after treatment.

On the clinical level, the present study has significant implications for personnel in the mental health field. Clinicians are made aware of plausible variables and factors that could work against the efforts of both clients and clinicians in relapse prevention and therefore guide them to explore further on such psychosocial precipitants as found in this study.

As evidenced from Table 1, majority of the relapsed and non-relapsed respondents were in their youthful ages. From the analysis, most of them started abusing substances from their during their Senior High School days. It is recommended that the Ministry of Education introduces and intensifies substance abuse education at this level of education, in particular, to help curb the menace.

More than ever, the findings underscore the need to employ Clinical Psychologists to all regional and district hospitals to manage substance abuse and the several other psychological disorders. This study commends that the Ministry of Health engage the services of clinicians as recommended in the Ghana Psychological Law and the Ghana Mental Health Law.

Lastly, it is recommended, following the critical role of family and social support in the relapse process that clinicians engage relatives and primary caregivers in the treatment process. Clinicians should provide education to families on the critical role they can play in the relapse prevention and assign them their respective roles.

5.3 Conclusion

In this study, the researcher explored the psychosocial factors that precipitate relapse and the rate of relapse to substance abuse. Several were found to speed up a lapse into a full blown relapse among relapsed respondents. A number of biopsychosocial and economic consequences were found to accompany the continuous relapses that affect the individual, family, community and nation as a whole. Among the non-relapsed respondents, personal and clinical coping and relapsed prevention strategies were employed to help them prevent relapse. Using retrospective data from the relapsed respondents, the rate of relapse was also estimated. Findings from this study are expected to inform and guide clinicians about the psychosocial factors that precipitate substance abuse relapse as well as guide them to develop a more effective coping and preventive strategies.

It is expected that this qualitative study will spark more research interest to investigate the exactitude and generalizability of these psychosocial factors that precipitate former substance abusers to relapse and to expound the coping and relapse prevention strategies clients employ to prevent relapse.

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APPENDICES**APPENDIX A****CONSENT FORM****SECTION A – BACKGROUND INFORMATION**

Title Study:	Psychosocial Precipitants And Rate Of Relapse Of Substance Abusers: A Case Study Of Sunyani Metropolis
Principal Investigator	Richard Appiah
Certified Protocol Number	

SECTION B – CONSENT TO PARTICIPATE IN RESEARCH**General Information about Research**

You are invited to participate in an academic research project which is aimed at exploring the psychological and social factors that precipitate relapse and the rate of relapse of substance abusers. I am investigating this topic to understand the nature, pattern and influence of these precipitants on relapse to substance abuse. The findings will aid clinicians develop better relapse prevention strategy. It is a face-to-face interview that will require you to describe in depth your experience with the relapse phenomenon. It is estimated to take between 45 minutes to 1 hour. Feel free to ask questions if you do not understand something.

Possible Risks and Discomforts

You may experience fatigue as a result of long period of interview. You will be given ample time in the form of periodic breaks to prevent fatigue during the interview. You are required to answer to the questions as applied to your case and not from a general viewpoint. Your responses will be digitally recorded and notes taken where necessary.

Possible Benefits

This study was not planned to benefit you directly. Nonetheless, your participation in this research will enrich the understanding of the psychosocial factors that precipitate the relapse of substance abusers and the rate at which this relapse occurs. Clinicians will be guided by the findings from this study to develop a more effective substance abuse relapse preventive strategy.

Confidentiality

Your responses will be treated with utmost confidentiality. Only the researcher and approved research assistants will have access to the individual data you will provide. The results will be reported descriptively and under no circumstances will any individual participant be identified in a publication or presentation describing this study.

Compensation

This study will not include any compensation apart from a verbal appreciation of your valued time and efforts.

Withdrawal from Study

Your participation in this study is entirely voluntary. You may refuse to participate in this research without any penalty. You may at any time, for any reason, discontinue your participation without any negative consequences after having begun as a participant.

Contacts for Additional Information

The following numbers can be contacted in case of any discomfort, explanation or further information.

