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Addiction, Repetitive Relapse and Shattered life: A Slippery Road of the Individuals with Alcohol and Substance Use Disorder (ASUD) of Kathmandu, Nepal

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Abstract

Background: Alcohol and Substance Use Disorder (ASUD) is a complex and pervasive public health issue globally. While efforts to address substance abuse have led to an advancement in prevention, treatment, and harm reduction strategies, relapses, which is different than the 'lapse' or 'slip' as it involves a more extended and excessive return to substance use after a period of voluntary abstinence, has been seen as a significant challenge in recovery treatment.

Purpose: Exploring the causes and consequences of Relapse and repetitive Relapse of individuals with ASUD in Kathmandu, Nepal, is the primary objective of this research, followed by expanding the understanding of repetitive relapse and identifying its prevention strategies.

Methods: This research adopted a qualitative methodology. Data are collected between August and October 2024. The collected data were analysed using a thematic analysis approach. The data were collected through in-depth interviews with eight participants (six males and two females), followed by a focus group discussion, after a preliminary analysis of information obtained from in-depth interviews. The respondents have been selected through purposive sampling, by identifying the information-rich informants who have experienced repetitive relapses but are sober at present.

Findings: Peer pressure, curiosity, stemming from social circles, including spousal encouragement, interactions, and reservations about abstaining and pleasure-seeking behaviours, are the key influential factors of addiction and relapse. Furthermore, an individual's misconception of one's ability to control substance use patterns, exacerbated negligence, feeling of hopelessness, and disregard for consequences, were the triggering factors of repetitive relapse. The implications of repetitive relapses are, but not limited to: individuals isolating themselves, deepening the cycle of regret into remorse, compounded by psychological victimisation of oneself, including - attempts to suicide, and a perceived lack of coping capacity as well as undergoing a soul-crushing experience, numbed senses, dysfunctional brain's reward system, and hopelessness.

Conclusion: The causes of relapses and repetitive relapses are variable across the respondents, but the implications of addiction, relapse, and repetitive relapses are similar, although the phases of addiction and increased frequency of relapse accelerated the intensity of suffering, which is critically serious from a treatment and recovery perspective. The findings contribute to understanding relapse's psychological and social triggers and their severe consequences, which is valuable for both academic and clinical audiences.

Key words: *Cause and consequences; Recovery; Rehabilitation; Substance abuse; Triggering factors*
I12, I18, Z13, I31

1. Introduction

A common yet growing number of Individuals with Alcohol and Substance Use Disorder (ASUD) has already become a serious global health problem that has profound consequences on individuals, families, and societies. In 2021, 1 in 17 adults, between the ages of 15 and 64 (accounting 5.8% of the world's population of the age group), reported using drugs within the previous year, hence the population of individuals with ASUD increased by 23% to 296 million in 2021, from 240 million in 2011 (UNODC, 2023). While efforts to address substance abuse have led to an advancement in prevention, treatment, and harm reduction strategies, relapse remains a significant challenge for individuals in their recovery journey (Volkow & Boyle, 2018).

An estimation shows 130424 individuals, with over 90% being males, as drug users in Nepal (Ministry of Home Affairs, 2020). Research showed a high rate of Relapse in Nepal, usually reaching 40-75% within three weeks to six months after treatment (Sapkota et al, 2016). There were around 390 treatment and rehabilitation centres in 2023 in the country. However, the precise number of clients who are enrolled in these facilities, who have recovered and been discharged, and who have relapsed after being discharged from treatment remains unknown .

ASUD is a critical societal issue from a social and legal context. Therefore, despite ASUD being a psychological health problem, there is an issue that they do not disclose until addiction becomes acute, at which point recovery is highly challenging. Furthermore, despite the relapse being critical, many factors encourage it. Limited access to information about the triggers of addiction and relapses is also discouraging social-behavioural researchers from digging deeper into the issue. Therefore, we are trying to bring the issue to the forefront, with an exploratory assumption that the factors triggering relapse do not necessarily contribute to repetitive relapse. Rather, there could be other factors that trigger it. We designed a conceptual framework (Figure 1) to explain the issues that guided this research.

In the field of addiction, the term relapse has long been used to describe the return to alcohol and drug use after a period of voluntary abstinence by individuals with a history of substance use issues. However, there has been an effort to differentiate between a 'lapse' or 'slip', which refers to a brief episode of alcohol or other drug (AOD) use by individuals with ASUD history. Still, relapse involves a more extended and excessive return, often accompanied by symptoms that meet the diagnostic criteria for a substance use disorder (Marlatt & Donovan, 2005).

This research aims to identify the process of relapse, second by repetitive relapse, their promoters, and corresponding consequences on the life of the individuals with ASUD. Employing a multidimensional approach that integrates insights from the diverse academic disciplines including but not limited to behavioral science, psychology and sociology to reach to the depth of the issue, we unravel the complex interplay of factors contributing to recurrent relapse episodes by answering following research questions: What are the key factors contributing to repetitive relapse among individuals with Alcohol and Substance Use Disorder (ASUD)? and What are the psycho-social consequences of repetitive relapse on the life of individuals with ASUD?

We expect that the findings of this work will draw attention to clinical practice, public health policy makers, and academics who can collaborate to improve the treatment process and corresponding changes in the quality of life of the individuals with ASUD background through designing and implementing informed or evidence-based interventions.

This paper is structured into six broader sections. The first section introduced the research problem, followed by the state of knowledge. The third section elaborates on the methods adopted in the research, while the fourth section is dedicated to analysis and interpretation. Finally, the findings concerning existing scholarships are discussed in the fifth section, followed by concluding statements.

2. Literature review

Epidemiological research shows that nearly 50% of successfully treated SUD patients relapse, highlighting the need for effective prevention measures (Chetty, 2011). It has been identified that between 40 to 60% of people relapse within the first year after the completion of their treatment package (National Institute of Drug Abuse, 2020), which also highlights the necessity of appropriate prevention strategies. In this research, we adopted the definition of relapse as the recurrence of substance use after a period of abstinence, as defined by DiClemente and Crisafulli (2022). Relapses are a phenomenon that undermines the success of the treatment of individuals with ASUD.

