



ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND LANGUAGE STUDIES

SCHOOL OF PSYCHOLOGY

**PSYCHOSOCIAL PREDICTORS OF RELAPSE RISK AMONG SUBSTANCE
USE DISORDER PATIENTS IN MENTAL HEALTH FACILITIES IN**

ADDIS ABABA, ETHIOPIA.

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JUNE, 2026

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Addis Ababa University

College of Education and Language Studies

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**Psychosocial predictors of relapse risk among patients with substance use disorders in
mental health facilities in Addis Ababa, Ethiopia**

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Declaration

Tizitawork Enkubahiry Woldemedhin, hereby declares that the thesis on the title “Psychosocial predictors of relapse among patients with substance use disorder in mental health facilities in Addis Ababa, Ethiopia” Is my original work and it has not been presented for any academic purpose in any other university prior to this time and that all source of materials used for thesis have been properly acknowledged.

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ABBREVIATIONS AND ACRONYMS

AAU	Addis Ababa University
APA	American Psychiatric Association
AWARE	Advanced WARNING of RELapse
DSM –	Diagnostic and Statistical Manual of Mental Disorders
DSM-IV-TR Revision	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
GBD	Global Burden of Disease
IRB	Institutional Review Board
LMICs	Low- and Middle-Income Countries
MA	Master of Arts
MSPSS	Multidimensional Scale of Perceived Social Support
PSAS	Perceived Stigma of Substance Abuse Scale
SPSS	Statistical Package for the Social Sciences
SUD	Substance Use Disorder
UCLA	University of California, Los Angeles
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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ABSTRACT

Substance use disorder is a major public health concern characterized by high rates of relapse, which negatively affects treatment outcomes and long term recovery, and despite the existence of treatment programs, psychosocial factors such as loneliness, perceived stigma, and social support remain insufficiently understood as predictors of relapse, particularly in the Ethiopian context. As a result, this study assessed psychosocial factors as predictors of relapse among patients with substance use disorder receiving treatment in mental health facilities in Addis Ababa, Ethiopia. The study was conducted using an institution based cross sectional design, and a consecutive sampling technique was employed to select 422 patients receiving treatment for substance use disorder in selected mental health facilities. To gather relevant data, the research employed standardized questionnaires, including the AWARE scale for relapse, the revised UCLA Loneliness Scale, the Perceived Stigma of Addiction Scale (PSAS), and the Multidimensional Scale of Perceived Social Support (MSPSS), and the data were analyzed using IBM SPSS Statistics version 26 through descriptive statistics, Pearson correlation analysis, and multiple linear regression analysis, with statistical significance considered at $p < .05$. Among the main findings of the study, all three psychosocial factors predicted relapse independently and jointly, with loneliness and perceived stigma positively associated with relapse ($\beta = .465$, $p < .05$ and $\beta = .424$, $p < .05$, respectively), while perceived social support was negatively associated with relapse ($\beta = -.566$, $p < .05$), and together these factors accounted for approximately 41.4% of the variance in relapse among patients with substance use disorder. According to the findings of the study, the researcher concluded that psychosocial factors play a significant role in relapse among patients with substance use disorder attending treatment facilities, and recommended that mental health facilities and other stakeholders should consider strengthening social support systems, reducing stigma, and addressing loneliness within treatment and rehabilitation services in order to improve long term recovery and reduce relapse rates.

Keywords: Substance use disorder, Relapse, Loneliness, Perceived stigma, Social support

Chapter 1

1. Introduction

1.1 Background

Substance use disorder (SUD) is a diagnosable mental health condition that describes persistent problems associated with substance use leading to clinically significant impairment or distress, including loss of control, tolerance, withdrawal and continued use of substance despite harmful consequences (American Psychiatric Association, 2000). Globally, SUD represents a major public health burden. A total of 100.4 million people were estimated to be affected by alcohol use disorder in 2016 and millions more experiencing other drug use disorders such as opioid and cannabis dependence (Global Burden of Disease Study, 2016).

The United Nations Office on Drugs and Crime (2003) reported over 296 million people used substances globally in 2021, meaning that about 3 million of them fit the criteria for substance use disorders. Substance use is a rapidly expanding global concern. Substance abuse causes serious problems for millions of people, including early death, long-term impairment and serious economic impacts (World Health Organization; Global Burden of Disease Collaborators).

Even though many people receive treatments for substance use disorders, relapse rates following treatments are consistently high worldwide, studies showing that 40-75% of individuals experience relapse within weeks to months after treatment, which is explained by a return to substance use after a period of abstinence or recovery efforts, which is often marked by a breakdown in attempts to maintain a behavior change and a return to pre-treatment levels of use (Kabisa et al., 2021). For example, a study in Nepal estimated rates of 33% and 55.8% in China and 60% in Switzerland (Kabisa et al., 2021).

Treatment can be exhausting and costly for many people. Due to high rates of relapse, which affects treatment and recovery, which also reduces the efficacy of treatment intervention and long-term recovery goals. This frequently results in a recurring cycle of treatment. Relapse also contributes to emotional distress, social instability and troubled relationships and financial hardship for patients and their families. Increased use of treatment resources and extended care requirements have an impact on health systems as well (Ajayi et al., 2025).

Studies found that psychosocial factors including “loneliness, perceived stigma and social support “are important predictors of relapse in substance use disorder patients. People who feel socially isolated and lonely are more likely to experience emotional distress, have lower coping skills and increased substance use to deal with negative emotions (Ajayi et al., 2025).

Patients with substance use disorder frequently experience “loneliness”, which is closely linked to poor “recovery” outcomes (Ingram et al., 2020). Crapanzano et al. (2018) and Earnshaw (2020), reported that perceived stigma undermines self-esteem by reducing treatment adherence and leading to internalized shame which negatively affects treatment outcomes and increases the likelihood of relapse. In contrast, individuals with perceived social support from their friends, families or peers has shown to be more motivated and recover more quickly (Cohen and Wills, 1985).

Studies showed that “substance use and relapse are an increasing public health concerns” in countries of low- and middle-income. With challenges in treatment systems often being underdeveloped, which results in a high relapse rate of 40% to 70 % following detoxification and rehabilitation. This indicates that more than half of treated individuals return to substance use within months after treatment (Kabisa et al., 2021).

Studies in Ethiopia found that a “high burden of substance use” , including high consumption of alcohol, khat and tobacco which resulted in significant social problems, health consequences and mental health services remaining limited with high reported relapse rate after treatment (Adem et al., 2025).

1.2 Statement of the problem

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) states the global burden of disease attributable to alcohol and drug use has been increasing. Resulting a substantial morbidity, mortality and social consequences across both high and low-income countries. Substance use disorders (SUDs) becoming a major global public health concern resulting from combined effect of biological, psychological and social factors that contribute to chronic and relapsing patterns of use. (Global Burden of Disease Collaborators, 2018).

The United Nations Office's on Drug and Crime 2023 and the World Drug report (2023) reported that "the pattern of substance use are evolving." With increasing demand for both legal and illegal drugs, posing severe challenge in health care system worldwide. In Africa, including Ethiopia, substance use remains a burden, with emerging evidence indicating rising prevalence, especially in urban centers like Addis Ababa World Health Organization., 2017).

Relapse undermines recovery attempts and results in repeated cycle of treatment and substance use. Studies reported that relapse rates are high worldwide, ranging from 40% to 70% with in the first year following treatment, despite the availability of treatment programs (Kanisa et al., 2021). Relapse is becoming widely acknowledged as a "significant problem" in Ethiopian mental health facilities, with recent data showing 73% of individuals continue substance use after finishing treatment (Adem et al., (2025). This result emphasizes the need to understand factors that contribute to relapse, especially in Ethiopia where sociocultural and economic factors may interact with personal vulnerabilities in a particular way.

Psychosocial factors have been consistently identified as critical determinants of relapse in substance use disorders. These factors include perceived social support, coping strategies, stigma, stress and family or peer influences (Ajayi et al., 2025; Cohen & Wills, 1985). For example, inadequate social support has been shown to increase vulnerability to relapse, whereas strong social networks and supportive family environments can buffer the effects of stress and reduce the likelihood of returning to substance use (Cohen & Wills, 1985). Similarly, stigma associated with substance use disorders causes barrier to sustained recovery.

Perceived stigma can reduce help-seeking behaviors, lower treatment adherence and exacerbate social isolation, all of which may increase the risk of relapse (Earnshaw, 2020; (Crapanzano et al., 2018).

In Ethiopia, few studies have systematically investigated the psychosocial predictors of relapse among SUD patients. A study conducted in Tigray reported that relapse is influenced by multiple factors, including lack of family support, inadequate post treatment follow up and environmental triggers (Adem et al., 2025). The consequence of relapse extend beyond individual health outcomes to affect families, strain mental health resources and may lead to repeated hospitalizations, creating a cycle that is difficult to break (Global Burden of Disease Collaborators, 2018).

In conclusion relapse among SUD patients continues to be a major national and international problem. There is a little context specific evidence from Addis Ababa, despite the fact that previous research highlight the relevance of psychosocial factors in relapse. In order to achieve improved mental health care outcomes and guide targeted interventions, this study intends to investigate psychosocial predictors of relapse among patients with substance use disorder attending mental health facilities in Addis Ababa, Ethiopia.

1.3 Research questions

1. What is the relationship between loneliness and relapse among SUD patients?
2. How does perceived stigmatization influence relapse?
3. Is there a correlation between perceived social support and relapse?
4. Do loneliness, perceived stigmatization and perceived lack of social support jointly and independently predict relapse among patients with SUD.

1.4 Objective

1.4.1 General objective

To examine psychosocial factors as predictors of relapse rate among substance use disorder patients in mental health facilities in Addis Ababa, Ethiopia.

1.4.2 Specific Objectives

1. To assess the relationship between loneliness and relapse among SUD patients.
2. To determine the influence of perceived stigma on relapse.
3. To examine the association between perceived social support and relapse.
4. To evaluate the association between loneliness, perceived stigma and perceived lack of social support with addiction relapse.

1.5 Significance of the study

Studying the psychological factors of relapse rate of patients with substance use disorder is significant for several reasons. First, it contributes to the academic sector in which there is a limited literature on relapse predictors in Ethiopian context. Therefore, by integrating psychological and social perspectives that are commonly examined in global research, the findings of this research will expand theoretical knowledge on how factors such as loneliness, perceived stigma and social support influence relapse.