Researcher: Richard Appiah (Tel: 0245823866)

Principal Supervisor: Prof. Emeritus Samuel. A. Danquah (Tel: 0265191590)

SECTION C – VOLUNTEER AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

Name of Volunteer

Signature or mark of volunteer

Date

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Name of witness

Signature of witness

Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

Name of Person who Obtained Consent

Signature of Person Who Obtained Consent

Date

APPENDIX B**SEMI-STRUCTURED INTERVIEW GUIDE**

ID No.....

Time started..... Time ended.....

**SECTION A
BIOGRAPHIC DATA**

1. Sex: a). Male _ b). Female _
2. Age
3. Marital status
 - a). Married _ b). Single _ c). Divorced _ d). Cohabiting _
 - e). Widowed _ f). Other Specify
4. Level of education
 - a). Basic school_ b). Secondary school_ (c) Tertiary_
5. Occupation
 - a). Student _ b). Unemployed _ c). Self-employed _ d). Public
Servant _
 - e). Other Specify
6. Substance use treatment regimen
 - a). Medication Only_ b). Medication and Psychotherapy_ c). Psychotherapy
Only_
7. Years after 1st substance abuse diagnosis.....
8. Client's diagnosis.....
9. Period of abstinence before first relapse.....
10. Number of previous relapse episodes.....

SECTION B (For Relapsed Participants)**QUESTION 1.**

What substance (s) do you use and how long have you used them?

QUESTION 2.

Please tell me about the psychological and social factors that have influenced your return to substance use after treatment.

QUESTION 3.

How has other factors (such as the family, culture and religion) influenced or protected your relapse?

QUESTION 4.

What physical, psychological, social and economic effects has the relapse brought to you, your family and society?

SECTION C (For Non-relapsed Participants)**QUESTION 1.**

What substance (s) did you use and how long have you used them?

QUESTION 2.

What coping or preventive strategies have you used to prevent you from relapsing?

QUESTION 3.

How has other factors (such as the family, culture and religion) helped your abstinence?

SECTION D (For Mental Health Staff)**QUESTION 1.**

What psychological and social (contextual) factors have clients cited as reasons for their substance abuse and relapse?


QUESTION 2.

What coping mechanisms and other protective factors have clients cited as having protected them from relapse?

QUESTION 3.

What other reasons (such as the family, cultural and religion) have clients cited as having precipitated or protected their relapse?

APPENDIX C
Ethical Clearance Letter

 **UNIVERSITY OF GHANA**
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

20th January, 2014

Mr. Richard Appiah
Dept. of Psychology
University of Ghana
Legon

Dear Mr. Appiah,

**PROTOCOL ECH 005/13-14: PSYCHOSOCIAL PRECIPITANTS AND RATE OF RELAPSE OF
SUBSTANCE ABUSERS: A CASE STUDY OF SUNYANI METROPOLIS**

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities and the following actions taken subject to the conditions and explanation provided below:

Expiry Date: 14/01/15


On Agenda for: Initial Submission

Description: 10/10/13


ECH Action: Approved

Please accept my congratulations.

Yours Sincerely,


Prof. J. O. Y Mante
ECH Chair

CC: Director, ISSER



APPENDIX D
Letter of Introduction



UNIVERSITY OF GHANA
DEPARTMENT OF PSYCHOLOGY

Tel: (233-0302) 500381 Ext. 3754/3310 P. O. Box LG 84, Legon Ghana E-mail: psychology@ug.edu.gh
028 955 04 63

Our Ref. No
PSYC 2/33/01

24th January, 2014

The Regional Hospital-Sunyani
P.O. Box 27
Sunyani
Brong -Ahafo
Ghana

Dear Sir/Madam,

LETTER OF INTRODUCTION
MR. RICHARD APPIAH

The above-named is an M.Phil Clinical Psychology student at the University of Ghana, Legon.

In partial fulfillment of the requirement for the awards of the M.Phil degree Mr. Richard Appiah has to write and submit an original thesis.

He has selected the topic: "*Psychosocial Precipitants and Rate of Relapse of Substance Abusers: A Case Study of Sunyani Metropolis.*"

To enable him collect data for his work he would need to administer questionnaires and/ or conduct interviews. He has selected your institution as suitable for his data collection.

Any assistance you may give him would be greatly appreciated.