Relapses have been linked to several factors, including post-treatment imprisonment, mental or other co-morbid illness, and drug cravings (Moradinazar et al., 2020). These factors create a challenging environment for individuals attempting to maintain sobriety. Physical factors such as medical conditions, drug dependency, drug withdrawal, and being in poor physical health also play a significant role in increasing the risk of Relapse (Andersson et al., 2019). Particular medical conditions may also require treatment that inadvertently triggers relapse, while ongoing drug dependency creates a psychological need that is difficult to overcome.

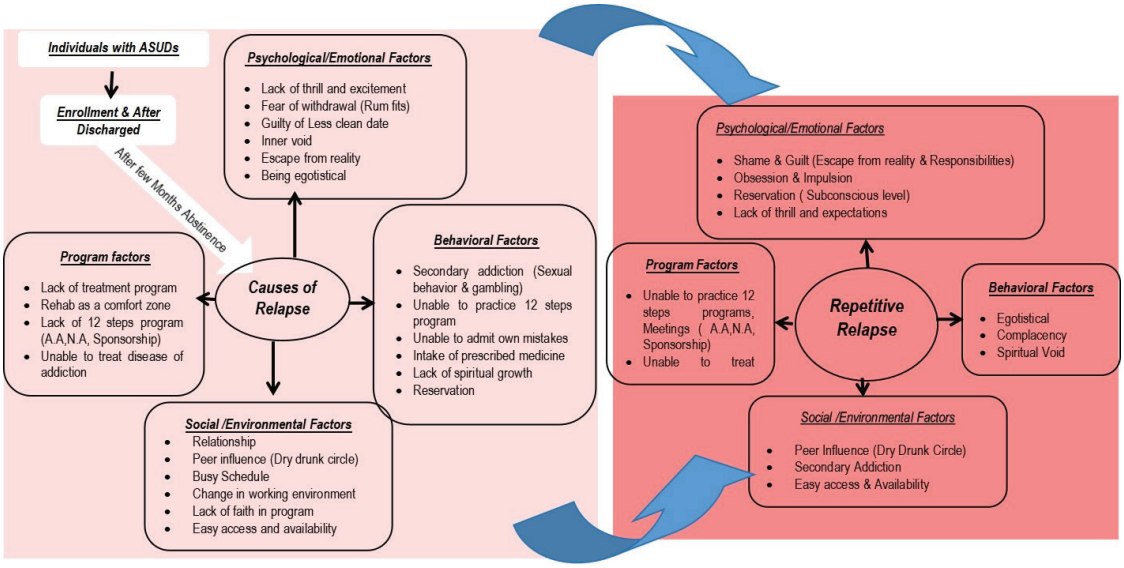
Additionally, social influences are critical in the relapse process. For example, a study showed that 50% of former friends influenced individuals with an addiction background to relapse after being treated and discharged from rehabilitation centres (Latib et al., 2019). Furthermore, psycho-social characteristics, such as a history of trauma, various mental health illnesses, and socioeconomic stresses, have been demonstrated as the factors triggering Relapse (Sliedrecht, 2023). Another study indicated that relapse development is influenced by neuroadaptations, epigenetic modifications, and genetic predispositions (Bohnert et al., 2021). Additionally, environmental variables like peer pressure, social networks, drug availability, and cultural norms also influence relapse trends internationally (UNODC, 2021).

The review of these research works sheds light on many contributing factors and underscores the complex nature of relapses among individuals with ASUD. However, there are still significant issues in understanding and treating relapses among individuals with ASUD. Degenhardt et al. (2022) have paid attention to disparities in the availability of evidence-based therapy, especially in lower and middle-income nations. Additionally, the COVID-19 pandemic has also created unexpected challenges for addiction treatment and recovery initiatives, aggravating relapse risk factors such as social isolation and unstable economic conditions (Volkow, 2021).

The literature reviewed above indicated the occurrence of relapse among individuals with ASUD, albeit with limited focus on repetitive relapse phenomena. Given the scarcity of literature specifically in the field of repetitive relapses, researchers' personal engagement in the field for various services to the individuals with ASUD for several years, and our own understanding or conceptualisation of the issue led us to formulate our own set of variables and framework (Figure 1) to conduct this study, which requires further refinement through a case study. To fulfil this purpose, we have conducted this work where the variables and corresponding interactions, as presented in the framework, guide our investigation.

There are two parts depicted in the framework (Figure 1). The first part provides an overview of the factors contributing to relapses in individuals with ASUD, highlighting various triggers and influences that may lead them to return to alcohol or substance use after a considerable period of abstinence. Conversely, the second part focuses specifically on the causes of repetitive relapse, identifying the factors that perpetuate a cycle of repetitive relapse. This means that relapse itself is the foundation stone of repetitive relapse that requires special attention from a policy perspective.

Figure 1: Triggering Factors of Relapse and Repetitive relapse among individuals with ASUD



In the background above, this research addresses the relapse leading to its repetition by integrating several phenomena, as presented in the framework. By doing so, we seek to enhance our understanding of the intricate pathways and dynamics involved in progressing from initial relapse to a pattern of repetitive relapse episodes.

3. Research Methods

3.1 Research Design

A descriptive phenomenological research design, a qualitative research approach that focuses on exploring and describing lived experiences of individuals (Van Manen, 2023), was adopted to provide a comprehensive understanding of the factors contributing to substance use relapses after the recovery process. Since the issue of individuals with ASUD is sensitive in society and repetitive relapses are their complex journey, the adopted approach assisted us in entering into the heart of the respondents, building trust, and exploring the depths of the phenomenon. Hence, this study involved individuals with insightful expertise in the field of complete abstinence at present who have been in recovery for a long time but have experienced repeated relapse.

