

CORRELATION BETWEEN LEVELS OF EMOTIONAL REGULATION AND RELAPSE RISK AMONG CLIENTS IN DRUG TREATMENT CENTERS IN KIAMBU COUNTY, KENYA

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ABSTRACT

Purpose of the Study: The study examined the correlation between levels of emotional regulation and relapse risk among clients in drug treatment centers in Kiambu County, Kenya.

Statement of the Problem: Despite the increasing number of rehabilitation programs and awareness campaigns on substance use in Kenya, relapse rates remain high, estimated between 40% and 60% globally. In Kiambu County, many clients' completing treatment often relapse shortly after discharge, suggesting gaps in psychological preparedness and emotional control. While existing studies have explored social and environmental predictors of relapse, limited attention has been given to emotional regulation as a determinant of treatment success and long-term abstinence.

Methodology: The study adopted a correlational research design integrating both quantitative and qualitative approaches. A census sampling method was employed, targeting all 162 clients in their final month of treatment across fifteen NACADA-accredited drug treatment centers in Kiambu

County. Quantitative data were collected using standardized tools including the Difficulties in Emotion Regulation Scale (DERS) and the Advance Warning of Relapse (AWARE) scale, while qualitative insights were gathered through semi-structured interviews. Data were analyzed using descriptive statistics, correlation, and regression analyses to establish the relationship between emotional regulation and relapse risk.

Findings: The study revealed a significant negative correlation between emotional regulation and relapse risk ($r = -0.469$, $p < 0.05$), indicating that higher emotional regulation skills are associated with a lower likelihood of relapse. Regression analysis further showed that combined measures of emotional awareness and regulation significantly predicted relapse risk ($F(2,157) = 22.257$, $p < 0.05$).

Conclusion: The study concludes that emotional regulation plays a critical role in sustaining recovery among clients in treatment for substance use disorders. Clients with higher emotional awareness and control were better equipped to manage stress and resist relapse triggers, while those with limited regulation were more vulnerable to relapse after treatment.

Recommendations: The study recommends that treatment centers should integrate structured emotional regulation training into rehabilitation programs to strengthen clients' coping capacity and resilience. Additionally, government agencies and policymakers should develop guidelines emphasizing emotional regulation as a core component of addiction treatment. Further interventional research is recommended to examine how enhancing emotional regulation impacts relapse prevention and to extend the investigation to clients with behavioral addictions.

Keywords: *Emotional regulation, emotional awareness, relapse risk, substance use disorder, Kiambu County, Kenya.*

INTRODUCTION

Substance abuse treatment for alcohol and drugs aims to equip patients with skills that help them overcome substance use and abuse. Unfortunately, substance use and abuse persists despite the presence of interventions meant to cure addiction. Although some addicts who eventually overcome their addiction, there is evidence showing that there are clients who relapse after treatment and subsequent discharge. According to the National Institute on Drug Abuse (NIDA,

2020), 40% to 60% of clients relapse following treatment. These high rates of relapse can be attributed to several reasons that vary depending on an individual's social and emotional disposition. This then calls for scholarly inquiry so as to understand the actual causes of relapse, as well as to find out whether these clients have had adequate levels of emotional regulation that could have enabled them to overcome addiction.

Emotional Regulation (ER) refers to how an individual “tries to influence which emotions one has, when one has them” (Gross, 1998), and how an individual expresses the emotions. Ottonello, Fiabane, Pistarini, Spigno and Torsello (2019) conducted a study in Italy, and they concluded that lack of regulation of emotions might increase the likelihood of a patient experiencing the risk of relapse especially in one of the emotional regulation components such as emotional clarity. Similarly, findings from a study conducted in Australia by Dingle, Costa Neves, Alhadad and Hides (2017) showed that regulation of emotions predicts the clients' ability to maintain abstinence after undergoing treatment.

In Europe, a study by Jakubczyk, Trucco, Kopera, Kobylinski, Sussek, Fudalej, Brower and Wojnar (2018) showed that an individual's impulsivity could be a factor that may affect aspects of emotional regulation, which may then make one susceptible to experiencing relapse. In Kenya, in addition to having a dearth of research on emotional awareness and regulation, scholarly inquiry has focused on severity of use, preparedness to cope, perceived harmful criticism, individual and family dynamics as factors influencing relapse (Githae, 2019; Wainaina, 2020; Wangithi & Ndurumo, 2020) among others. Although emotions evidently play a role in behavior, it is not clear how emotional awareness and regulation influences the risk of relapse, forming a solid basis for the current research.