Second, the study will provide clinically insights for mental health professionals, rehabilitation centers and community-based organizations with evidence-based findings that is essential for designing more comprehensive relapse prevention interventions.

Third, understanding the psychosocial challenges faced by SUD patients can support the development of therapeutic approaches that address emotional and social triggers rather than focusing only on detoxification.

1.6 Limitation of the study

The limitations of the study were the following. First, since it was conducted within a predetermined academic schedule, information is gathered all at once and a cross sectional approach was required. Which makes it more challenging to identify the causal relationships between psychosocial factors including loneliness, perceived stigma and perceived social support and relapse.

Second, logistical problems with patients' access in crowded treatment facilities may be impacted patients' availability and response rate. Some eligible patients might not be available during data collection due to early discharge, treatment schedules or withdrawal due to relapse, which could have an impact on representativeness.

The other limitation was reliance on self-report, self-report questionnaires were used to determine relapse status, loneliness, perceived stigma and perceived social support which is vulnerable to recall bias and social desirability bias. Patients might over report positive factors like the social support or under report relapse, which could affect the accuracy of the predictive model.

1.7 Delimitation of the study

Geographical scope: the collected data collected only from patients with substance use disorders attending at the time or recently been discharged from the selected mental health and rehabilitation facilities physically located in Addis Ababa, Ethiopia.

Target Population: The population was strictly limited to patients who have finished a period of initial abstinence or treatment and have been officially diagnosed with substance use disorder (SUD) based on international diagnostic criteria such as the DSM 5. It excluded patients with co-occurring severe mental illnesses, including acute psychosis, which could interfere with relapse measurement was not included.

1.8 Operational definition of terms used

Substance use disorder patients: “Individuals who have been formally diagnosed with an SUD and are either currently receiving inpatient/outpatient treatment or were discharged within the last six months from the participating rehabilitation facilities.”

Relapse Rate: Relapse was defined as “the frequency of return to substance use after a period of abstinence among patients receiving treatment for Substance Use Disorders.” Measured by participants’ self-reported relapse rate using the “Advance Warning of Relapse (AWARE)” Scale.

Loneliness: refers to “the subjective experience of social isolation or perceived lack of meaningful social connections, regardless of actual social contact.” The revised UCLA loneliness scale was used to assess subjective feeling loneliness, higher scores were associated with higher levels of loneliness (Russell et al., 1978).

Perceived stigma: refers to a “person’s understanding or opinion that others have negative thoughts, assumptions, or discriminating beliefs about them due to specific identity or circumstances, like substance abuse.” The perceived stigma of substance abuse scale (PSAS), was used to assess the view of negative societal perceptions regarding patients with substance use disorders. Higher total scores indicated higher level of perceived stigma (Luoma et al., 2010).

Perceived Social support: refers to a “person’s subjective perception of receiving practical and emotional support from friends, family and significant others”. To assess perceived support from friends, family and significant others “The multidimensional scale of perceived social support” was used (Zimet et al., 1988).

Chapter 2

2. Literature review

2.1 Relapse rate among substance use disorder patients

Substance use disorder is commonly known as a chronic, recurrent condition characterized by compulsive substance seeking and use despite negative outcomes (American Psychiatric Association, 2013). Unlike many other chronic health problems, recovery for patients with substance use disorder is characterized by the cyclical pattern of abstinence, relapse and returning to treatment (McLellan et al., 2000).

In the context of substance use disorders, the term “relapse” has been defined in a different ways throughout literatures, it refers to “return to substance use after a time of successful treatment engagement or abstinence” (Marlatt and Donovan, 2005). Some studies make a distinction between “relapse”, a complete return to pretreatment levels of substance use and a “lapse” a single or brief return to substance use (Witkiewitz and Marlatt, 2004). Others, however consider any return to use regardless of how long or how much to be relapse (Miller and Harris, 2000).

Relapse, from a cognitive behavioral perspective seen as a dynamic process that starts long before the actual act of substance use takes place rather than as a single event (Marlatt and Gordon, 1985). Marlatt’s well known “relapse prevention (RP)” model conceptualizes relapse as the result of series of psychological and behavioral events such as being in high risk situations or having fewer coping mechanisms, which can turn a single lapse in to full relapse through cognitive attributions of failure and decline in self efficacy (Marlatt and Gordon, 1985).

Studies showed that relapse can often be the result of substance use treatment. Globally, relapse rates after treatment are significant with estimates ranging from 40% to 75% in the first year of recovery (Kabisa et al., 2021).

A descriptive cross sectional study conducted in Nepal found that 63.9% of patients relapsed within three weeks to six months after completing therapy, highlighting the vulnerability of early recovery period (Sapkota et al., 2017). Large number of patients relapsed within months of being discharged from treatment facilities which makes relapse a common problem in addiction recovery (Andersson et al., 2019).

Researchers at Sakary University, Turkey reviewed previous studies about associated factors with relapse in alcohol and substance use disorders and showed that half of the patients experienced relapses throughout the follow up period, showing continuous challenges in sustaining abstinence despite prescribed treatment plan. These results showed that relapse is a common problem in substance abuse treatment hospitals and rehabilitation settings rather than being unique to certain substance or therapeutic modalities and factors such as positive family functioning and strong social support appear to reduce relapse (Yazıcı and Bardakçı 2023).

A retrospective cross sectional survey conducted at Rwanda's Icyizere psychotherapeutic center found that 59.9% of patients who had completed treatment had relapsed. In this case, relapse frequently happened shortly after discharge and associated with psychosocial issues such as peer pressure, family conflict and lack of social support (Kabisa et al., 2021).

An institution based cross sectional study conducted in Mekelle, Ethiopia also showed a relapse prevalence of 73.3% following treatment, suggesting a significant burden of relapse in Ethiopian treatment settings (Adem et al., 2025). Over all, these findings showed that relapse is a common outcome of substance abuse treatment both locally and internationally, stressing the importance of identifying psychological and social factors that influence relapse risk.

2.2 Theories guiding the study

Substance use relapse and their relationship with psychosocial factors has been explained by number of theories. These theories offer the conceptual framework for understanding how factors like social support, perceived stigma and loneliness interact to affect the probability of using substance again following a time of abstinence. Three main theoretical perspectives are used in this study, 'The stress buffering hypothesis' (Cohen and Wills, 1985), "The social stigma theory" (Goffman, 1963) and "The self-medication hypothesis" (Khantzian, 1997).

The “self-medication theory”, which suggests that people use substances as a maladaptive coping mechanism to deal with psychological distress, emotional pain, or unfulfilled societal needs, is among the first theories. This hypothesis suggests that although substance use temporarily reduces unpleasant emotional states, it eventually increases dependence and relapse risk (Khantzian, 1997).

The self-medication theory is especially important in the situation of relapse when loneliness is taken in to consideration. People who experience social isolation while they are in recovery might not have the emotional support they needed to maintain abstinence. The resulting loneliness creates a type of long term psychological suffering that is similar to the emotional experiences that initially motivated the substance use (Ingram et al., 2020). The urge to use substance as a substitution for emotional connections increases when there are no good interpersonal relationships to help alleviate this suffering.

Loneliness could increase negative emotions which decreases the motivation for recovery and social support networks, all of which are very important for maintaining sobriety. These processes support the self-medication hypothesis, where using substance temporarily reduces psychological distress at the expense of strengthening addictive behaviors (Khantzian, 1997).

Social stigma theory may additionally be used to better understand relapse. This theory argues that stigma is a socially fabricated process that minimizes and ignores individuals due to a socially undesirable characteristics, such as substance abuse. Perceived and internalized stigma, which can negatively impact ones worth, reducing treatment adherence and contribute to psychological distress, might increase the likelihood of relapse (Goffman, 1963).

According to Goffman (1963), stigma is a distorted societal identity that is socially formed through interactions in which a person is criticized or viewed as abnormal rather than being naturally related to a feature. In addition to reducing social possibilities and undermining one’s worth, this social judgment can create long term stressors that have a negative impact on recovery processes.

For patients with substance use disorder, perceived stigma is a particularly potent mechanism of harm. In many societies, including Ethiopia, the stigmatizing term “addict” or “substance abuser” carries moral implication, as addiction commonly seen as a moral sin or failing rather than a medical problem (Belete et al., 2021). Patients who internalize this negative societal judgments may feel ashamed, have lower self-esteem and feel excluded from society, which prevents them from seeking or sustaining treatment (Earnshaw, 2020).

Building on Goffman’s pioneering work, Link and Phelan (2001) created a detailed sociological model of stigma that outlines five interconnected elements, “discrimination, separation, labeling, stereotyping and status loss” this concept highlights that stigma is a structural phenomenon rooted in social power relations rather than only a psychological experience at individual level. Based on this concept, the societal effects of stigma, such as being excluded from social network or jobs can lead to long term stressors that greatly increase the chance of relapse when it comes to substance use (Link and Phelan, 2001).

Cohen and Wills (1985) presented a theory called “The stress buffering hypothesis”, suggesting that social support improves coping skills and emotional resilience, which in turn lessens the negative effects of stress. Due to increased stress, loneliness and decreased willingness for long term care, people with poor perceived social support were therefore more vulnerable to relapse.

According to the “Stress buffering hypothesis” perceived social support dramatically decreased stress and minimized maladaptive coping strategies, including substance use relapse. Their research provided an important concept for understanding how long term recovery outcomes had been affected by support perceptions rather than just objective support (Cohen and Wills, 1985).

People who experience high level of support from friends, families and significant others are better able to handle the stressors that lead to relapse, such as cravings, environmental triggers and interpersonal conflict (Cohen and Wills, 1985). Perceived social support increases participation with formal treatment programs, lowers the emotional effect of high risk situations and increases one confidence for maintaining abstinence. On the other hand, people who believe they have insufficient social support are more likely to become overly reactive to stress and turn to unhealthy coping mechanisms like substance abuse (Abdelaal et al., 2025).

Together, these theoretical views suggest that psychological factors including loneliness, perceived stigma and perceived social support affect the likelihood of relapse by influencing coping mechanisms, emotional management and willingness to engage in treatment related journeys.

2.3 Empirical studies

2.3.1 International studies

Studies from around the world has shown that psychosocial factors including loneliness, perceived stigma and perceived social support significantly predict relapse among patients with substance use disorder. Gutkind et al. (2022) defined loneliness as “A subjective emotional state resulting from discrepancy between desired and actual social relationships.” Studies has connected loneliness to craving, anxiety and increased stress sensitivity, all of which contribute to increased relapse risk (Chen et al., 2021).