3.2 Sampling process and Samples

In qualitative research, the richness of information on the sampled respondents and their diverse backgrounds, rather than sample size, matters. Considering this fact, this study was conducted with a limited number of but information-rich respondents (six males and two females), employing purposive sampling, followed by a semi-structured Focus Group Discussion (FGD) to get additional insights into the complex interplay of factors contributing to repetitive relapse. Purposive sampling was also used because there was a lack of specific data about the repetitive relapse on the one hand, and access to informants who have experienced repetitive relapse despite being in the recovery stage from substance and alcohol use disorders is a complex process. We carefully identified the respondents, among the eight, four were service providers specialising in substance and alcohol use disorders. The three (two males and one female) were from a business background and operated their own business in fields other than ASUD service, while one female worked as a counsellor (employee) in one of the rehabilitation centres. Considering their richness in information, we brought them into the research to represent diverse professional expertise. The rest of the two were house-makers and employees, offering a diverse perspective on the research topic. As

Merriam and Grenier (2019) state, selecting participants for research should align with the goals of the study and the phenomenon being explored. We selected the respondents relevant to the research question and objectives of the research we set.

3.3 Data Collection Method

Data were gathered through individual face-to-face in-depth conversational interviews, more specifically, utilising a checklist to guide the talk, with a few open-ended questions followed by necessary and context-specific probing questions generated during conversation. After the conversation interview of eight respondents and preliminary analysis of the stories, checklist prepared for a Focused Group Discussion (FGD), which was a joint meeting and corresponding conversation with the same 6 (only males, females were left in the FGD due to their denial to be introduced in such groups due to privacy issue) respondents, was also conducted to further refine the information obtained during the individual interviews. The FGD was possible since they were known to each other because of the long journey in the addiction world. However, during the interviews at the individual level, they were unaware of who the other research participants were. Afterwards, we identified some key elements requiring further clarification, and a proposal to have an FGD meeting was forwarded to them individually, seeking their consensus for a talk in a group. Since only six males agreed, an FGD meeting was arranged among them to seek some sort of conclusion on causes, consequences, and remedies. The importance of using open-ended questions lies in their ability to elicit rich, detailed responses that provide deep insights into the experiences and perspectives of the research participants (Hancock et al., 2021). These interviews were arranged at locations and times convenient for participants and conducted in Nepali and English. An initial open-ended question started from: please tell me your childhood and family background, schooling, behaviours, and the factors that compel you to return to substance use, and continued to a long journey of repetitive relapse, probing questions were generated as required to obtain comprehensive responses. The interviews were conducted using qualitative interviewing techniques, and each session typically lasted over 90 minutes, taking breaks according to the needs of the respondents. Data was collected between August and October 2024.

3.4 Ethical Considerations

Our top priorities were the respondents' identity and confidentiality while conducting this study. Ethical requirements are satisfied by upholding respondents' right to privacy and preserving their dignity and well-being throughout the research process. Klenke (2016) emphasised that researchers must ensure that participants' voices are accurately represented and their confidentiality and anonymity are maintained to protect their privacy and minimise potential harm – we fully abide by this principle. Additionally, as this research was conducted by self-motivated researchers, there was no formal ethical clearance. However, the researchers are trained in 'ethical conduct of research involving human subjects,' we gain the trust from the respondents and obtain verbal consent to participate in the research process, and allow them breaks or withdraw from the interview, if they want to do so. We also obtained permission to audio-record the conversation. The interviews were transcribed later. We clarified our position in this research and assured that we maintained the highest level of ethical research despite being in a 'low risk category' because we only interviewed the respondents.

3.5 Data Analysis

We adopted thematic content analysis and meaning-making methods in this research. Content analysis principles in qualitative research involve systematic procedures for analysing textual or visual data to uncover the collected data's patterns, themes, and meaning (Krippendorff, 2018). Research participants were considered experts in the field of recovery. Hence, in-depth interviews and written narratives were collected from individuals with a history of repeated relapses on their experiences, triggers, coping strategies, and barriers to sustaining recovery. We systematically analysed their life-stories, both audio and textual data, to identify recurring themes and patterns related to identity construction and the development of relapse processes. Through manual coding, we identified over 18 themes, approximately 30 codes, and

around 46 sub-codes, organising the data into various code groups. The data were then used to create sub-themes, and the categories and themes at each step of the study were insightfully examined before we agreed on appropriate themes and sub-themes. Verbatim quotes are used to serve as evidence or support for interpretations. The conclusions drawn from the data provide a tangible basis for our claim and help justify the study's findings, as stated by Corden and Sainsbury (2006).

4. Results and Findings

This study explored the triggering factors of Relapse and repetitive Relapse and corresponding consequences among the individuals with ASUD in Kathmandu, Nepal. The study engaged six male and two female respondents in a group, and an additional FGD with six males. Each of the interviews and the FGD has provided valuable insights into the intricate phenomenon of the life of individuals with ASUD.

4.1 Social demography and economic life of respondents

Representing the diverse backgrounds of the respondents makes the study more meaningful (Johnson, 2022). However, that is not always possible, particularly if one is doing research on sensitive issues such as ASUD. In our context, of the total, four respondents (males) were from Brahmin communities, one (male) was from Kshetri, and the last one (male) was from Muslim communities; and two females were from Janajati communities. All participants had a middle-class economic status. Of them, four (males) had completed grade 12 education, one had obtained a university first (Bachelor's) degree, and another had an advanced university degree. In the case of female respondents, one has completed her 12th grade while the other has completed her university first degree.

All the respondents have shown a high level of understanding of individuals with ASUD. Having experienced Relapse and repetitive Relapse, all eight respondents fully recovered, living a clean and serene life. As presented in the Table 1, they reported that they are clean since last 4 years, as the shortest duration (c.7, female), to 12 years as the longest (c. 5). Their narratives offered profound insights into the challenges and triggers associated with relapses, as well as the failure of strategies and support systems essential for successful recovery journeys. As Creswell and Poth (2016) stated, we assign code (c.) numbers, which were used in the presentation of results below, to ensure confidentiality and anonymity of the research participants.