STATEMENT OF THE PROBLEM

An individual's emotional regulation may determine his or her ability to cope when they encounter various challenges such as loneliness, lack of family support and lack of employment, among others. Specifically, when a person who is undergoing substance use treatment lacks emotional regulation strategies, he or she risks relapsing to substance use. Apparently, one's acquisition or development of skills in emotional regulation may positively influence clients and facilitate abstinence from drug use. Considering these critical observations, the current study aimed at

interrogating whether focusing on individuals' lack of emotional regulation and awareness contributes to relapse and how it can be included as a part of the treatment program. Thus, there was need to seek and establish if emotional regulation may be related to relapse risk.

RESEARCH OBJECTIVES

This study was guided by the following objectives:

- i. To investigate the levels of emotional regulation among clients in drug treatment centers in Kiambu County, Kenya.
- ii. To establish the relationship between emotional regulation and relapse risk among clients in drug treatment centers in Kiambu County, Kenya.

RESEARCH QUESTIONS

This study had the following research questions:

- i. What levels of emotional regulation exist among clients in drug treatment centers in Kiambu County, Kenya?
- ii. What levels of emotional regulation and relapse risk exist among clients in drug treatment centers in Kiambu County, Kenya?

RESEARCH HYPOTHESIS

This study was guided by the following hypothesis:

- i. H_{a1} : There is a significant relationship between levels of emotional regulation and relapse risk among clients in drug treatment centers in Kiambu County, Kenya.

THEORETICAL FRAMEWORK

This study was guided by the tenets of Transtheoretical Model of Behavior Change (TTM) which was developed by Prochaska and DiClemente (1984). The TTM model addresses psychological mechanisms related to behavior change. The TTM model was developed by Prochaska and DiClemente (1984). This model evolved through studies that examined the experiences of smokers who had managed to stop smoking, without help and those that required further treatment. The model focuses on decision making and intentional change. This model posited that change occurs through the six stages that include: precontemplation, contemplation, preparation, action,

maintenance, and termination. However, there are varied explanations as to why some individuals can quit substance use without requiring treatment while others require treatment to overcome their addiction. Partly, the ease or difficulty to overcome addiction can be dependent on an individual's willingness to acknowledge the effects of their addiction and to take the necessary steps. In this regard, the TTM model offers some vital insights that influenced this study's interrogation of the processes of addiction treatment, success and even failures and the underlying explanations.

According to the TTM model, the first stage is precontemplation where the individual does not have the intention to change his or her behavior. The individual may be unaware of his or her problem or does not see his behavior as one that needs attention. The second stage is contemplation where the individual has started thinking about the detriments of using substances. This individual has realized that s/he needs to act and make changes. In this stage, the individual is weighing the advantages or disadvantages of making the change. For instance, a systematic review was conducted using the TTM for physical activity in older adults.

The findings revealed that use of this model was suitable and useful in the designing interventions that can assist in the attainment of behavior change (Jimenez-Zaro et al., 2020). In addition, "interventions for individuals in the contemplation stage may include both audio and visual messages from peers" (Ford et al., 2013), medical practitioners (Chapman, 1993), and influential people in society (Green Ford et al., 2013 et al., 2008), "to help change the perception of social norms of smoking and creating cognitive dissonance within the individual by influencing their personalized perception of smoking" (Ahmad & Singh, 2021).

In the third stage known as preparation stage, the individual decides to act towards their problematic behavior. At this stage, the individual has noted that there is need to make change. These individuals have started to make small changes and is working towards reducing incrementally lowering indulgence. It is noted that at this stage the individual desires to make meaningful change leading to a healthy lifestyle. In the action stage, the individual works towards maintaining the behavior change by doing what is required such as attending meetings, therapy sessions and having an accountability partner. In this stage there is a decrease in cravings and urges in the use of the substances. It is during this stage that the client needs to continue working on

unresolved issues that are likely to interfere with the progress that has been made. In the final stage that is maintenance, the individual continuously puts the skills that they have learned to practice and avoids situations that may cause them to experience a relapse. What is important to note is an individual's progress from one stage to another is dependent on their ability to navigate through the different stages of the change process.