Yours faithfully,

(Prof. C. C. Mate-Kole)
HEAD OF DEPARTMENT

LIST OF TABLES**Table 1: Demographic Characteristics of Respondents.**

Participant	Age	Gender	Educational Level	Occupation	Marital Status	Category	Number of treatment episodes prior to the study	Length of time drug free (years)	Length drug use (years)	Substance of abuse
1	26	M	Secondary	Unemployed	Single	Relapse	2	-	4	Alcohol/ Cannabis
2	30	M	Tertiary	Self-employed	Single	Relapse	3	-	3	Marijuana
3	22	M	Basic	Unemployed	Single	Relapse	3	-	4	Marijuana/ Alcohol
4	24	M	Tertiary	Self-employed	Single	Relapse	1	-	2	Tobacco/ Alcohol
5	43	M	Secondary	Unemployed	Married	Relapse	5	-	2	Alcohol/ Cannabis
6	27	F	Basic	Unemployed	Co-habiting	Relapse	3	-	3	Alcohol
7	41	M	Secondary	Self-employed	Married	Relapse	2	-	6	Marijuana/ Cocaine
8	25	M	Secondary	Unemployed	Single	Relapse	2	-	2	Marijuana
9	28	M	Basic	Unemployed	Single	Relapse	4	-	4	Cannabis/ Marijuana
10	34	M	Secondary	Self-employed	Married	Relapse	2	-	2	Alcohol
11	29	F	Secondary	Unemployed	Married	Relapse	3	-	1	Alcohol/ Tobacco
12	35	M	Tertiary	Public Servant	Married	Relapse	3	-	1	Marijuana
13	49	M	Tertiary	Unemployed	Co-habiting	Relapse	3	-	8	Alcohol/ Cannabis
14	29	M	Secondary	Self-employed	Single	Relapse	4	-	6	Marijuana
15	32	M	Basic	Self-employed	Married	Relapse	3	-	4	Alcohol/ Marijuana
16	24	M	Secondary	Unemployed	Single	Non-relapse	2	2	2	Alcohol/ Cannabis
17	38	M	Secondary	Unemployed	Married	Non-relapse	1	2	4	Marijuana
18	31	M	Basic	Unemployed	Divorced	Non-relapse	1	3	3	Marijuana
19	40	M	Tertiary	Public Servant	Married	Non-relapse	3	1	2	Cocaine

Participant	Age	Gender	Education Level	Occupation	Marital Status	Category	Number of treatment episodes prior to the study	Length of time drug free (years)	Length of drug use (years)	Substance of abuse
20	31	M	Secondary	Unemployed	Married	Non-relapse	2	3	2	Alcohol
21	54	M	Tertiary	Public Servant	Divorced	Non-relapse	3	2	4	Alcohol
22	39	M	Tertiary	Public Servant	Married	Non-relapse	1	3	4	Marijuana
23	31	M	Secondary	Unemployed	Single	Non-relapse	1	4	3	Alcohol/ Marijuana
24	24	M	Basic	Unemployed	Single	Non-relapse	2	2	4	Tobacco/ Marijuana
25	29	F	Secondary	Unemployed	Single	Non-relapse	1	3	4	Alcohol
26	41	M	Tertiary	Public Servant	Married	Mental Health Staff	—	—	—	—
27	32	F	Tertiary	Public Servant	Single	Mental Health Staff	—	—	—	—
28	43	F	Tertiary	Public Servant	Married	Mental Health Staff	—	—	—	—
29	54	M	Tertiary	Public Servant	Married	Mental Health Staff	—	—	—	—
30	60	M	Tertiary	Public Servant	Married	Mental Health Staff	—	—	—	—