Table 1: Frequency of repetitive relapses of the studied cases, with the longest abstinence and current clean period

Case no.	Repetitive relapse (frequency)	Abstinence duration in general (months)	Longest abstinence (years)	Duration of Last Abstinence (years)
1	40	2-3	6	9
2	25	20-22	5	8
3	7	2-3	11	11
4	35	2-3	3	6
5	15	3-4	5	12
6	10	2-3	10	8
7	20	3-4	4	4
8	16	2-3	2	6

Source: Field Study 2024

4.2 Journey towards ASUD

The beginning of Alcohol and Substance use might vary widely from person to person; some trends and characteristics frequently appear. Some people may begin experiencing Alcohol and Substance use due to

influence, curiosity, pressure, or the effort to fit in or feel accepted by their circles.

According to c.1, 4, 5, 6, and 7, they began smoking cigarettes and using tobacco between the ages of 13 and 14. They also started consuming alcohol and substances like pills and cough syrup with friends, while frequently skipping classes at school. As they expressed, there was always a curiosity about the activities involving substance use and as that curiosity grew, one day, we also began using substances' (c.2, P1, 31; c.4, P1, 19; c.5, P1, 13; c.6, P1, 14; c.7, P1, 9) . This suggests that engaging in risky behaviours such as bunking classes and hostel to use substances can be influenced by factors like peer pressure, the desire for heroism, and curiosity (Henneberger et al., 2019; Veenstra & Laninga-Wijnen, 2022), and the present study also identified the same triggers.

The c.2 explained: "When I was 14, I completed my 8th grade while living in a hostel, where I formed friendships with senior students. I started smoking in class to appear more mature. During this time, I was introduced to cough syrup. I did not use it then, but I saw seniors using it. Later, I also started using it" (c.2, P1, 22). The c.7 stated: "when I was staying in a hostel studying in 10th class. One day, I ran away from the hostel with friends to use drugs, but things took a dark turn when one of them overdosed" (c.7, P1, 15). These stories indicated that the influence of seniors and the desire to appear mature contributed to their substance use. The c.3 stated: "When I was 19, my addiction began. I used to love riding motorbikes, and my father promised to buy me one if I got a first division in the School Leaving Certificate (SLC) examination. I dreamed of owning a CG 125 bike (the Japanese motorbike, the legacy of the middle class of the time). I studied for 18 hours a day with that goal in mind. After I graduated in SLC with a first division, I joined Amrit Science College, Tribhuvan University (ASCOL, TU), the renowned science campus of the time. However, contrary to his promise, my father bought me a bicycle. This incident demotivated me - I felt betrayed, causing a loss of trust in the family, ultimately diverting my path. I started using substances (c.3, P1, 30)." For some, spousal influence, spouse with addiction history, led to addiction that: "while I was under severe stress, he (my husband) introduced me to drugs, suggesting it would help relieve my tension" (c.8, P1, 11).

There is also evidence that individuals begin using substances due to environmental factors such as easy access within their community, having a family history of substance use, or a lack of proper guardianship (Repetti et al., 2002). During the interview, c.1 stated: "I grew up in New Baneshwor, in the middle of the Kathmandu valley. Due to my father's job-related transfer, shifting to different parts of the country, Nepal, had been my routine, and I never had a proper guardianship in my life" (c.1, P1, 11). Similarly, c. 6 explained, "There was no parental guidance in my life. I was free to do whatever I wanted, nobody was there for me to control" (c.6, P1, 21). These informants indicated that parental guidance, which typically involves setting rules, expectations, and boundaries for children, and a lack of it may bring difficulties in developing a sense of self-discipline and an impulsive control mechanism in children, resulting in deviation, including addiction (Jacob et al., 2016). The examples of c.1 and 6 seem to support the claim.

The family environment of substance use, offspring, or siblings can also lead to addiction. For example, c.1 and c.2 expressed that "At my home, my elder brother was a substance user as a result of the hippy influence in the 1970s, in Kathmandu" (c.1, P1, 11). Similarly, c.2 claimed that "Father used to take alcohol and cannabis excessively, with his younger grandfather, who was in a higher post in Nepal Police" (c.2, P1, 12). Witnessing a family member using substances, these two children were sparked by curiosity, prompting them to experiment with substances and alcohol use themselves, consistent with what was reported by Johannessen et al. (2022).

However, the c.4 started using alcohol and drugs because of their freedom-seeking behaviour. It was also because of the deviant behaviour since doing so was against the rules and regulations of the house. He stated, "I only like freedom, and I do not like to be bound in disciplines, rules, and regulations at home" (c.4, P1, 26). As parental guidance of setting boundaries for children, such as for the c.4, observed, such controls also resulted in children developing a sense of defying rules and regulations, which led to deviant behaviours.

4.3 Factors contributing to relapses

Relapses among individuals with ASUD are a complex phenomenon influenced by various factors such as psychological, behavioural, and environmental. Literature indicated that stress, negative emotions, and exposure to individuals with ASUD can evoke intense cravings, while inadequate coping skills and unresolved trauma may prompt individuals to revert to individuals with ASUD as an alternative coping mechanism (Marlatt & Donovan, 2005). In reference to this statement, the studied c.1 represents a similar state:

"I was unmarried, young, and I had a sexual desire at the same time. I had a girl with whom I was in love. In a relationship, I went emotionally rather than physically as a life partner, but the girl always used to talk about leaving the relationship. When I did not get a chance to control her, I used to do emotional blackmail to her by saying, 'I shall drink, I shall drink.'" And one day I started to drink a quarter of alcohol (250 ml), after five years of recovery" (c.1, P4, 4). Having been married to a person with an addiction history also facilitated the spouse towards addiction, such as for the c.8.

The c.1 indicated that state of relationship issues in young adults can play a significant role in an individual's recovery. If the relationship was positive, it may have supported the effort of remaining sober; however, as the relationship is not favourable, the c.1 got relapsed, as theorised by Mansson et al. (2024). Furthermore, as stated by c.2 and 3 "they were unknown about the truth of addiction, as an illness. They never practiced the 12 steps program seriously (Sandhurst, 2024). Rather, they could teach the message of 12 steps through actions" (c.2, P2, 40; c.3, P2, 20). This means one's experiences often contribute to developing a "non-systematic theory" of treatment and recovery. Therefore, recovery is not just about abstaining from substances but also dealing with life that inevitably presents challenges and demands practical problem-solving skills to navigate challenges without resorting to substance use. If individuals lacked these skills, anyone could turn to harmful behaviour again. Therefore, as identified through this study and reported in the literature, one must understand addiction as a chronic and relapsing illness, which may lead to repetitive relapse.