EMPIRICAL REVIEW

Empirical studies on emotional regulation show that one's ability to identify, understand, and manage emotions directly influences behavioral outcomes and recovery from addiction. Di Pierro, Benzi, and Madeddu (2015) found that individuals with substance use disorders who struggled to access emotional regulation strategies and lacked mature defense mechanisms were more likely to relapse. Similarly, Jakubczyk et al. (2018) reported that alcohol use disorder symptoms were characterized by poor emotional regulation and high impulsivity, though they found no direct link between impulsivity and emotional control. Rahbarian et al. (2017) also revealed that poor emotional regulation was a strong predictor of addiction potential among Iranian students, while Menin, Fresco, O'Toole and Heimberg (2018) established that patients receiving Emotional Regulation Therapy exhibited greater improvement than those under modified attention control conditions. Estevez et al. (2017) further demonstrated that emotional regulation significantly predicted both substance and behavioral addictions among youth, confirming that regulation skills form a crucial buffer against addictive behaviors.

Globally, studies have consistently indicated that relapse rates remain high despite treatment interventions. Williams et al. (2015) found that 16% of U.S. military personnel categorized as problem drinkers relapsed, while Andersson et al. (2019) reported a 37% relapse rate among 607 clients in Norway three months post-discharge. In Asia, Mohammadpoorsal et al. (2012) observed a 64% relapse rate after six months, linking it to smoking and family drug use. Fairbairn et al. (2015) in Thailand found that 66% of clients relapsed after release from compulsory drug detention centers due to the lack of voluntary treatment motivation, and Kvamme, Asplund and Bjerke (2015) identified craving, self-image, and time as critical elements in the relapse process. Collectively, these findings demonstrate that relapse risk is influenced by psychological, environmental, and treatment-related factors that extend beyond mere abstinence efforts.

Within the African context, Appiah et al. (2017) showed that negative emotional states significantly increased the likelihood of relapse in Ghana, while Swanepoel (2015) reported a 22% relapse rate among clients in South Africa, attributing this to environmental and social factors. In Kenya, Chepkwony, Chelule and Barmao (2013) identified past risks, environmental factors, and coping capacity as key relapse predictors, whereas Kuria (2013) found that low self-efficacy and lack of coping skills contributed to relapse after community-based treatment. Githae (2016) established that family emotional over-involvement intensified relapse risk among alcoholics in Nairobi. Taken together, these studies illustrate that while social and environmental factors are important, emotional regulation remains a central psychological determinant of sustained recovery from substance use disorders.

CONCEPTUAL FRAMEWORK

The study's conceptual framework was guided by the theoretical framework and the reviewed literature. Emotional regulation components including “refusal to accept emotional response”, “finding it difficult to engage in goal directed behavior”, “difficult in controlling impulse” “lack of emotional regulation”, “inaccessibility of emotional regulation strategies”, and “inability to attain emotional clarity” were considered. An individual's emotional regulation skills can influence the likelihood of a relapse. However, age, gender, level of education, identified in this study as extraneous variables that influence people's emotional awareness and regulation levels.