Table 2: Relapsed Respondents' Themes

PARTICIPANTS	GENERATED THEMES
Relapsed Participant 1	Alcohol and marijuana, 6 years, feelings of boredom, when angry with self or others, overcome depression, feeling lonely, pressure from friends, stimulant for sex, being unemployed, neglect by family, culture permits alcohol use, withdrawal from religious activities, abstained for three months, loss of respect, unemployment, failure in life, suicidal thoughts, rejection/neglect by loved ones
Relapsed Participant 2	Alcohol, 4 years, pressure from peers in school, experience of frustration, to relief physical pain, being in conflicts and arguments with others, being angry with others, being served alcohol during social occasions, family “gave-up” on me, abstained for 9 months, sense of failure in life, having poor relationships, experiencing financial crisis, loss of respect
Relapsed Participant 3	Tobacco and alcohol, 8 years, divorce, experience of personal loss, to relief self from pain and anguish, feeling of loneliness, feeling of sadness, spiritual attack, family has been supportive, church has been helpful, 6 months of refrain, health problems, underemployment, disgrace to family, “swimming” in poverty
Relapsed Participant 4	Marijuana, 6 years, peer pressure, sense of freedom, substance availability, sense of loneliness, frustration, availability of substance, sense of failure, withdrawal from religious (church) activities, 11 months, unable to save, loss of respect, suicidal thoughts, neglect by loved ones, unemployment, dissension between parents
Relapsed Participant 5	Alcohol and marijuana (“laka”), 6 years, frustrations in life, feelings of guilt, conflicts and arguments with mother, influences from peers, having been neglected by family, substance availability, substance use by elder brother, abandonment by family, not partaking in religious (church) activities, 13 months, loss of job, problems with law enforcement agencies, health problems, family acting aloof and withdrawn
Relapsed Participant 6	Cocaine and marijuana, 8 years, for fun and relaxation, having experienced divorce, offers during funerals and parties, having fights and arguments with others, for relief from pain and anguish, loss of a loved one or property, little or no encouragement and support from family and friends, rejection by family and friends, no cultural and religious influence, 7 months, breakdown of marriage, problems at workplace, neglect by family
Relapsed Participant 7	Alcohol and tobacco, 6 years, sense of self-worthlessness, being served alcohol at social events, for relaxation after hard work, during financial crisis, having received money, no offer of support and encouragement from family, culture permits alcohol use at social events, almost 7 months of abstinence, problems at workplace, unable to save salary, problems with marriage and relationships, being disrespected by neighbors

Relapsed Participant 8	Alcohol and marijuana, 11 years, sadness (tragic loss of parents in road traffic accident and loss of baby), to relief occasional experiences of anxiety, easy substance availability in community, short in supply of medication, non-adherence, freedom from family scrutiny, stopped for 2 years before starting again, high expenditure on drugs, frequent health problems, problems at workplace
Relapsed Participant 9	Marijuana and alcohol (“laka”), 3 years, spiritual problem in family, frustration, neglect by family and friends, influence from friends and relatives for continuous use, no significant influence by culture and religion, 3 weeks, psychological problems (hallucinations), migraine, health problems, poor relationship with family and others
Relapsed Participant 10	Marijuana, 6 years, to feel belonged, during times of sadness/anger, pressure from friends, nature of work, low cost of substance, initial support by family, continuous support/counseling by religious group members, 8 months, neglect by family and others, loss of valued relationships, stigmatization from neighbours
Relapsed Participant 11	Cocaine and alcohol, 5 years, to feel “high”, to cope with depression, to cope with boredom, feelings of disappointments by family, family not very supportive, not very religious, 7 months, have no career, family unconcerned with my welfare, multiple relationships breakdown, serious withdrawal symptoms, social stigma
Relapsed Participant 12	Alcohol, 8 years, periods of frustration, in times of depression, influence from friends, free offers at social events, criticisms by family, culture protection (frowns on women drinking), spiritual interventions at prayer-camps, 9 months, disgrace to self and family, health problems, wayward children, marital conflicts
Relapsed Participant 13	Marijuana and alcohol (“laka”), 4 years, to enhance academic performance, feeling lonely, pre-requisite for group belongingness, constant disagreement/conflicts at home, family influenced my relapsed, religious (church) folks were very condemning, loss of respect, occasional hallucinations/headache, family neglect
Relapsed Participant 14	Alcohol and tobacco, 11 years, concerns about responsibility, traumatic experience of spouse’s death, conflicts with children, family unhelpful, culture and religion quite helpful to abstain, 1 year and 3 months, loss of respect, unemployment, health problems, divorce
Relapsed Participant 15	Marijuana and alcohol, 6 years, to sexual strength, fear of rejection by fiancée, nature of job (bar-attender), free and easy access to alcohol, family and religion has no influence, 11 months of abstinence, health problems (migraine and seizure), relationship problems, disgrace and stigma to self and family