Brick house (2024) claims that a lack of faith in underestimating specific treatment programs leads to frequent relapses. For example, c.4 stated, "I used to think that taking the program in America was A.A. and N.A. Started, but it did not work for me. I always wondered if that program would work for me here in Nepal. Such types of thinking patterns always triggered me for my relapse" (c.4, P3, 25). The c.5 on the other relapsed through taking over-doses of prescribed medicines. He stated that "while I was waiting for my father in the hospital, I had a cough and when I took cough tablets, I started to feel like it was giving me a trip, as it used to give by the substance. Afterwards, I started taking the tablet more than I was supposed to. Ultimately, I started taking the substance again - I relapsed" (c.5, P2, 22). Because of his background of substance use disorder, using some prescription medications such as cough syrups or pills triggered him towards relapse. The c.6 has a different story that forced treatment of individuals with ASUD, such as pressure from family members or well-wishers, also does not work well. He stated, "I was enrolled in treatment because of my family pressure" (c.6, P2, 9). But after discharge, which is common among substance users. As stated by c.6, treatment that lacks internal motivation of the individuals with ASUD (lack of personal motivation) to be cured of the substance use behaviour, pressurised or externally desired treatment primarily by family pressure, results in relapse.

4.4 Repetitive Relapse

Repetitive relapse refers to the recurrent return to alcohol and substance use after repeated attempts to achieve and maintain abstinence. This pattern of cyclical relapse and recovery is a common but challenging aspect of the treatment of individuals with ASUD. This pattern reflects a chronic nature of addiction; an illness deeply rooted in the brain of the addicted individuals. There is no defined specific duration of abstinence before relapse; however, whenever the episodes of abstinence and ASU repeat in a cycle, we define it as repetitive relapse. Marlatt and Donovan (2005) conceptualise repetitive relapse as a process influenced by various internal and external factors, such as emotional distress, lack of coping mechanisms,

environmental triggers, and peer influences. This form of relapse is distinct because it happens despite individuals with ASUD continually struggling to maintain sobriety. Their multiple efforts to remain clean failed, often making them feel hopeless and frustrated. Since the focus of this research is repetitive relapse among individuals with ASUD, the study collected data on the number of times they relapsed. As presented in Table 1, relapse frequency ranges from 7 times as the least (c.3) to over 40 times as the most (c.1). The rest of the respondents reported 35, 25, 15, 10, 20, and 16 times of relapse episodes for c.4, 2, 5, 6, 7, and 8, respectively. Typically, relapse occurred within 2-3 months; nevertheless, there were considerable periods of abstinence, ranging from 3 years as the shortest (c.4) to 11 years as the longest (c.3) before Relapse (Table 1). The causes of repetitive relapses among the respondents are variable.

4.4.1. Triggers of repetitive relapses

According to the c.1: "My character always seeks thrill and excitement, which I get in my addiction. But whenever I come to a simple life (in recovery), I find a lack of thrill and excitement that results in repetitive relapses in my life" (c.1, P5, 2). In the treatment and recovery process, individuals are encouraged to develop healthy coping mechanisms to manage stress, boredom, and other triggers for substance use. However, as an ASUD fails to develop such skills and does not find effective alternatives, only relapse is the alternative available to them. Consequently, the c.1 relapsed again. As stated by c.2, "due to dry drunk circle and my sexual behaviour, I started getting relapse" (c.2, P2, 28). Here, the "dry drunk" refers to an individual who is unable to put the 12-step program of treatment and recovery into action. As the c.2 was involved in sexual activities (pleasure-seeking behaviour), which increased the recovery failure. Furthermore, the social environment of individuals with ASUD plays a crucial role in preventing or triggering relapses. The c.2 was surrounded by a "dry drunk" circle, who were not using substances but still exhibited destructive behaviours. He relapsed, indicating that peers with negative influence in recovery and the coping process trigger relapse. The c.3, on the other hand, stated "Unable to treat my illness of addiction, I relapsed, after 11 years of abstinence, in late 2011. Money, power, sex, name and fame, the five elements, which I could not handle appropriately in my life, I relapsed again and again, even after being clean for 11 years" (c.3, P2,7). This demonstrated that destructive activities emerged as he could not manage those five things, rather than germinating creative things. It was because he had an untreated addiction within him, or he did not treat his addiction illness properly and adequately.

According to c.4 and 5, due to their impulsive acts, obsession, and feelings of complacency, they had repeated relapse problems (c.4, P3, 36; c.5, P2, 19). Sometimes, individuals may start to feel overly confident in their ability to stay sober, which can also lead to complacency. This overconfidence can result in neglecting ongoing self-care, therapy, or support group attendance, which increases the risk of relapse. As stated by c.6, "I had expectations when I went to America. When those expectations were not fulfilled, I felt frustration and disappointment, which ultimately drove me back to addiction. I was in company with one of my friends who was suffering then. After that incident, I returned to Nepal. After arriving here, I started going to N.A. meetings. But while going to meetings, I could not admit that I slipped. By not admitting that, I slowly fell back into addiction" (c.6, P3, 6). This highlights the fact that relapses among individuals with ASUD can occur for various reasons, yet unmet expectations are the most common trigger. Unmet expectations created a sense of dissatisfaction with his reality and a lack of appropriate support at the time. The situation drives the person to think that substance use is the way to escape from reality since it creates a sense of relief, at least temporarily. Another reason c.6 relapsed was his attachment to his friend, who was suffering from drug addiction. The c.6 could not reject a friend's proposal to use the substance again.