Independent Variable

Dependent Variable

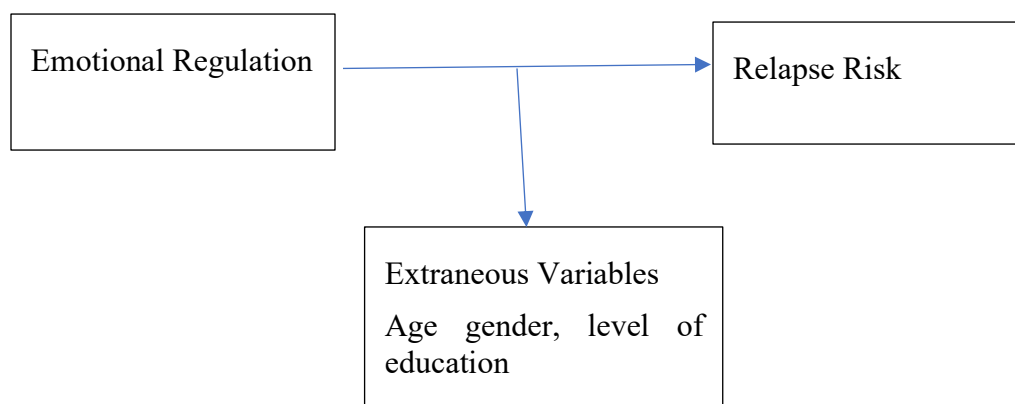


Figure 1: Dependent and Independent Variables

RESEARCH METHODOLOGY

The study adopted a correlational research design integrating both quantitative and qualitative approaches to examine the relationship between emotional regulation and relapse risk among clients in Kiambu County's drug treatment centers. Quantitative data were obtained through structured questionnaires assessing emotional awareness, regulation, and relapse risk, while qualitative insights were gathered using semi-structured interviews. The research was conducted across fifteen NACADA-accredited centers, targeting all clients in their final month of treatment, thus employing a census sampling technique that yielded 162 participants. Data collection instruments included the Difficulties in Emotional Regulation Scale (DERS) by Gratz and Roemer (2004), a 36-item self-report tool using a six-point Likert scale to measure facets such as non-acceptance of emotional responses, impulse control difficulties, and lack of emotional awareness, and the Advance Warning of Relapse (AWARE) scale by Gorski and Miller (1982), refined to 28 items by Miller and Harris (2000), which reliably predicted relapse occurrences ($r = .42, p < .001$). Demographic data were also collected to test the influence of extraneous variables on the study outcomes.

RESULTS AND DISCUSSIONS

The results and discussions are presented in sections.

Emotional Regulation levels

Table 1 presents the summary of results of emotional regulation levels.

Table 1: Emotional Regulation Levels

	Frequency	Percent
Low level of emotional regulation	2	1.3
Moderate level of emotional regulation	75	46.9
High level of emotional regulation	83	51.9
Total	160	100.0

Findings from the table reveal that over half of the clients at 51.9% had difficulties emotional regulation, while 46.7% had moderate level of regulation. These findings therefore contrast with most of the literature available on emotional regulation. One explanation for these results is that this could be an indicator that during the program they had undergone some form of training on

how to regulate their emotions. These findings contradict those of Kun and Demetrovicsn (2010) who found that over 50% of alcohol addicts have low levels of emotional regulation. Another study by Karaer and Akdemir (2019) found that over 60% individuals with internet addiction had low levels of emotional regulation. These findings therefore contrast with most of the literature available on emotional regulation. One explanation for these results is that it could be an indicator that during the program the participants had undergone training on ways of regulating their emotions. It is also noteworthy that the participants were still undergoing treatment hence it may not be clear if the treatment they received had impact on their emotional regulation. These findings contradict those postulated by studies conducted among Iranian students by Rahbarian et al. (2017); Estevez et al. (2017) which indicated that limited or low access to regulatory skills may be an indication of addictive behaviors.

This information was not established during this research but would be worth considering in future research. Another key issue that emerges from the results of this study as regards to levels of emotional regulation is that it was expected that the participants would generally have low levels of emotional regulation. Findings on the levels of emotional regulation were further analyzed by means and standard deviation. The standard deviation allows the researcher to determine how the emotional regulation scores are spread in relation to the mean.

Table 2: Emotional Regulation Levels by mean and standard deviation

	N	Minimum	Maximum	Mean	Std. Deviation
Emotional regulation interval	160	28	170	121.24	24.372
Valid N (listwise)	160				

As shown above, the lowest score achieved was 28 and the highest score achieved was 170, indicating the scores on emotional regulation were distributed from low level to high level of emotional regulation, with a mean score of 121.24, standard deviation of 24.372, with most of the scores are concentrated between the moderate to high levels. Contrary to findings in other studies, the results in this study showed that the participants had higher levels of emotional regulation and were normally distributed. It is also possible that just like the previous studies on emotional regulation, the results of this study could be indicative of the cultural differences. Further research and deeper investigations need to be conducted to unequivocally determine if indeed the levels of emotional regulation are high among those with substance use disorders.

Provision of qualitative data was important since it offered insights shared by the participants regarding their patterns of substance use and what triggers substance use. Qualitative data enables the researcher to understand peoples lived experiences and further understanding of the emotional experiences associated with the risk of relapse. This information gathered will bring forth data that is enriched. This was summarized using verbatim excerpts for the participants as discussed in the following section.