Ingram, Kelly, Deane, Baker, Goh, Raftery and Dingle (2020), reported that loneliness is both an indirect cause of relapse and a predictor of increasing substance use. Substance abuse has been thought to be a maladaptive coping mechanism used by those who experienced chronic loneliness to self soothe their distress and fill the emotional gap left by perceived social separation. Ingram and his colleagues conducted a narrative systematic review and found that loneliness was linked with poor physical and mental health outcomes, including higher substance use index which was common among patients with substance use disorder (Ingram et al., 2020).

Longitudinal data from United States showed that adults with problematic alcohol and or cannabis use who reported moderate to severe loneliness has significantly more days of substance use at follow ups than non-lonely individuals (Gutkind et al., 2022). These results suggested that loneliness increases substance use frequency, a known predictor of relapse followed by loneliness.

Along with anxiety and depression, loneliness was found to be a powerful motivational factor for relapse in a study of substance users in china (Chen et al., 2021). Although this study didn't measure relapse rates, the strong association between loneliness and craving suggested an automatic pathway by which loneliness could increase relapse risk.

Relapse is also known to be significantly predicted by perceived stigma. Among patients with substance use disorders, perceived stigma was common and negatively affected treatment engagement through lowered self-efficacy, emotional distress and decreased motivation, thus increasing relapse risk (Crapanzano et al., 2018).

Data showed that early treatment discontinuation, which is a major predictor of relapse was also predicted by higher perceived stigma.

A large observational data from US treatments settings reported that “higher perceived stigma strongly predicted early treatment discontinuation”, which is a strong predictor of relapse. Each unit increase in perceived stigma decreased odds of treatment completion, indicating that stigma negatively impacted staying sober and thus increased vulnerability to return to substance use (Isman et al., 2025). Poor long term recovery outcomes and a higher chance of relapse is strongly linked with treatment discontinuation.

Perceived stigma was positively associated with multiple relapse features including cravings, ruined relationships and emotional instability, which are known to cause relapse, based on a cross sectional study from Egypt (Sonbol et al., 2023). These researchers concluded that perceived stigma was a significant risk factor for relapse, especially when paired with socio demographic concerns like “unemployment” and “debt” (Sonbol et al., 2023). On the other hand, perceived social support has been frequently identified as a protective factor. Perceived social support substantially reduced stress and maladaptive coping behaviors, such as substance use and return to using substance (Cohen and Wills, 1985). These results provided a basic structure for understanding how long term rehabilitation outcomes were affected by support perceptions rather than just objective support.

Lower social support was significant predictor of addiction relapse (Nikmanesh et al., 2016). In this Iranian study, in comparison to those who remained clean, those who went back to using showed notably reduced perceived social support. Social support as measured by “multidimensional scale of perceived social support” was found to be more powerful predictor of relapse than self-efficacy, accounting for about 22% of change in relapse outcomes (Nikmanesh et al., 2016). These suggested that patient’s subjective opinion of support from friends, family and significant others were strongly associated with relapse risk.

Perceived social support was one of the psychosocial factors of relapse among patients with SUD that were examined in Nigerian study (Ajayi et al., 2025). The protective role of social support in recovery processes and the importance of holistic interventions that promote sense of social connection with in addiction treatment approaches were highlighted by the study’s result that higher social support significantly predicted lower relapse rates (Ajayi et al., 2025).

Abdelaal and his colleagues conducted a descriptive correlational study on patients with substance use disorders to assess “how relapse risk was predicted by perceived social support and acceptance of unpleasant situations”. These results showed that “higher level of perceived social support were strongly associated to lower risk of relapse”, highlighting perceived social support as a protective factor in maintaining healthy lifestyle. (Abdelaal et al., 2025).

2.3.2 Local studies

Studies in Ethiopia and Africa showed that psychosocial factors affected the outcome of recovery. The majority of studies agreed that “psychosocial factors impacted the recovery process”, stressing the necessity of modifying strategies to strengthen adherence to treatment and lower the risk of relapse.

In Ethiopian context, direct studies linking psychosocial factors to relapse were limited. However, the results of a study conducted in Tigray, Ethiopia showed that “isolation from society and lack of supportive social connections contributed to early treatment discontinuation and increased relapse risk” (Adem et al., 2025).

Among adults with problematic substance use in Ethiopia, perceived stigma was common 63.9% and associated with poly substance use and socio economic stressors which are factors associated with prolonged use and relapse. The high prevalence of stigma suggested that higher number of substance users continued to be stigmatized by the society, which probably made it difficult for them to seek help and maintained abstinence (Belete et al., 2021).

An institutional based cross sectional study conducted at Mekelle rehabilitation center found that “73.3% of patients who had completed treatment had relapsed and socio demographic characteristics such as age and education are important predictors of relapse” (Adem et al., 2025). These results indicated the higher rates of relapse in Ethiopian addiction treatment centers and the need for studying additional psychosocial factors in future researches.

2.4 Conceptual framework

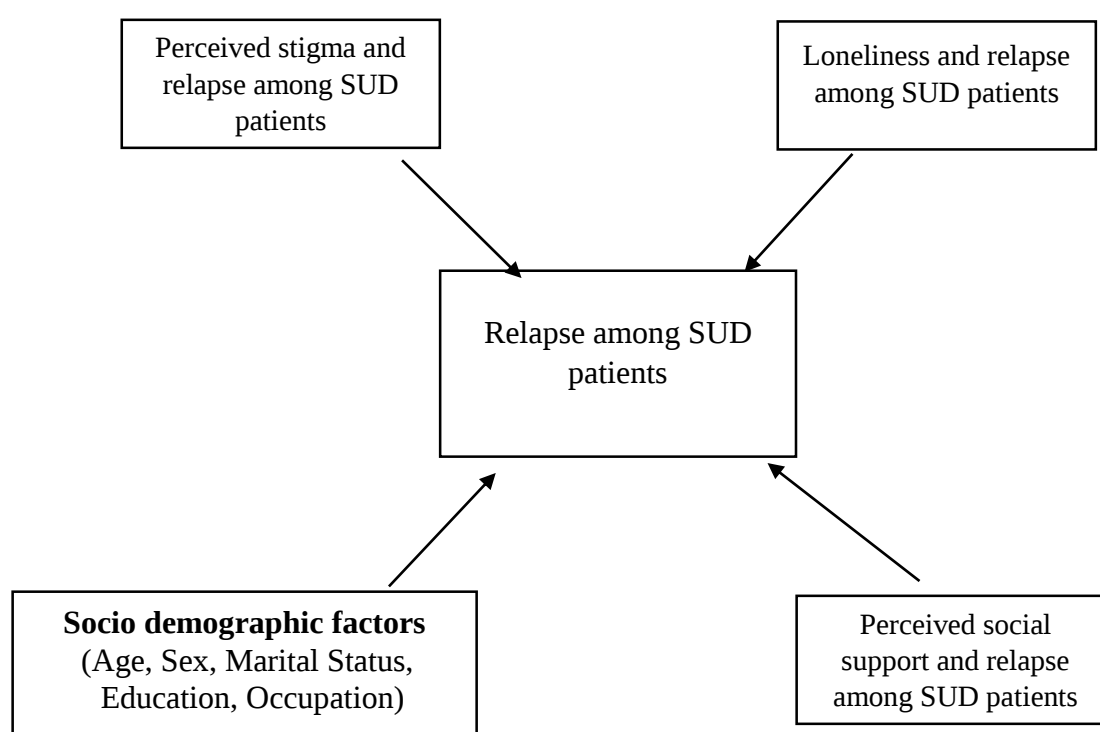


Figure 1: Conceptual framework showing psychosocial predictors of relapse among substance use disorder patients

Chapter 3

3. Methodology

3.1 Study design

This study examined psychosocial predictors of relapse among patients with substance use disorders attending in mental health facilities in Addis Ababa, Ethiopia, using quantitative institutional based cross sectional study design. This study design involved collecting data on both dependent and independent variables at a particular point in time (Creswell & Creswell, 2018; Setia, 2016).

This study design worked for this study because it enabled effective assessment of loneliness, perceived stigma and perceived social support in relation to relapse without manipulating variables, which would be unethical in substance use related researches. It was commonly used in mental health and substance use related studies to assess the prevalence and examine associations between psychological and social variables and clinical outcomes like relapse (Kabisa et al., 2021; Ajayi et al., 2025).

Cross sectional studies are useful for identifying important factors that could direct the creation of solutions and future longitudinal study, even when they cannot prove causality (Creswell & Creswell, 2018).

3.2 Study setting

Five mental health facilities in Addis Ababa, Ethiopia, each offering mental health services at different levels of care and organizational focus, were the centers of the study. The centers included were Amanuel Mental Specialized Hospital, Zewditu Memorial Hospital, ALERT Comprehensive Specialized Hospital, Eka Kotebe General Hospital and St. Paul Millennium Medical College (SPHMMC).

ALERT Comprehensive Specialized Hospital

ALERT is one of Ethiopia's biggest multidisciplinary medical facilities, located in kolfe Keraniyo sub city of Addis Ababa. It serves more than 1500 patients daily and 450,000 annually across a broad range of medical services. The hospital's mental health and rehabilitation department established in 2005 E.C. it provides comprehensive psychiatric care including emergency, inpatient with approximately 20 beds and outpatient services. The department is staffed by mental health professional including psychiatrists, psychiatry nurses and psychologists. ALERT also offers ongoing mental health awareness and rehabilitation programs and plans to expand to include dedicated addiction rehabilitation service.

St. Paul's Hospital Millennium Medical College (SPHMMC)

St. Paul's Hospital Millennium Medical College is a major public teaching and referral hospital in Gulele sub-city, Addis Ababa, with a bed capacity exceeding 700 and it provides care to an estimated 200,000 patients annually. It functions both as a clinical service provider and a medical education institution, offering undergraduate and postgraduate training. As part of its wider clinical services, the hospital has a psychiatric unit that treats patients with mental health issues, including substance use related problems. In addition to providing limited inpatient services, specialist mental health professionals deliver wider outpatient services and collaborates with and consult other rehabilitations to support patients with mental health issues and substance use disorders.