The stories analysed above indicated that relapse is a complex process, and denial or inability to admit is a common factor that may contribute to a future relapse in addiction. These stories demonstrated variable triggers of relapses in individuals with ASUD. After a preliminary finding, we conducted a Focus Group Discussion (FGD) with all of these stories that are bringing them to a single place, and tried to find the concluding consensus of the triggers of repetitive relapse. The findings of the FGD generally had similar triggers with psychological factors listed below, having been overly cited.

Repetitive relapses start with the pattern that the substance use is perceived as a necessity for survival. This shift often leads to an intense feeling of loneliness and isolation, because of their alienation from friends and family, and corresponding erosion in their trust and support, the situation results in stripped coping mechanisms, intensified remorse, and a deepened sense of alienation. In the next stage, their sense of self-feels diminished, emotions become blunted, and the brain's reward system is disrupted, making relapses nearly inevitable (Figure 3).

Hence, the key psychological factors that trigger the repetitive relapse of individuals with ASUD identified by this research are:

1. The perception of substance use as a survival source changes to one of necessity.
2. This change frequently results in strong emotions of isolation and loneliness from oneself, friends, and family.
3. Loss of support and trust.
4. Loss of a coping strategy.
5. Hopelessness despite efforts to stop using, and
6. Disruption in the brain's reward system.

The relapsed person may feel guilty or ashamed after a slip, as he/she knows he/she is doing wrong or escaping from responsibilities. However, the person lacks the determination to stay away from the influence of substance, which badly affects their lives, as presented below.

4.4.2 The Shattered life of the individuals with ASUD

There are a variety of consequences of repetitive relapses: Respondent c.1 stated that "The girl vanished from my life and I went into depression" (c.1, P4, 17). Losing or having a break-up from a loved one, who was once a source of emotional support, has intensified feelings of loneliness and isolation to the extent of c.1. Such situations contributed to his living a depressing life.

The c.2 stated, "Insecurity, fear, and scepticism have made my abnormal lifestyle. Sometimes I used to be so sceptical towards my wife, and due to my addiction, my mother separated from us, and my relatives were out of contact. The society viewed me as a failed person. Even more, I lost my job and have to ask for money from my wife, which has fueled our conflicts. My children used to cry seeing those 'domestic environment" (c.2, P3, 41). This information shows that substance abuse can hinder effective communication and become a barrier for emotional bonding in spousal, family, and social networks and relationships. Misunderstandings and miscommunication may arise, contributing to Insecurity and fear in individuals with ASUD as they are dependent on others in many respects. The individuals with ASUD also feel that they are becoming irresponsible, guilty, and ashamed, which may lead them to feel inferior to others and have low self-esteem. These psychological feelings promote negativity about the surroundings, including spouse and family members, leaving the neighbours apart.

Cultural attitudes and historical contexts influence societal perceptions towards individuals with ASUD. And due to the addiction-induced loss of job, individuals with ASUD and their corresponding family suffer from financial instability, which impacts their ability to meet family needs. Consequently, poverty-induced conflict in the family environment becomes common (Pandey, 2008). The boomerang effect is that children are neglected, their educational and health rights are unsecured, and they suffer from distress, followed by psychological and traumatic implications for them.

The c.3 stated that "It did not take me six or seven months from relapse to chronic addiction. Frustration, guilt, and isolation, even being addicted, I did not get the pleasure that I used to get before. During the relapse, my family relationship and many things had deteriorated, and I was financially corrupted because of my addiction" (c.3, P3, 10). This was because of his inability to manage his own life since the relapse and drug-using pattern turned his life into chaos within a short time. As he could not enjoy what he used to

think, it was because he was aware of the treatment program and the concept of illness of addiction. As he relapsed, his relationship turned into mistrust with his spouse and other family members, as well as with his professional colleagues. All led him to frustration and guilt, which put him into isolation.

The c.4 stated, "There was not enough money, and the drinking habit had become very unmanageable, even after reaching the US. In the treatment program, one graduates in 127 hours, but I dropped out at 80 hours due to my inability to continue the program due to my drinking habit. As I was there for study, there was a regular contact with the family members, they used to ask me about my study, which was difficult to answer because it was not going smoothly. Therefore, I began to have less contact with family members. I slowly fell into depression due to my drinking habit. My family sent me to study, but I felt guilty as I could not study.

Furthermore, because of drinking under the Influence (DUI) and driving while Intoxicated (DWI) five times, I spent time in various prisons in America, including, I also got house arrest" (c.4, P2, 41). Similarly, because of spousal conflict, because the husband introduced to addiction to wife, family life have become worst (c.8). Since use of narcotic drugs is against the law in Nepal,: "I also faced legal trouble in Nepal as well, spending time in custody and eventually served a five year jail sentence" (c.8, P1, 20). These incidents indicated that living with addiction can result in various psychological stresses, such as guilt, shame, and a sense of loss of control. These factors have contributed to the life expectancy of the c.4 years towards depression.