Some of the excerpts from the qualitative data on emotional regulation are presented as follows: “Keeping myself busy drawing or coloring something. Pacing about, listening to music, exercise, and meditation.” “I relate with friends and loved ones joyfully. I use them, for problem-solving amongst us.” “For most of the stressing situations, I make a list of options that would help solve the problem.” “Prayer and meditation has truly helped me, talking to God and with God.” “I feel stronger, more fulfilled and I have serenity and peace flowing in me, which id never imagine.” “By changing the environment and being with new friends that don’t use the substance.’ ‘Positive self-talk.’ ‘Practicing the 12 steps program of A.A and its spiritual principles.”

The excerpts provided indicate that qualitative data enriches quantitative data by providing information that emanates from peoples lived experiences. It also helps to establish a pattern on the various aspects that the quantitative data may not otherwise provide. The qualitative data supports the earlier data from questionnaires because it gives information that is very specific to the issue that is being addressed and in this case the understanding how lack of emotional regulation will contribute to the risk of relapse. As shown by the findings from objective two on the quantitative and qualitative data, 50% appear to have the ability to regulate their emotions.

Emotional regulation is the individual’s ability to influence which emotions they have and how they control and express them. A histogram was used to plot the levels of emotional regulation of the research participants. Figure 2 presents findings of the histogram.

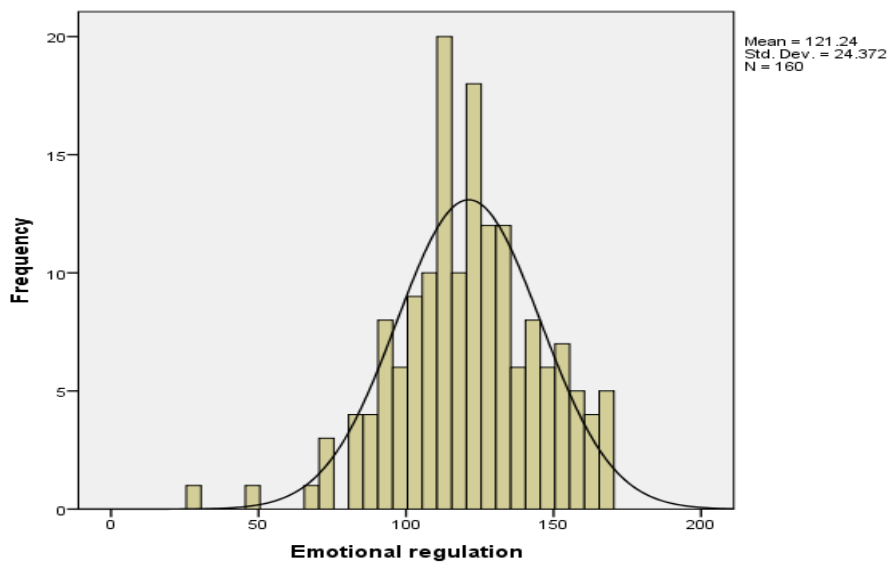


Figure 2: Emotional Regulation Histogram

Data was further analyzed for the components of emotional regulation namely: failure to accept emotional responses, difficulty to engage in goal directed behavior, difficulties in controlling impulsive behavior, lack of emotional awareness, limited or lack of emotional regulation strategies and lastly lack of emotional clarity.

Nonacceptance of Emotional Responsibility

Non-Acceptance of emotional responsibility is one of the components in emotional regulation. It refers to the situation where an individual is unwilling or unable to experience emotional states; either cognitively or behavioral. In this study it was operationalized as the ability of the participants reluctance to experience their emotions.

To determine the levels of acceptance of emotional responsibility, items 11, 12, 21, 23, 25 and 29 assessing the sub-scale were transformed. There being 6 items, the highest probable score was 30 (6x5) and the least probable score was 6 (6x1). The total scores for a participant were derived from the computation of the sum total scores obtained from all the responses. The negative worded items were reverse coded. The computed scores were then grouped into 3 cohorts, where scores between 1 and 10 were indicative of “low level of acceptance”, scores between 11 to 20 were indicative of “moderate level of acceptance” and scores falling between 21 to 30 were indicative of “high level of acceptance”, as shown in table 3

Table 3: Nonacceptance of Emotional Responsibility Levels

	Frequency	Percent
Low level of nonacceptance	10	6.3
Moderate level of nonacceptance	65	40.6
High level of nonacceptance	85	53.1
Total	160	100.0

As demonstrated in the table, 53.1% of the sampled population showed high level of nonacceptance of emotional responsibility, 40.6% had a moderate level, while 6.3% had a low level of nonacceptance of emotional responsibility. Findings on the levels of nonacceptance of emotional responsibility were further evaluated using mean and standard deviation, as shown in the following table.