Eka Kotebe General Hospital

Eka Kotebe General Hospital, also known as Eka Kotebe Hospital & Neuroscience Institute, is a relatively new public hospital in Addis Ababa. It was developed to expand general and mental health services and is envisaged as a neuroscience and mental health institute. The facility is equipped with approximately 350 beds, of which around half are allocated for people with mental disabilities and related services. In addition to general medical and surgical care, the hospital's mental health services include psychiatric evaluation, psychotherapy, rehabilitation and mental health support integrated with neurology and neurosurgery services.

Zewditu Memorial Hospital

Zewditu Hospital is a public hospital located in central Addis Ababa. While not exclusively a mental health hospital, it forms part of the health system where outpatient mental health and substance use interventions are available in other comprehensive services. The hospital serves thousands of patients each month and is well known for its HIV/AIDS care program. It also incorporates outpatient mental health services. In its outpatient department, it primarily offers integrated services including counseling and support for patients with, substance use disorders or other mental health issues and also for comorbid conditions (such as depression and substance abuse).

Amanuel Mental Specialized Hospital

The main referral center for mental health services in Ethiopia is Amanuel Mental Specialized Hospital, which is the only public psychiatric hospital in the country. The hospital was found in 1930 E.C and it is located in Addis Ketema sub city of Addis Ababa. Inpatient and outpatient psychiatric care, emergency mental health services, counseling and rehabilitation programs are among the various mental health services provided by the center. Additionally, the center also plays an important role to Ethiopian mental health by conducting researches and training mental health professionals. It also serve as an important setting for mental and substance use disorder treatment in the country since it has large patient flow and specialized services for both psychiatric illness and substance abuse.

3.3 Population

3.3.1 Source population

Source population refers to the subset of target population that is theoretically accessible to the researcher (Checkoway et al., 2007). In this case, all patients with substance use disorder attending mental health facilities in Addis Ababa city administration were the source population.

3.3.2 Study population

The study population were patients diagnosed with substance use disorder who are being treated at selected mental health facilities in Addis Ababa city administration. The centers included were Amanuel Mental Specialized Hospital, Zewditu Memorial Hospital, ALERT Comprehensive

Specialized Hospital, Eka Kotebe General Hospital and St. Paul Millennium Medical College (SPHMMC).

3.4 Eligibility criteria

3.4.1. Inclusion criteria

SUD patients (aged 18 years and above) without active psychosis who are currently undergoing treatment at the selected facilities and who provide informed consent to participate.

3.4.2 Exclusion criteria

Patients with other severe psychiatric diagnoses (e.g., active psychotic disorders) that might impair their cognitive ability to provide reliable self-report or informed consent, or those who decline participation.

3.5 Sample size determination

A single population proportion formula, which is commonly applied when estimating prevalence or associations in cross sectional studies was used to determine the sample size for this study (Lwanga & Lemeshow, 1991). Due to the absence of precise prevalence data for relapse in the study settings, a prevalence of 50% was assumed to maximize sample size. Using a 95% confidence level, 5% margin of error and adding a 10% non-response rate, the final calculated sample size was 422 participants. This sample size is considered adequate to provide sufficient statistical power for multiple linear regression analysis (Field, 2018).

$$N = Z_{\alpha/2}^2 \times P(1-P) / W^2$$

Where $Z_{\alpha/2}$ = confidence level (1.96) at c of 95%

N= Sample size

P = estimate of the proportion/sample proportion of the success

W = maximum tolerable error

1- $P = \text{sample error proportion failure}$

$$N = (1.96)^2(0.5)(0.5) / (0.05)^2 = 384$$

Then we added 10% of our sample size by considering for non-respondent rate.

$$= 10 \times 384 / 100 = 38.4, \text{ approximately } 38$$

Therefore our sample size is $n = 38 + 384 = 422$

3.6 Sampling procedure

From mental health and rehabilitation centers found in Addis Ababa, Ethiopia 5 centers were selected randomly using lottery method. Those are ALERT Hospital, St. Paul's Hospital Millennium Medical College (SPHMMC), Eka Kotebe General Hospital, Zewditu memorial Hospital and Amanuel Mental Specialized Hospital.

The required sample size was allocated to each selected mental health and rehabilitation center proportionally depending on the average patient flow of substance use disorder patients over the previous 3 months, 308 for St. Paul, 226 for Zewditu, 185 for Amanuel, 48 for ALERT and 126 for Eka Kotebe. The average patient flow was calculated for each center and proportional allocation was performed using the population proportion formula. Accordingly, 132 participants were selected from St. Paul's Hospital Millennium Medical College, 97 from Zewditu Memorial Hospital, 79 from Amanuel Mental Specialized Hospital, 61 from ALERT Hospital and 53 from Eka Kotebe General Hospital. Following proportional allocation, participants were selected consecutively from each center until the required sample size was achieved.

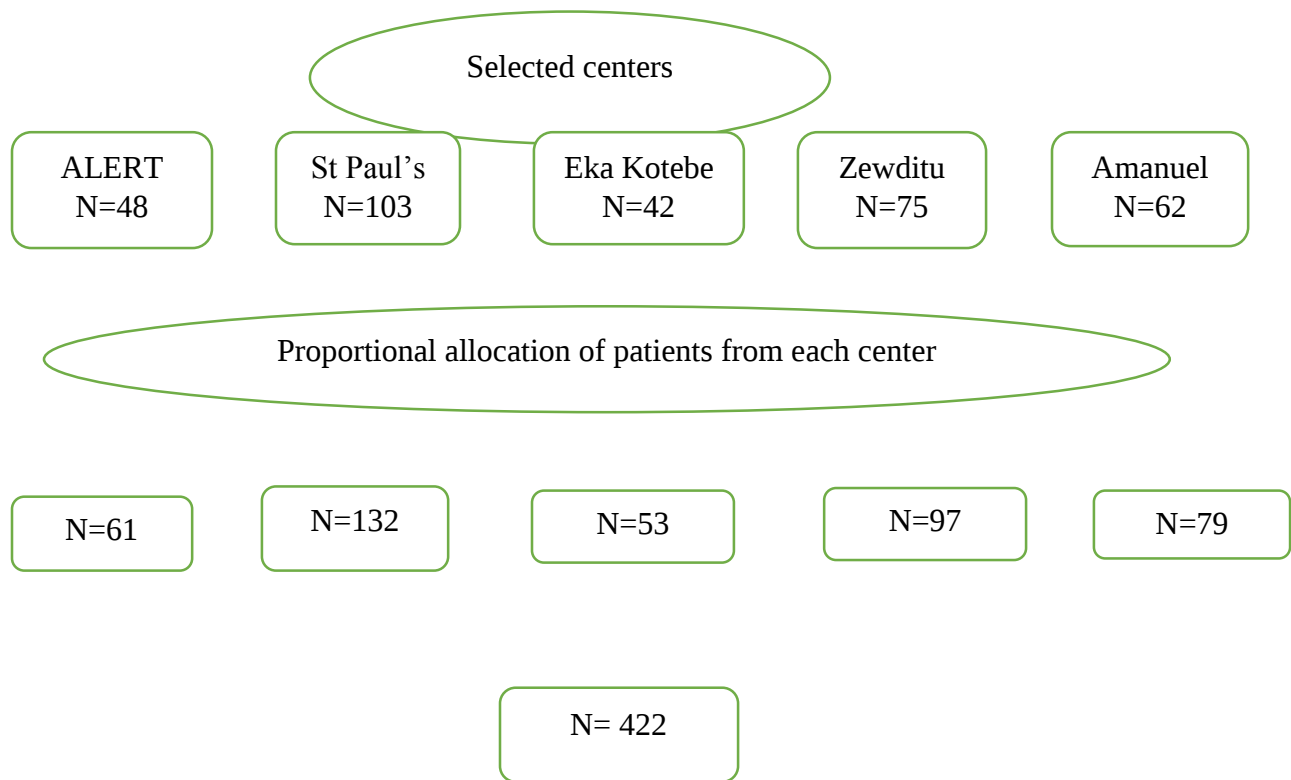


Figure 2: Schematic presentation of selection of hospitals and participants for the study

3.7 Study variables

1. Dependent variable

- Relapse rate

2. Independent variables

- Age
- Sex
- Marital status
- Educational background
- Occupation
- Loneliness
- Perceived stigmatization
- Perceived social support

3.8 Data collection tools

The data collection involved a comprehensive, five part questionnaire structure, with each section aligned to a distinct construct in the study. All the data collection tools were translated to Amharic and then translated back to English for comparison with the original English version of the tool.

Section I: gathered socio demographic data, such as age, sex, marital status, educational background and occupation. Section II: assessed relapse rate using the “Advance Warning of Relapse (AWARE)” Scale, a validated self-report instrument designed to identify early cognitive, emotional and behavioral warning signs of relapse.

The AWARE Scale consists of 28 items, rated using 7 point Likert scale ranging from 1 (Never) to 7 (Always). Scores with higher total indicate greater risk of relapse. The Scale that show strong psychometric properties, including high internal consistency (Cronbach’s $\alpha = .92$) and good construct validity in populations with substance use disorders. It is commonly used in both clinical and research settings to assess relapse risk during recovery (Miller & Harris, 2000).

Section III assessed loneliness using the “Revised UCLA Loneliness Scale,” a validated 20-item measure created by Russell et al. in 1978. On a scale of 1 (Never) to 4 (Often), participants scored each item. It is suitable because to its good psychometric qualities, high internal consistency (coefficient alpha =.96), and test-retest correlation over a two-month period of.73. Using the “PSAS (perceived stigma of substance abuse scale),” Section IV assessed felt stigmatization. 8-item test that gauges how society views people with substance use disorders negatively.

The “Multidimensional Scale of Perceived Social Support (MSPSS)” was used in Section V to assess perceived social support. In addition to being widely used in psychological research, this 12-item test has a high reliability value ($\alpha = .95$).

3.9 Data collection procedures

Prior to data collection, the questionnaire was reviewed for clarity and completeness. Participants were informed about the purpose of the study and informed consent was obtained before

participation. Confidentiality and anonymity of the participants were maintained throughout the study.

The data collection was conducted at the selected mental health and rehabilitation centers from March to April, 2026. To ensure clarity and participant understanding, detailed explanations were provided for each section of the questionnaire, along with instructions on how to respond. Trained data collectors were there to address any questions from participants.

3.10 Data processing and analysis

Data were entered, cleaned and analyzed using IBM SPSS Statistics version 26. Prior to analysis, data were checked for completeness, missing values and outliers. Reverse coding was performed for relevant items and composite scores were computed for relapse, loneliness, perceived stigma and social support.