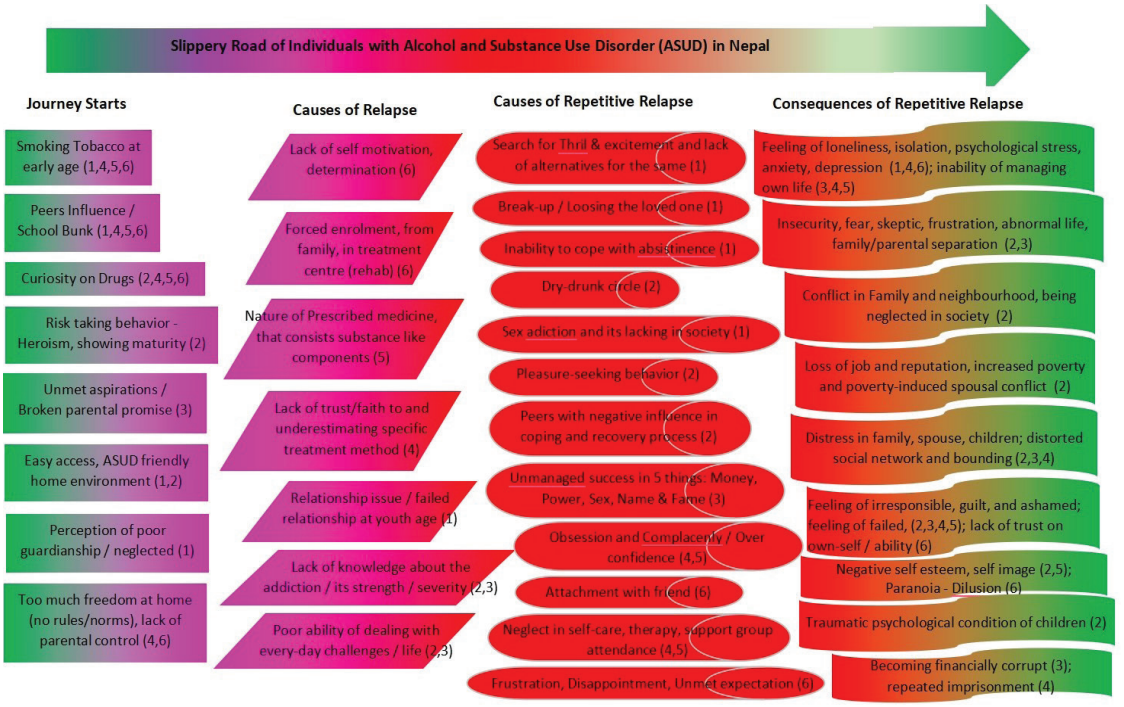
Respondent c.5 stated that "Even in the situation of relapse, I tried many times to quit drugs, but I could not do so. By that time, I had lost my self-confidence that I could live without using substances" (c.5, P2, 41). This addiction led him towards negative self-esteem and a negative perception of himself. He may have felt guilty, ashamed, or failed, contributing to diminished self-esteem. This negative self-image has made it challenging to believe in his own ability towards change.

The c.6 stated that "I was diagnosed with the HIV virus and I had hallucinations while using drugs, and fell asleep while driving. I went into anxiety. I was not aware of person-to-person HIV transmission" (c.6, P2, 15). As hallucinations, fear, and anxiety are common psychological symptoms associated with substance use, specific substances, especially stimulants like coke and crack, can induce paranoia and delusions. All of the triggering elements chronically influence the personal life of individuals with ASUD.

5. Discussion

We have prepared a theoretical framework based on our findings (Figure 2) that demonstrates that, firstly, the relapse is seen during the recovery journey, which can be attributed to numerous factors, including, but not limited to, peer pressure, negligence, and curiosity. Peer pressure played a crucial role, as individuals felt compelled to engage in substance use or risky behaviours to fit in their social circle, as theorised by Smith (2018). Moreover, negligence towards one's recovery plan is found to be the lack of vigilance in avoiding triggers of relapse. For instance, individuals may become complacent in their efforts to stay sober, leading to relapse, due to old habits (Sibley et al., 2020). Additionally, curiosity can drive individuals to experiment with substances or behaviours they had previously abstained from, further heightening the risk of Relapse (Dutton, 2023). Reservation, which refers to the hesitancy or doubt individuals may have towards their recovery journey, also weakens their ability to resolve the problem and open the door to relapse (Ndou, 2019). The pleasure-seeking behaviours, such as engaging in sexual activities, and one's own belief that 'would be able to control addictive patterns,' have also contributed to relapse and vulnerability, which is consistent with Fonseca et al. (2021). The individuals with ASUD with repetitive relapse seek immediate gratification, disregarding the consequences, ultimately jeopardising their life and the community and society they belong to.

Figure 2: Causes and Consequences of Repetitive Relapse in People with ASUD in Nepal



On the other hand, repetitive relapse presented a harrowing narrative where the pursuit of substance use transitions from a source of pleasure to a perceived necessity for survival and existence. This shift is accompanied by profound loneliness and isolation, further compounded by anxiety and depression. The scenario is depicted as the individual finds themself abandoned by friends and family, doubted and lacking trust in their surroundings, and detached from professions such as jobs. The ensuing psychological victimisation leaves them bereft of coping mechanisms and healing capacity, exacerbating their remorse and sense of alienation. Hence, despite repeated attempts to recover at rehabilitation centres, characterised by moments of hope upon admission to rehab, the individual remains ensnared in the cycle of addiction. The soul feels extinguished, the senses dulled, and the brain's reward system becomes dysfunctional, perpetuating the relapse cycle, consistent with Volkow (2019).

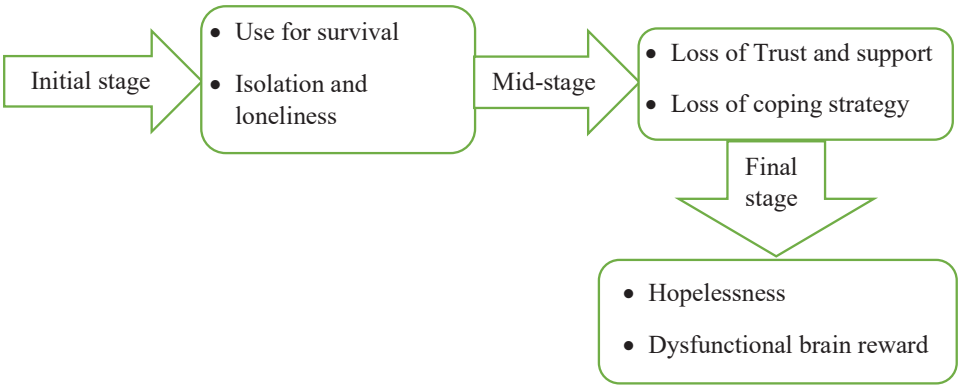
Underlying this tragic cycle lies a critical factor contributing to repetitive relapse. The failure to integrate the principles of the 12-step program into daily life and a lack of proactive engagement in treating the illness of addiction can be termed as 'X factor' , underscoring the importance of ongoing support and commitment to recovery. The individuals may find themselves trapped in relapse despite their earnest desires to quit. Hence, without addressing this fundamental issue and implementing comprehensive treatment strategies, individuals are doomed to repeat the cycle of relapse, unable to break free from the grip of addiction (Steverson, 2020).