Table 4: Nonacceptance of Emotional Responsibility Levels by mean and standard deviation

	N	Minimum	Maximum	Mean	Std. Deviation
Emotional acceptance	160	1	30	20.27	6.296
Valid N (listwise)	160				

According to this tabulated data, the lowest score achieved was 1, and the highest was 30. The level of nonacceptance of emotional responsibility mean score was 20.27 (SD = 6.296). This shows that on average; the patients had a moderate level of acceptance of emotional responsibility. Nonacceptance of emotional responsibility is described as the unwillingness to experience emotional states. From the findings of this study, 35.6% of the participants reported that when they were upset they felt weak, while 35% indicated that when they are upset, they experience irritation from experiencing these feelings. About 24-27% indicated that when they were upset, they would experience shame, or anger. These results implied that the participants had high levels of emotional responsibility, and this is likely to be attributed to having undergone treatment and had gained the adequate skills.

Difficulties in Goal Directed Activity Levels

Difficulties in goal directed activity is another component in the emotional regulation scale. This is the ability for an individual to complete a particular task. In this study, goal directed activity is operationalized as ability to complete assigned tasks in their course of treatment. To determine the levels of difficulties in engaging in goal directed activity, items 13, 18, 20, 26 and 33 assessing the

sub-scale were transformed. There being 5 items, the highest and lowest score was 25 (5x5) and 5 (5x1) respectively. For each participant, the total score was a result of the addition of the total scores from all the responses. The negative worded items were reverse coded. The scores were later grouped into 3 levels, where scores between 5 to 12 indicated “low levels of difficulties engaging in goal directed behavior” scores between 13 to 17 indicated “moderate levels of difficulties in engaging in goal directed behavior” and scores between 18 to 25 indicated “high levels of difficulties in engaging in goal directed behavior”. The results are as shown below:

Table 5: Difficulties in Engaging in Goal directed activity levels

	Frequency	Percent
Low level of engagement	50	31.3
Moderate level of engagement	65	40.6
High level of engagement	45	28.1
Total	160	100.0

From table shown above, 40.6% of the participants had a moderate level of engagement in goal directed behavior, 31.3% had a low level of engagement, while 28.1% had a high level of engagement in goal directed behavior. Findings on the levels of difficulties in goal directed behavior were further assessed using mean and standard deviation, and the results are as tabulated below.

Table 6: Difficulties in Engagement of Goal directed behavior levels by mean and standard deviation

	N	Minimum	Maximum	Mean	Std. Deviation
Goal directed activity	160	5	25	14.72	4.566
Valid N (listwise)	160				

As shown, the lowest score achieved was 5, and the highest score was 25. The level of difficulties in engagement of goal directed behavior by mean score was 14.72 (SD = 4.566), demonstrating that on average, the sampled population had moderate levels of difficulties in engagement of goal directed behavior. Difficulties in engagement in goal directed behavior, the ability of participants to take part in scheduled activities during their course of treatment, was another aspect that this study interrogated. The findings revealed that most times 33.8% of the participants’ reported that “when they are upset, they have difficulty getting work done most of time,” while 31.9% indicated

that “when upset they have difficulty focusing on other things.” Other responses at 26.3% indicated that “when upset they can still get things done sometimes,” and at 20% they sometimes “have difficulty thinking about anything else.” About 11.3% and 15% participants reported that they almost never “have difficulty thinking about anything else when upset” and almost never “have difficulty getting work done when upset” respectively. These results reveal a moderate improvement and could be attributed to being in the treatment center.