Table 3: Non-Relapsed Respondents' Themes

PARTICIPANTS	GENERATED THEMES
Non-Relapsed Participant 1	Alcohol and tobacco, 9 years, changed job, church participation, , family support, pastoral counseling/advice,
Non-Relapsed Participant 2	Marijuana and alcohol, 11 years, destroying substances and relocating, psychological interventions, culture's negative reinforcement,
Non-Relapsed Participant 3	Alcohol, 6 years, religious intervention, informing friends of decision to quit, fast and prayer,
Non-Relapsed Participant 4	Marijuana and tobacco, 8 years, positive verbal reinforcement, exercise, change of job, good family support, relaxation
Non-Relapsed Participant 5	Cocaine, 11 years, religious intervention, family support, counseling, relaxation, time-out, thought stopping
Non-Relapsed Participant 6	Alcohol, 9 years, self-help group, relaxation, relocation, family support, counseling, assertiveness training
Non-Relapsed Participant 7	Marijuana, 12 years, religious intervention, culture's negative reinforcement, family support,
Non-Relapsed Participant 8	Alcohol and marijuana, 10 years, self-punishment, counseling, building new positive friendship and activities cultural/social factors,
Non-Relapsed Participant 9	Marijuana and tobacco, 8 years, change of job, family support, fast and prayer,
Non-Relapsed Participant 10	Alcohol, 13 years, counseling, culture's negative reinforcement, family support, religious intervention

Table 4: Mental Health Staff Respondents' Themes

PARTICIPANTS	GENERATED THEMES
Mental Health Staff 1	Frustrations of life, feelings of boredom and loneliness, feelings of sadness, craving, friends, offer at social events, shortage of medical supplies, distracting oneself, identifying triggers, relaxation, time-outs, positive self-talk, prayer and fasting, diverse cultural support
Mental Health Staff 2	Anger, frustrations of life, sense of failure, pressure from friends, non-adherence to treatment, availability of alcohol at home, type of job, feeling lonely and bored at home, unemployment, positive self-talk, spending time with family,
Mental Health Staff 3	Peer pressure, boredom at home, unemployment, poverty, shortage of medication, loss of valued relationship and property, depression, to relieve pain and anguish, building new positive friendship and activities
Mental Health Staff 4	Disappointments and failures in life, depression, lack of proper coping skills, pressure from friends, easy access of alcohol in community and home, lack of a full-time clinical/counseling psychologist, distracting oneself, identifying triggers, building new positive friendship and activities
Mental Health Staff 5	Inability to withstand cravings, neglect by family, conflicts and arguments with others, type of client's job, inability to make contact/follow-up, positive self-talk, spending time with family, religious/spiritual interventions,

Table 5: Retrospective Data on Relapse Episodes for Relapsed Respondents

PARTICIPANTS	DATE FIRST SEEN (DFS)	1 ST MONTH (DFS)	2 ND MONTH	3 RD MONTH	4 TH MONTH	5 TH MONTH	6 TH MONTH	7 TH MONTH	8 TH MONTH	9 TH MONTH	10 TH MONTH	11 TH MONTH	12 TH MONTH
1	16/06/12			Relapse				Relapsed				Relapsed	
2	02/04/12		Relapsed			Relapsed					Relapsed		
3	13/04/12				Relapse					Relapsed			
4	18/01/12	Relapsed				Relapsed			Relapse				Relapsed
5	11/03/12			Relapse				Relapsed					
6	19/06/12		Relapsed				Relapsed			Relapsed			
7	03/03/12		Relapsed				Relapsed			Relapsed			
8	09/01/12				Relapse			Relapsed				Relapsed	
9	29/03/12			Relapse			Relapsed						
10	07/02/12	Relapsed				Relapsed			Relapse				Relapsed
11	28/04/12				Relapse				Relapse		Relapsed		
12	08/05/12		Relapsed				Relapsed					Relapsed	
13	10/04/12				Relapse					Relapsed			
14	19/03/12			Relapse		Relapsed						Relapsed	
15	30/01/12			Relapse			Relapsed						

Figure 1: Average relapse rate of Relapsed Respondents for 12 months