In summary, the variables identified in the conceptual framework (Figures 2 and 3) intertwine to create a complex web of triggers that increase the vulnerability of individuals with ASUD. These factors significantly influence the likelihood of Relapse and repetitive Relapse in the recovery process, which can lead to chronic, repetitive relapse, despite multiple attempts to achieve sobriety (Figure 3 and Table 1).

[7]The term "X factor" in addiction refers to the complex and multifaceted nature of the disease, where no single cause explains why some individuals become addicted. It involves a mix of genetic, environmental, psychological and social factors, making addiction unpredictable and unique to each person (National Institute on Drug Abuse, 2020).

Figure 3: Psychological factors as the main trigger of Repetitive Relapse among individuals with ASUD

Figure 3: Psychological factors as the main trigger of Repetitive Relapse among individuals with ASUD



As presented in Figure 3, psychological factors trigger repetitive relapse, which progresses through distinct stages (Stillman & Sutcliffe, 2020). Initially, repetitive relapse reveals a troubling pattern in which substance use shifts from being a source of pleasure to a perceived necessity for survival. This shift often leads to intense loneliness and isolation, as individuals become alienated from friends and family (Ingram et al., 2020). In the mid-stage, the psychological impacts of addiction strip individuals of effective coping mechanisms, intensifying their remorse and deepening their sense of alienation (Caparros & Masferrer, 2021), leading them to the cycle of addiction. At the final stage, despite their multiple attempts at rehabilitation, which are often only marked by brief moments of hope during the treatment, and only for a few, the relapsed individuals' sense of self diminishes, emotions become blunted and the brain's reward system is disrupted, making relapse nearly inevitable (Blum et al., 2017). This suggests that the progression of psychological factors in individuals with ASUD plays a critical role in making them relapse repeatedly.

In instances of repetitive relapse, various factors come into play that may impede traditional approaches to recovery. Programmatic factors, such as the structure and design of treatment programs, behavioural factors encompassing the individual's actions and responses, and environmental factors, including the surroundings and social influences, often prove insufficient in addressing the underlying issues of repetitive relapse. According to research by Razali et al. (2023), despite the efforts directed towards addressing the issues of repetitive relapse, individuals with ASUD continue to struggle to sustain their recovery journey. For instance, a person may repeatedly relapse despite being enrolled in a well-structured treatment program, demonstrating positive behavioural changes and being in a supportive environment. This highlights the complexity of addiction and the need for a more nuanced approach to addressing it.

In such cases, prioritising the treatment of psychological factors is paramount in guiding individuals towards recovery and resilience. Psychological factors encompass a range of aspects, including underlying trauma, unresolved emotional issues, and mental health disorders that may contribute to addictive behaviours. By addressing these psychological factors through therapy modalities such as Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), or trauma-informed care, individuals can gain insights into their thought patterns, emotional triggers, and coping mechanisms. For example, a study conducted by Mooney et al. (2023) demonstrated that integrating trauma-focused therapy alongside traditional addiction treatment significantly reduced relapse rates among individuals with co-occurring trauma and ASUD. Therefore, by prioritising the treatment of psychological factors, individuals with repetitive relapse can embark on a more effective path towards long-term recovery.

6. Conclusion

Researching Relapse and repetitive Relapse among individuals with Alcohol and Substance Use Disorders (ASUD) in Kathmandu, Nepal, is crucial for several reasons. Firstly, Nepal, Kathmandu, and other metropolitan cities face a significant burden of substance abuse, with detrimental effects on individuals, families, and society as a whole. Understanding the factors contributing to Relapse and repetitive Relapse, hence, can help tailor interventions to the specific needs of the individuals with ASUD, ultimately reducing the personal and societal impact of substance abuse. Secondly, although relapse is a common challenge in recovery worldwide, its determinants vary across different cultural and socioeconomic contexts. Understanding the factors contributing to Relapse and repetitive Relapse can thus help tailor interventions to the local context.

Major findings unveil a complex interplay of influential factors of relapse among individuals with ASUD, such as peer pressure stemming from social circles and interactions, alongside negligence by individuals with ASUD regarding the consequences. Moreover, curiosity coupled with reservations about abstaining and pleasure-seeking behaviours such as engaging in sexual activities, also served as contributing factors for relapse. The misconception of one's ability to control substance use patterns exacerbated these tendencies, as individuals falsely believe they can manage consumption without succumbing to addiction. Conversely, repetitive relapse among individuals with ASUD created a miserable representation of desperation and isolation. Driven not only by pleasure but also by a dire necessity for survival, individuals' isolation deepened the cycle of regret into remorse, compounded by psychological victimisation of oneself, and a perceived lack of coping capacity. In the state of repetitive relapse, individuals undergo a soul-crushing experience, their senses rendered non-functional, and the brain's reward system rendered dysfunctional.

The gendered aspect of the findings, specifically, is that females had a shorter duration of clean period between relapses, followed by taking higher doses quickly in the journey to addiction. Also, their peers show more curiosity towards men (probably fewer females are addicted, so they want to show a masculine attitude, or explore the addicted world). In females, conjugal relation with an ASUD partner often influences them towards addiction.

This research was conducted using a qualitative method, followed by a group conversation to cross-validate the findings and ensure their accuracy. This process helped us to reach the conclusion that psychological issues are the predominant factors contributing to repetitive relapse in individuals with ASUD. Most importantly, the primary cause of all relapses, even repetitive relapse, is the inability to implement the concept and the principles of the 12-step program of treatment and recovery into daily life, and individuals who are not doing anything to treat their own disease of addiction (X factor). These profound insights underscore the urgent need for comprehensive strategies to effectively address the multidimensional dynamics of underlying Relapse and repetitive Relapse among individuals with ASUD. Therefore, addressing these underlying psychological problems is crucial in preventing the cycle of repetitive relapse. Nevertheless, being a study based on a limited number of informants with finding variables across the research participants, generalisation to a wider context may not be accurate. Therefore, we suggest further research in different contexts, using an extended sample size, and identifying and analysing relapse and repetitive relapse predictors.

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