Impulse Control Difficulties Levels

Impulse control difficulties are another component in emotional regulation. A person’s ability to control impulsive behavior aids in the regulation of their emotions. The reaction that they exhibit when facing a stressor either increases or decreases the possibility of a relapse. In this study, it was operationalized as the inability to control an action or reaction. To determine the levels of impulse control difficulties, items 3, 14, 19, 21, 27 and 32 assessing the sub-scale were transformed. There being 6 different items, the maximum probable score was 30 (6x5) and the least probable score was 6 (6x1). The total scores for a participant were calculated from the addition of the total scores from the responses. The negative worded items were reverse coded. The scores were later grouped into 3 cohorts, where scores between 6 to 15 were indications of “low level of impulse control difficulties”, scores falling between 16 to 21 indicating “moderate level of impulse control” difficulties and scores of 22 to 30 indicative of “high level of impulse control difficulties”, as shown in the following table.

Table 7: Impulse Control Difficulties levels

	Frequency	Percent
Low level of impulse control difficulties	34	21.3
Moderate level of impulse control difficulties	63	39.4
High level of impulse control difficulties	63	39.4
Total	160	100.0

Findings as tabulated indicate that 39.4% of the participants had moderate and high levels of impulse control difficulties respectively, while 21.3% of the participants had low levels of impulse

control difficulties. Findings on the levels of impulse control difficulties were further analyzed by means and standard deviation. The findings are presented in table 8

Table 8: Impulse Control Difficulties levels by mean and standard deviation

	N	Minimum	Maximum	Mean	Std. Deviation
Impulse control	160	6	30	19.77	5.244
Valid N (listwise)	160				

From the table, there was a minimum score of 6 and a maximum score of 30, and the mean score for impulse control difficulties was therefore 19.77 (SD = 5.244). This clearly demonstrates that the participants had a moderate level of impulse control difficulties.

This study also explored individuals' impulse control difficulty. This is described as an individuals' action or reaction when they experience a situation. Responses from the participants revealed that 38.8% reported that "most of the time the emotions that they experience are overwhelming and hard to control," while 36.3% indicated that almost always "when they are upset, they lose control of their behavior." On the other hand, 35.6% that most of the time "when they are upset, they have difficulty in controlling their behavior." While 31.3% reported that "sometimes the feel like they can remain in control of their behaviors." Further, 27.5% reported that they lose control "when they are upset." The items analysis reveals that on average the client's ability to manage their impulses' and moderately increased. This shift could be attributed to the skills acquired at the treatment center.

CONCLUSION

The study concludes that most individuals undergoing treatment for substance use disorders in Kenya are young, middle-aged, educated males who possess sufficient cognitive ability to recognize their emotions but lack the capacity to effectively regulate them. This limited emotional regulation was reflected in their reliance on mood-altering substances to cope with distress, indicating a psychological gap in managing emotions without external stimulation. The findings also showed that nearly half of the participants had a moderate to high risk of relapse, suggesting that while rehabilitation improves awareness, it may not fully equip clients with sustainable emotional coping mechanisms necessary for long-term recovery. Furthermore, the study establishes that emotional regulation significantly affects the likelihood of relapse among clients,

emphasizing its central role in determining the success of addiction treatment programs. It concludes that treatment outcomes are compromised when interventions fail to strengthen emotional awareness and control as part of therapy. Therefore, rehabilitation programs should integrate emotional regulation strategies into their core frameworks to enhance self-management skills and reduce relapse risk among recovering individuals.

STUDY'S RECOMMENDATIONS

The study recommends that professionals working in substance abuse treatment facilities should incorporate interventions that strengthen emotional regulation skills as part of routine therapy to minimize the risk of relapse among clients. Such interventions should focus on enhancing clients' capacity to identify, manage, and express emotions constructively, helping them to cope with stressors without reverting to substance use. Training institutions that prepare psychological counselors and rehabilitation specialists should also include modules on emotional regulation and its relationship with relapse in their curricula to equip practitioners with the skills needed to address emotional vulnerabilities among clients undergoing treatment.

Additionally, the study recommends that government agencies and policymakers should develop policies and regulatory frameworks that recognize emotional regulation as an essential component of substance abuse rehabilitation programs in Kenya. Policies should promote the integration of psychological interventions alongside medical treatment to ensure a more holistic recovery process. Future research should also be undertaken to assess emotional regulation levels before, during, and after treatment, conduct intervention-based studies to evaluate how improved emotional regulation reduces relapse rates, and replicate similar research among individuals with behavioral addictions to determine the broader applicability of emotional regulation in preventing relapse.

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