The data was summarized using descriptive statistics, such as means, standard deviations, frequencies, and percentages. The study instruments' internal consistency reliability was evaluated using Cronbach's alpha.

The association between psychosocial factors and relapse was investigated using Pearson correlation analysis. To find important relapse factors, multiple linear regression analysis was used. Significant predictors were defined as variables with statistical significance at $p < .05$.

Regression analysis assumptions such as normality, linearity, and multicollinearity were verified before the results were interpreted.

3.11 Data quality assurance

To ensure the quality of data, several measures were taken before, during and after data collection. Initially, questionnaire was prepared in English and translated into Amharic and then back translated into English to ensure consistency of meaning.

Prior to actual data collection, a pre-test was conducted on 21 patients with substance use disorder in a facility with similar characteristics to study sites. Based on the pre-test findings, necessary modifications were made to improve clarity, consistency and relevance of the questionnaire.

Data collectors received training on the objectives of the study, data collection procedures, ethical considerations and proper handling of instruments. During data collection, close supervision was carried out to ensure that procedures were followed correctly.

Data were coded and entered into IBM SPSS Statistics and further data cleaning procedures, including checking for missing values, outliers and data entry errors, were performed before analysis.

In addition, internal consistency of the study instruments was assessed using Cronbach's alpha and all scales demonstrated acceptable reliability.

3.12 Ethical consideration

The Addis Ababa University Institutional Review Board (IRB) granted ethical approval. Prior to data collection, formal permission letters were obtained from the chosen mental health facilities.

Before any data was collected, each participant gave their informed consent after being made aware of the study's goals, methods, possible risks, and advantages. Additionally, participants were made aware of their freedom to decline or leave the research at any moment without facing any repercussions for their care or services.

Participants' privacy and confidentiality were upheld at all times. The questionnaire did not include any personal identifiers, such as names or medical record numbers, and the information was utilized only for research.

Chapter 4

4. Result

4.1 Socio demographic Characteristics of Participants

A total of 422 participant were included in the study. The socio demographic characteristics of the participants (n=422) as indicated in Table 1, (30.1%) participants were between 18–25 years. The majority of participants were male (88.6%). The majority of participants were unemployed (46.4%) and single (59%). With respect to educational status, 38.4% had completed secondary education.

Table 1 the socio demographic characteristics of participants

Socio demographic variables		Frequency	Percent
Age	18-25	127	30.1
	26-35	125	29.6
	36-45	69	16.4
	>=46	101	23.9
Sex	Male	374	88.6
	Female	48	11.4
Marital status	Single	249	59
	Married	106	25
	Divorced	67	15.9
Occupation	Student	88	20.9
	Employed	138	32.7
	Unemployed	196	46.4
Education	No formal	52	12.3
	Primary	104	24.6
	Secondary	162	38.4
	Degree and above	104	24.6

4.2 The descriptive statistics of the study variables

The descriptive statistics of the study variables showed that the mean relapse score of the participants was 126.75 (SD=21.15) with a score ranging from 75 to 172. This standard deviation indicated a significant degree of variation among participants relative to the mean, suggesting that although the overall risk towards relapse is rather high, patients within the sample reported highly varied risk of relapse. The mean loneliness score was 58.1 (SD=10.26), this relatively small standard deviation compared to the mean indicated that the data points are clustered around the average, showed relatively moderate level of loneliness among the majority of the participants. The average perceived stigma score was 25.43 (SD=4.51), the small standard deviation relative to the mean indicated that the data values are closely packed around the average and showed that participants' perception of social stigma were highly uniform and strong. While the mean perceived social support score was 31.07 (SD=8.55) the larger standard deviation relative to the mean indicated that data values are more widely spread and showed that how participants' perception or availability to social support were highly varied.

Table 2 Descriptive statistics of study variables

Variables	N	Minimum	Maximum	Mean	Std. deviation
Relapse total	422	75	172	126.75	21.149
Loneliness total	422	37	76	58.1	10.255
Stigma total	422	12	32	25.43	4.51
Social support total	422	12	50	31.06	8.545

4.2 Predictive role of loneliness on relapse

Hypothesis 1: Loneliness will significantly predict Relapse among Patients with substance use disorder

The result showed that loneliness was a major predictor of relapse among patients with substance use disorders. The simple linear regression indicated that Loneliness and relapse rates were

positively and significantly correlated ($\beta = .465$, $p < .05$). This suggested that a higher probability of relapse was related with higher levels of loneliness. This means that loneliness has contributed to substance use disorder relapse 21.6%.

The result supported the assumption that loneliness plays a significant role in the difficulties patients have during their rehabilitation. People who are socially isolated might lack the emotional support and feeling of belongingness they needed to maintain a healthy lifestyle. The probability of using substance again increased because patients use it as a coping mechanism for negative emotions or to ease feeling of emptiness.

Table 2 Summary of Linear Regression Showing the Predictive Role of Loneliness on Relapse

Variable	B	SE	β	t	R	R ²	p
(Constant)	71.048	5.256	—	13.517	.465	.216	< .05
Loneliness	.959	.089	.465	10.761			< .05

4.3 Predictive role of perceived stigma on relapse

Hypothesis 2: Perceived Stigma will Significantly Predict Relapse among Patients with substance use disorder

The result indicated that, perceived stigma was also a significant predictor of relapse. The simple linear regression showed that relapse and perceived stigma were positively associated ($\beta = .424$, $p < .05$). Relapse was more common among those participants who felt more stigmatized. This means that perceived stigma has contributed to substance use disorder relapse 18%.

The result supported the assumption that stigma has caused lower self-esteem, negative self beliefs and increased feeling of shame, all of which affected the motivation of patients' capability to stay sober. Additionally, stigma prevented them from asking for or accepting support and treatment services they needed due to fear of rejection or judgment, which increased relapse among them.

Table 2 Summary of Linear Regression Showing the Predictive Role of Perceived Stigma on Relapse

Variable	B	SE	β	t	R	R ²	p
(Constant)	76.163	5.352	—	14.231	.424	.180	< .05
Perceived stigma	1.989	.207	.424	9.599			< .05

4.4 Predictive role of social support on relapse

Hypothesis 3: Perceived Social Support will Significantly Predict Relapse among SUDs Patients

The result showed stronger negative correlation between social support and relapse. The regression analysis showed that higher level of social support were associated with lower rate of relapse ($\beta = -.566$, $p < .05$). Social support had strong protective effect against relapse. This indicated that when patients received more support from their closer people, families or friends, their probability of relapsing will be decreased. Perceived social support demonstrated a better predictive role than other psychosocial factors examined in the study. This means that perceived social support has contributed to substance use disorder relapse 32%.

The result of this study indicated how important social supports could be for improved recovery and long term sobriety in patients with substance use disorder. Support from friends, families and closed ones could create emotional comfort and sense of belongingness. These are important defenses against stressors and environmental triggers that could increase the risk of relapse.

Table 3 Summary of Linear Regression Showing the Predictive Role of Perceived Social Support on Relapse

Variable	B	SE	β	t	R	R ²	p
(Constant)	170.269	3.207	—	53.088	.566	.320	< .05
Perceived social support	-1.401	.100	-.566	-14.072			< .05

4.5 Predictive role of loneliness, perceived stigma and perceived social support on relapse

Hypothesis 4: Loneliness, Perceived Stigma and Social Support will jointly and independently predict Relapse Rates among SUDs Patient

The result of the multiple regression showed that all three psychosocial factors including loneliness, perceived stigma and perceived social support together strongly predicted relapse. Together, these variables predicted around 41.4% relapse rate among patients with substance use disorder, indicating a significant combined effect on relapse rate. The outcome of each predictor's independent contribution within the combined model showed that loneliness ($\beta = .228$, $p < .05$), perceived stigma ($\beta = .198$, $p < .05$) and perceived social support ($\beta = -.396$, $p < .05$) remained significant predictors of relapse even after controlling for the effects of the other psychosocial factors.

This study's result particularly indicated that higher level of loneliness and perceived stigma were associated with higher relapse rate. Whereas stronger perceived social support was associated with significantly lower relapse rate. Among the three variables, perceived social support showed the strongest independent effect, indicating its important protective role against relapse. These findings showed that while stigma and loneliness increase the risk of relapse, strong social support alone reduces the chance of using substance again even when these unfavorable psychosocial factors are present.

The results presented further emphasize on the importance of holistic intervention strategies that simultaneously reduce stigma and loneliness and strengthen social support as a way to improve recovery outcomes for patients with substance use disorder.

Table 4 Summary of Multiple Regression Analysis Showing the Prediction of Loneliness, Perceived Stigma and Social Support on Rate of Relapse.

Variable	B	SE	β	t	R	R²	F	p
Constant	106.296	8.384	—	12.678	.643	.414	98.402	< .05
Loneliness	.470	.088	.228	5.373				< .05
Perceived stigma	.926	.194	.198	4.770				< .05
Perceived social support	-.980	.106	-.396	-9.235				< .05

Chapter 5

5. Discussion

In this study, patients with substance use disorders who attended particular mental health facilities in Addis Ababa, Ethiopia, were examined for psychosocial determinants of recurrence. This study specifically examined the relationship between loneliness, perceived stigma, and perceived social support and relapse rates. The study's findings demonstrated that, both separately and in combination, all three psychosocial factors significantly predicted relapse.

5.1 The predictive role of loneliness on relapse

The finding of this study reported that approximately 21.6% of relapse rates were predicted by loneliness. Which showed a strong relation between loneliness and relapse risk. These results are supported by the “self-medication hypothesis”, which suggested that people might use substance as a coping strategy for managing psychological distress and emotional pain (Khantzian, 1997). During early stages of recovery, patients frequently experience feeling of emptiness after cutting the connections with peer networks of substance users. When this gap is not filled with healthy and meaningful interactions, the resulting loneliness causes extreme emotional instability and cravings.

These results are also consistent with the previous study that indicated the predictive role of loneliness as 28% of relapse rate (Ajayi et al., 2025). The slight variation may point to cultural variations, however the underlying fact remains consistent.

The previous studies also found that loneliness may lead to a loss of meaningful interpersonal relations and emotional connections which can increase emotional sensitivity and finally, the risk of relapse (Ingram et al., 2020; Gutkind et al., 2022; Chen et al., 2021). Loneliness reduces tolerance of distress by acting as an internal stressor. Patients use substance to artificially self soothe their feelings of emptiness when there is no system to provide interpersonal support.

This result has important clinical implications for treatment planning the sample's high mean loneliness score indicates that significant number of patients at Addis Ababa's mental health facilities face higher level of social isolation while undergoing treatment and recovery. However as suggested by Ingram et al. (2020) and Crabtree et al. (2025), loneliness is rarely screened or addressed in standard addiction treatment protocols.

These results are further affected by the Ethiopian culture background. The feeling of social isolation carries a significant emotional burden in Ethiopia's primarily collectivist society, where personal identity and wellbeing are tightly linked to social belonging (Adem et al., 2025). Patients who have experienced social exclusion, job loss or other form of marginalization due to their substance use may perceive loneliness as fundamental break in their sense of self rather than just a lack of social interaction.

5.2 The predictive role of perceived stigma on relapse

The result showed that perceived stigma has contributed to 18% substance use disorder relapse and was a significant predictor of relapse. Participants who felt that society had negative or discriminating opinion of them due to their substance use were more likely to relapse, which is theoretically consistent with Goffman's (1963) social stigma theory. Stereotypical attitudes towards patients with substance use disorder appear to be deeply rooted in Addis Ababa's societal context, as seen by the uniformity of stigma experience across the sample and comparatively small standard deviation surrounding a high mean. This finding mirrors the high prevalence found by Belete et al. (2021), in Northwest Ethiopia.

At behavioral level, stigma takes patients from the protective structures that maintain abstinence by discouraging help seeking and decreasing treatment adherence. Higher perceived stigma was a stronger predictor of early treatment withdrawal, which is one of the most predictors of relapse as supported by Isman et al. (2025). These results are consistent with the previous study that indicated the predictive role of perceived stigma as 11.8% of relapse rate (Ajayi et al., 2025). The difference may be due to Ethiopian society's moralistic framing of addiction, where community and religious norms tend to emphasize personal responsibility over medical explanation (Belete et al., 2021).

Additional authors also found perceived stigma as strongest predictor of relapse highlighting its contribution to shame and low self-esteem (Sonbol et al., 2023; Crapanzano et al., 2018). Feeling of rejection and exclusion from society caused by stigma can lower motivation for recovery and treatment involvement. Therefore, stigma is a major barrier in treatment facilities.

5.3 Predictive role of social support on relapse

The result of this study reported that perceived social support was a protective factor that strongly predicted lower relapse rates. The finding of this study showed that lack of social support predicted around 32% of relapse rate among patients with substance use disorder. These results are consistent with the previous study that indicated the predictive role of lack of perceived social support as 19.9% of relapse rate (Ajayi et al., 2025).

The “stress buffering theory” which argued that social support promotes emotional resilience and adaptive coping, provides support to this result (Cohen and Wills, 1985). Additional study also found lack of perceived social support as strongest predictor of relapse highlighting its important in long term recovery (Nikmanesh et al., 2016). Similarly, Ethiopian research has highlighted the value of family support and social relationships in enhancing rehabilitation outcomes (Adem et al., 2025). Social support is important for lowering the isolating effects of loneliness and perceived stigma. Family, significant others and community support strengthens responsibilities and promotes motivation for long-term abstinence, all of which reduce the risk of relapse. This result raises awareness to an important cultural aspect, in Ethiopia’s collectivism norms, a patient’s subjective perception that friends and families will support them in decision making and sharing emotional burdens provides an important line of protection against environmental triggers. And strong social support directly addresses the negative impacts of loneliness and stigma.

5.4 Combined predictive role

The result of the combined analysis of these factors showed that social support, perceived stigma and loneliness together explained a significant percentage of change in relapse rates. It implied that lots of interdependent psychosocial factors have an impact on relapse in patients with substance use disorders rather than just one. Perceived social support continued to be the most powerful predictor of relapse among all variables, showing its important protective role even in lonely and stigmatized condition.

The result showed that psychosocial factors including loneliness, perceived stigma and social support together contributed to substance use disorder relapse 41.4%. The remaining 58.6% suggests other factors not included in this study, such as the severity and duration of past substance use, individual differences in coping style and so on.

Overall, the result supported an important argument, relapse in substance use disorder patients is not mainly a biological event but also a psychologically integrated process that occurs in a setting of isolation, societal devaluation and perceived interpersonal separation. Treatment strategies that simply center detoxification and pharmaceutical stabilization will inevitably fail. In order to achieve long term recovery outcomes, a holistic and person centered approach that simultaneously targets loneliness, addresses stigma and strengthens patient's perceived social support is not only beneficial but also therapeutically necessary.

6. Conclusion

This study examined the psychosocial predictors of relapse among patients with substance use disorders in Addis Ababa, Ethiopia, with an emphasis on loneliness, perceived stigma and social support. Although the results are statistically significant, their deepest significance goes far beyond the numbers. It showed that relapse is not mainly due to by pharmacological fail or lack of motivation, it is also a social and psychological process that is influence by the nature of human environment.

The study's most important finding is that current biomedical model for treating SUD I structurally insufficient. Any treatment plan that just targets the biomedical aspects of addiction while ignoring the social surroundings of a recovered patients is insufficient. If psychosocial factors alone account for 41% SUD relapse. Treatment programs that discharge patients in to situation of social isolation, stigma and poor social support network are not treating the whole person. They are simply treating the symptoms and send back patients to the situation that caused it.

There is clear and practical implication to the fact that perceived social support is the best single predictor of relapse, families and communities are essential to recovery. Patient's subjective feeling of belonging appears to be one of the most powerful relapse prevention strategies when they believe that those closest to them are truly supporting them. This implies that SUD treatment should formally include family in the therapeutic process as active participants who are informed and supported to make a significant contribution to a patient's recovery rather than as passive visitors.

For patients with SUD, stigma is more than just a social inconvenience. It function as an important clinical predictor that undermines self-worth, discourages help seeking and make it challenging to establish and maintain recovery. The fact that stigma universally perceived by the sample shows that this is a society issue rather than just an individual one. It highlight the need for institutional intervention at the level of community education, public health messaging and clinical training so that the moral and cultural framing of addiction as a behavioral flaw starts to give away more accurate understanding of it as a treatable health condition.

Loneliness, highlights one aspect of recovery that rarely addressed by clinical systems.. Even though they are harmful, patients in recovery lose the social network that gave them a feeling of community and daily routine. What closes that gap is important. The finding that loneliness is a major predictor of relapse on its own implies that recovery support should actively focus on fostering social connections rather than just eliminating negative ones.

Over all, these findings suggest that the current view and resources for SUD recovery need to be modified. Recovery doesn't take place in a treatment facilities I occurs in homes, work place and communities. And its probability largely determined by what such settings provide or withhold. In order to effectively reduce relapse, a treatment model must address the psychosocial conditions that sustain vulnerability, reach out to those environments and acknowledge that long term recovery necessitates both cured individual and supportive social environment for that individual to return to.

7. Recommendations

Based on the above findings and conclusion the following recommendations are proposed for mental health professionals, institutions, families and community.

For mental health professionals and institutions

Psychosocial aspects like loneliness, perceived stigma and social support should be often evaluated by mental health professionals dealing with individuals with substance use disorders during treatment and follow up care. Relapse preventive measures, emotional support services and psychosocial counseling should all be included in intervention programs. In order to improve patients' social connections and emotional resilience during recovery, treatment facilities should strengthen peer support and family based programs.

For families and communities

Families of people with substance use disorders should be encouraged to take an active role in their treatment and recovery process. Encouragement, acceptance and emotional support can lessen feelings of loneliness and increase treatment results. In order to minimize stigma related challenges to treatment, community awareness programs should be put in place to lessen discrimination and negative attitudes toward people with substance use disorders.

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Annexes

Annex 1: Consent form of the study (English version)



ADDIS ABABA UNIVERSITY
COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES
SCHOOL OF PSYCHOLOGY

My name is _____. I am a data collector for the study entitled “Psychosocial Factors as Predictors of Relapse among Substance Use Disorder Patients in Mental Health Facilities in Addis Ababa, Ethiopia.” This study is being conducted by Ms. Tizitawork Enkubahiry as part of the requirements for a graduate thesis in Counseling Psychology at Addis Ababa University. The purpose of the study is to better understand psychosocial factors that influence relapse among patients with substance use disorders. The study will be conducted from March, 2026 to April, 2026 in selected mental health and rehabilitation facilities in Addis Ababa.

You are invited to participate in this study after reading and understanding the following information and voluntarily giving your consent.

What is the study about?

This study aims to examine psychosocial factors that predict relapse among individuals diagnosed with substance use disorders. Specifically, the study seeks to:

- Assess the relationship between loneliness and relapse
- Examine how perceived stigmatization influences relapse
- Explore the role of perceived social support in reducing relapse

The findings of this study will contribute to improving relapse prevention strategies and psychosocial interventions in mental health facilities.

Why are you invited to participate?

You are invited to participate because you are an adult patient diagnosed with a substance use disorder and are currently receiving treatment or follow-up services at one of the selected mental health or rehabilitation facilities in Addis Ababa. Your experiences and perspectives are important for understanding factors that affect recovery and relapse.

What is expected from you?

If you agree to participate, you will be asked to complete a structured questionnaire. The questionnaire will include questions about your background information, feelings of loneliness, perceived stigma, perceived social support and experiences related to relapse. Completing the questionnaire will take approximately **30–45 minutes**. The data collection will be conducted in a private and respectful manner.

What are the benefits of participating in this study?

There is no direct financial or material benefit for participating in this study. However, your participation will help generate valuable information that may assist mental health professionals, rehabilitation centers and policymakers in developing more effective psychosocial support and relapse prevention programs for individuals with substance use disorders in Ethiopia.

What are the risks of participating?

There are no physical risks associated with participating in this study. Some questions may involve personal or sensitive topics related to substance use and recovery, which may cause mild emotional discomfort. If you feel uncomfortable at any point, you may skip any question or stop participating without any consequences.

What are your rights as a participant?

- Your participation in this study is entirely voluntary.
- You have the right to refuse to participate or to withdraw from the study at any time without any penalty or effect on your treatment or services.
- You may choose not to answer any question you do not feel comfortable answering.

How will your information be kept confidential?

All information you provide will be kept strictly confidential. Your name or any identifying information will not be written on the questionnaire. Codes will be used instead of personal identifiers. The data will be stored securely and will only be accessible to the principal investigator. The results of the study will be reported in aggregate form, ensuring that no individual participant can be identified.

Whom to contact if you have concerns or questions?

Institutional Review Board (IRB)

Addis Ababa University

Principal Investigator:

Ms. Tizitawork Enkubahiry

School of Psychology, College of Education and Behavioral Studies

Addis Ababa University

Advisor: Dr. Assefa Berihun (PHD), School of Psychology, Addis Ababa University

Informed Consent

Are you willing to participate in this study? (Please circle one)

1. **Yes** (Consent is given and participation continues)
2. **No**

I, the undersigned participant, confirm that I have read or had the above information read to me, have understood it and voluntarily agree to participate in this study.

Participant's Signature: _____

Date: _____

Data Collector's Signature: _____

Printed Name: _____

Date: _____

ANNEX 2: Questionnaire of the study (English version)

Section I: Socio-Demographic Information

1.	Age	_____ years
2.	Sex	1, Male 2, Female
3.	Marital status	1, Single 2, Married 3, Divorced
4.	Occupation	1, Student 2, Employed 3, Unemployed
5.	Education	1, No formal 2, Primary 3, Secondary 4, Degree and above

Section II: Relapse Assessment

Please read the following statements and for each one circle a number, from 1 to 7, to indicate how much this has been true for you recently. Please circle one and only one number for every statement.

No		Never	Rare ly	Some times	Fairly often	Often	Almost always	Alwa ys
6	I feel nervous or unsure of my ability to stay substance free.							
7	I have many problems in my life.							
8	I tend to overreact or act impulsively							
9	I keep to myself and feel lonely.							
10	I get too focused on one area of my life.							
11	I feel blue, down, listless, or depressed.							
12	I engage in wishful thinking.							
13	The plans that I make succeed.							
14	I have trouble concentrating and prefer to dream about how things could be.							
15	Things don't work out well for me.							
16	I feel confused.							
17	I get irritated or annoyed with my friends.							

18	I feel angry or frustrated.							
19	I have good eating habits.							
20	I feel trapped and stuck, like there is no way out.							
21	I have trouble sleeping.							
22	I have long periods of serious depression.							
23	I don't really care what happens.							
24	I feel like things are so bad that I might as well use substances.							
25	I am able to think clearly.							
26	I feel sorry for myself.							
27	I think about using substances.							
28	I lie to other people.							
29	I feel hopeful and confident.							
30	I feel angry at the world in general							
31	I am doing things to stay substance free.							
32	I am afraid that I am losing my mind.							
33	I am using substances out of control.							

Section III: Loneliness

INSTRUCTIONS: Indicate how often each of the statements below is descriptive of you.

No		Never	Rarely	Sometimes	Often
34	I feel in tune with the people around me.				
35	I lack companionship.				
36	There is no one I can turn to.				
37	I do not feel alone.				
38	I feel part of a group of friends.				
39	I have a lot in common with the people around me.				
40	I am no longer close to anyone.				
41	My interests and ideas are not shared by those around me.				
42	I am an outgoing person.				
43	There are people I feel close to.				
44	I feel left out.				
45	My social relationships are superficial.				
46	No one really knows me well.				
47	I feel isolated from others.				
48	I can find companionship when I want it.				
49	There are people who really understand me.				
50	I am unhappy being so withdrawn.				
51	People are around me but not with me.				
52	There are people I can talk to.				
53	There are people I can turn to.				

Section IV: Perceived stigmatization

No		Strongly disagree	Disagree	Agree	Strongly agree
54	Most people would willingly accept someone who has been treated for substance use as a close friend.				
55	Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.				
56	Most people would accept someone who has been treated for substance use as a teacher of young children in a public school.				
57	Most people would hire someone who has been treated for substance use to take care of their children.				
58	Most people think less of a person who has been in treatment for substance use.				
59	Most employers will hire someone who has been treated for substance use if he or she is qualified for the job.				
60	Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.				
61	Most people would be willing to date someone who has been treated for substance use.				

Section V: Perceived social support

No		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
62	There is a special person who is around when I am in need.					
63	There is a special person with whom I can share my joys and sorrows.					
64	My family really tries to help me.					
65	I get the emotional help and support I need from my family.					
66	I have a special person who is a real source of comfort to me.					
67	My friends really try to help me					
68	I can count on my friends when things go wrong.					
69	I can talk about my problems with my family.					
70	I have friends with whom I can share my joys and sorrows.					
71	There is a special person in my life who cares about my feelings.					
72	My family is willing to help me make decisions					
73	I can talk about my problems with my friends.					

ANNEX 3: Consent form of the study (Amharic version)

አባሪ 1: የጥናቱ የተሳትፎ ፈቃድ ፎርም (የአማርኛ ቅጂ)



አዲስ አበባ ዩኒቨርሲቲ

የትምህርትና የባህሪ ጥናት ኮሌጅ

የስነ-ልቦና ትምህርት ቤት

ስሜ _____ ነው። እኔ “በአዲስ አበባ ከተማ በሚገኙ የአእምሮ ጤና ተቋማት ውስጥ የሚታከሙ የንጥረ ነገር አጠቃቀም ችግር ያለባቸው ታካሚዎች ማገርሸትን የሚተነብዩ ማህበራዊ እንዲሁም ስነ ልቦናዊ ምክንያቶች” በሚል ርዕስ ለሚካሄደው ጥናት የመረጃ ሰብሳቢ ነኝ። ይህ ጥናት በአዲስ አበባ ዩኒቨርሲቲ የስነ-ልቦና ትምህርት ቤት ተማሪ ወ/ሪት ትዝታወርቅ እንቁባህርይ አማካኝነት የሚደረግ የመመረቂያ ዕሁፍ ክፍል ነው። ጥናቱ ከ መጋቢት እስከ ሚያዝያ 2018 በአዲስ አበባ የተመረጡ የአእምሮ ጤና ሕክምና ተቋማት ውስጥ ይካሄዳል።

ከታች የቀረበውን መረጃ አንብበው በሙሉ ከተረዱ በኋላ በፈቃድዎ በጥናቱ እንዲሳተፉ ተጋብዘዋል።

ጥናቱ ስለምንድን ነው?

ይህ ጥናት በንጥረ ነገር አጠቃቀም ችግር የታከሙ ታካሚዎች ወደ እንደገና መጠቀም (ማገርሸት) የሚያመጡ ማህበራዊና ስነልቦናዊ ምክንያቶችን ለመመርመር የተዘጋጀ ነው። በተለይም:

- ብቸኝነት እና ማገርሸት መካከል ያለውን ግንኙነት

- የመገለል ስሜት በማገርሽት ላይ ያለውን ተፅዕኖ
- የማህበራዊ ድጋፍ ስሜት ማገርሽትን እንዴት እንደሚቀንስ ለመገምገም ይሞክራል።

ለምን ተጋበዙ?

እርስዎ በአንዱ የተመረጠ የአእምሮ ጤና ሕክምና ተቋም ውስጥ የንጥረ ነገር አጠቃቀም ችግር ጋር በተያያዘ ሕክምና እየተቀበሉ ወይም ክትትል ላይ ስለሆኑ ፤ ልምድዎና አስተያየትዎ ለጥናቱ በጣም አስፈላጊ ነው።

ከእርስዎ ምን ይጠበቃል?

በጥናቱ ለመሳተፍ ከተስማሙ የተዘጋጀ መጠይቅ ፎርም እንዲሞሉ ይጠየቃሉ። መጠይቁ የማህበራዊ መረጃዎችን፣ ብቸኝነትን፣ የመገለል ስሜትን፣ የማህበራዊ ድጋፍ ስሜት እና ከማገርሽት ጋር የተያያዙ ጉዳዮችን ይዟል። መጠይቁን ለመሙላት 30—45 ደቂቃ ያህል ይወስዳል።

በጥናቱ መሳተፍ የሚያመጣው ጥቅም ምንድን ነው?

በቀጥታ የገንዘብ ወይም የንብረት ጥቅም የለም። ነገር ግን ይህ ጥናት በአእምሮ ጤና ባለሙያዎች፣ የሕክምና ተቋማት እና የፖሊሲ አውጪዎች ማገርሽትን ለመከላከል የተሻለ ማህበራዊ እንዲሁም ስነ ልቦናዊ እርምጃዎች እንዲዘጋጁ ያግዛል።

በጥናቱ መሳተፍ ሊያመጣ የሚችል አደጋ አለ?

ምንም የአካል አደጋ የለም። አንዳንድ ጥያቄዎች ስለ የግል ልምድዎ ሊሆኑ ስለሚችሉ ትንሽ አለመመቸት ሊያስከትሉ ይችላሉ። ካልፈለጉ ማንኛውንም ጥያቄ መመለስ ሊተዉ ወይም በማንኛውም ጊዜ መሳተፍዎን ማቆም ይችላሉ።

እንደ ተሳታፊ መብቶችዎ

- ተሳትፎዎ በፈቃድ ነው
- በማንኛውም ጊዜ መሳተፍ ማቆም ይችላሉ
- ያልፈለጉትን ጥያቄ መመለስ ግዴታዎ አይደለም

መረጃዎ እንዴት ይጠበቃል?

የሚሰጡት መረጃ በሙሉ ሚስጥራዊ ይሆናል። ስምዎ ወይም ሌላ መለያ መረጃ በመጠይቁ ላይ አይጻፍም። መረጃው በኮድ ተመዝግቦ በደህንነት ይጠበቃል፤ ውጤቶችም ማንኛውንም ግለሰብ ሳይገልጹ በጠቅላላ መልኩ ይቀርባሉ።

ጥያቄ ወይም ችግር ካለ?

የምርምር ሥነ-ምግባር ኮሚቴ (IRB)

አዲስ አበባ ዩኒቨርሲቲ

ዋና ተመራማሪ:

ወ/ሪት ትዝታወርቅ እንቁባህርይ

የስነ-ልቦና ትምህርት ቤት፤

የትምህርትና የባህሪ ጥናት ኮሌጅ፤

አዲስ አበባ ዩኒቨርሲቲ

አማካሪ: ዶ/ር አሰፋ በሪሁን (ፒ. ኤች. ዲ)

የስነ-ልቦና ትምህርት ቤት፤

የትምህርትና የባህሪ ጥናት ኮሌጅ፤

አዲስ አበባ ዩኒቨርሲቲ

የተሳትፎ ፈቃድ

በዚህ ጥናት ለመሳተፍ ፈቃደኛ ነዎት? (እባክዎ አንዱን ይምረጡ)

1. አዎን

2. አይደለሁም

እኔ ከታች ፊርማዬ ያረፈው ተሳታፊ ከላይ የቀረበውን መረጃ ተረድቻለሁ፤ በፈቃዴም በዚህ ጥናት ለመሳተፍ እስማማለሁ።

የተሳታፊ ፊርማ: _____

ቀን: _____

የመረጃ ሰብሳቢ ፊርማ: _____

ሙሉ ስም: _____

ቀን: _____

ANNEX 4: Questionnaire of the study (Amharic version)

ክፍል አንድ፡ አጠቃላይ መረጃ

1	ዕድሜ	_____ ዓመት
2	ፆታ	1, ወንድ 2, ሴት
3	የጋብቻ ሁኔታ	1፣ ነጠላ 2፣ ያገባ/ያገባች 3፣ የተፋታ/የተፋታች
4	ሙያ / ሥራ ሁኔታ	1፣ ተማሪ 2፣ ተቀጣሪ (የሚሰራ) 3፣ ስራ የሌለው
5	የትምህርት ደረጃ	1፣ መደበኛ ትምህርት ያልተማረ 2፣ መጀመሪያ ደረጃ 3፣ ሁለተኛ ደረጃ 4፣ ዲግሪ እና ከዚያ በላይ

ክፍል ሁለት፡ መልሶ መጠቀም / ማገርሽት መረጃ

መመሪያ፦ እባክዎን እያንዳንዱን ዓረፍተ ነገር ያንብቡ እና ከዋነኛ የሱስ አጠቃቀም ጋር በተያያዘ በቅርብ ጊዜ ውስጥ ለእርስዎ ምን ያህል እውነት እንደሆነ የሚገልጸውን ቁጥር ያክብቡ፡፡

ተ.ቁ		በፍጹም	በጣም አልፎ አልፎ	አንዳንዴ	ብዙ ጊዜ	ደጋግሞ	ሁልጊዜ ለማለት ይቻላል	ሁልጊዜ
6	ሱስ ሳይኖርብኝ የመቆየት ችሎታዬ ላይ ጭንቀት ወይም ጥርጣሬ ይሰማኛል።							
7	በሕይወቴ ውስጥ ብዙ ችግሮች አሉብኝ።							
8	ነገሮችን የማጋነን ወይም በስሜት የመገፋፋት ዝንባሌ አለኝ።							
9	ከሰው እገለጻለሁ እንዲሁም ብቸኝነት ይሰማኛል።							
10	በአንድ የሕይወቴ ክፍል ላይ ብቻ ከመጠን በላይ አተኩራለሁ።							
11	የድብርት፣ የሀዘን፣ የዝለት ወይም የጭንቀት ስሜት ይሰማኛል።							
12	ምኞታዊ በሆኑ ሃሳቦች ውስጥ እጠመዳለሁ።							
13	የማወጣቸው ዕቅዶች ይሳካሉ።							
14	ትኩረት የማድረግ ችግር አለብኝ፤ እንዲሁም ነገሮች ምን ሊሆኑ እንደሚችሉ ማለም እመርጣለሁ።							
15	ነገሮች ለእኔ መልካም አይሆኑልኝም።							

16	ግራ መጋባት ይሰማኛል።							
17	በጓደኞቼ እበሳጫለሁ ወይም እመረራለሁ።							
18	ቁጣ ወይም ብስጭት ይሰማኛል።							
19	ጥሩ የአመጋገብ ልማድ አለኝ።							
20	መውጫ እንደሌለው ሁሉ የታሰርኩ እና የተቀረቀረሁ ሆኖ ይሰማኛል።							
21	የመተኛት ችግር አለብኝ።							
22	ለረጅም ጊዜ የሚቆይ ከፍተኛ የድብርት ስሜት አለብኝ።							
23	ምን እንደሚፈጠር ግድ አይሰጠኝም።							
24	ነገሮች በጣም ከመበላሸታቸው የተነሳ ሱስ የሚያስይዙ ነገሮችን ብጠቀም ይሻላል ብዬ አስባለሁ።							
25	ነገሮችን በግልፅ ማሰብ እችላለሁ።							
26	ለራሴ የሀዘን ስሜት ይሰማኛል።							
27	ሱስ የሚያስይዙ ነገሮችን ስለመጠቀም አስባለሁ።							
28	ለሰዎች እዋሻለሁ።							
29	የተስፋ እና የመተማመን ስሜት ይሰማኛል።							

30	በአጠቃላይ በአለም ላይ የጥላቻ ስሜት ይሰማኛል።							
31	ከሱስ ነፃ ለመሆን ነገሮችን እያደረግኩ ነው።							
32	አእምሮዬን እያጣሁ እንደሆነ እፈራለሁ።							
33	ሱስ የሚያስይዙ ነገሮችን ከቁጥጥር ውጪ በሆነ ሁኔታ እየተጠቀምኩ ነው።							

ክፍል ሶስት: ብቸኝነት

መመሪያ : ከዚህ በታች ያሉት እያንዳንዳቸው መግለጫዎች እርስዎን ምን ያህል እንደሚገልጹ ያመልክቱ።

ተ.ቁ		ፈጽሞ	አልፎ አልፎ	አንዳንድ ጊዜ	ብዙ ጊዜ
34	በዙሪያዬ ካሉ ሰዎች ጋር እንደምስማማና እንደምቀራረብ ይሰማኛል።				
35	አጋር ወይም ጓደኛ ይጎድለኛል።				
36	ወደ እሱ ዘወር የምልበት (የምመካበት) ማንም ሰው የለም።				
37	ብቸኝነት አይሰማኝም።				
38	የአንድ የጓደኛ ቡድን አካል እንደሆንኩ ይሰማኛል።				
39	በዙሪያዬ ካሉ ሰዎች ጋር ብዙ የሚያመሳስሉን ነገሮች አሉ።				
40	አሁን ማናቸውም ሰው ጋር የጠበቀ ቅርበት የለኝም።				

41	ፍላጎቶችና ሃሳቦች በዙሪያዬ ባሉ ሰዎች አይጋሩልኝም።				
42	እኔ ሰው ወዳድና ተግባቢ ሰው ነኝ።				
43	የቅርብ ቁርኝት የሚሰማኝ ሰዎች አሉ።				
44	እንደተገለልኩ (እንደተተውኩኝ) ይሰማኛል።				
45	ማህበራዊ ግንኙነቶች ላይ ላዩን (ጥልቀት የሌላቸው) ናቸው።				
46	ማንም ሰው እኔን በትክክል አያውቀኝም።				
47	ከሌሎች ሰዎች እንደተለየሁ/እንደተገለልኩ ይሰማኛል።				
48	በምፈልግበት ጊዜ አጋር ወይም ጓደኛ ማግኘት እችላለሁ።				
49	እኔን በትክክል የሚረዱኝ ሰዎች አሉ።				
50	ለብቻዬ መገለጫ (ራሴን ማግለጫ) አያስደስተኝም።				
51	ሰዎች በዙሪያዬ አሉ ነገር ግን ከእኔ ጋር አይደሉም።				
52	ላናግራቸው የምችላቸው ሰዎች አሉ።				
53	እርዳታ ፍለጋ ወደ እነሱ ዘወር የምልባቸው ሰዎች አሉ።				

ክፍል አራት: የመገለል ስሜት መረጃ

ተ. ቁ		ሙሉ በሙሉ አልስማምም	አልስማምም	እስማማለሁ	ሙሉ በሙሉ እስማማለሁ
54	አብዛኛዎቹ ሰዎች ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለትን ሰው እንደ የቅርብ ጓደኛ በፈቃደኝነት ይቀበላሉ ::				
55	አብዛኛዎቹ ሰዎች ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለት ሰው እንደ አማካይ ዜጋ ታማኝ ነው ብለው ያምናሉ ::				
56	አብዛኛዎቹ ሰዎች ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለትን ሰው በሕዝብ ትምህርት ቤት ወጣት ልጆች አስተማሪ አድርገው ይቀበሉታል ::				
57	አብዛኛዎቹ ሰዎች ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለትን ሰው ልጆቻቸውን እንዲንከባከብ ይቀጥራሉ ::				
58	አብዛኛዎቹ ሰዎች ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለትን ሰው ዝቅ አድርገው ያስባሉ ::				
59	ብቁ ከሆነ ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለትን ሰው አብዛኛዎቹ ቀጣሪዎች ይቀጥራሉ ::				
60	አብዛኛዎቹ ቀጣሪዎች ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለት ሰው ማመልከቻን ለሌላ አመልካች ሲሉ ያልፋሉ (አይቀበሉም) ::				
61	ለአደንዛዥ ዕፅ አጠቃቀም ሕክምና የተደረገለት ሰው ጋር ለመገናኘት (በፍቅር) አብዛኛዎቹ ሰዎች ፈቃደኛ ይሆናሉ ::				

ክፍል አምስት: የማህበራዊ ድጋፍ ስሜት

ተ. ቁ		ሙሉ በሙሉ አልስማማም	አልስማማም	ገለልተኛ	እስማማለሁ	ሙሉ በሙሉ እስማማለሁ
62	ስፈልግ ከጎኔ የሚሆን ልዩ ሰው አለ ::					
63	ደስታዬንና ሐዘኔን የማካፍለው ልዩ ሰው አለኝ ::					
64	ቤተሰቤ በእውነት ሊረዱኝ ይሞክራሉ ::					
65	ከቤተሰቦቼ የምፈልገውን ስሜታዊ እርዳታ እና ድጋፍ አገኛለሁ ::					
66	ለእኔ የእውነተኛ የመጽናኛ ምንጭ የሆነ ልዩ ሰው አለኝ ::					
67	ጓደኞቼ በእውነት ሊረዱኝ ይሞክራሉ ::					
68	ነገሮች ሲበላሹ በጓደኞቼ መታመን እችላለሁ ::					
69	ችግሮቼን ከቤተሰቦቼ ጋር መነጋገር እችላለሁ ::					
70	ደስታዬንና ሐዘኔን የማካፍላቸው ጓደኞች አሉኝ ::					
71	ስለ ስሜቶቼ የሚጨነቅ ልዩ ሰው በሕይወቴ ውስጥ አለ ::					
72	ቤተሰቦቼ ውሳኔ እንድወስን ለመርዳት ፈቃደኛ ናቸው ::					
73	ችግሮቼን ከጓደኞቼ ጋር መነጋገር እችላለሁ ::					