INFLUENCE OF COUNSELLING SERVICES ON BEHAVIOUR CHANGE AMONG ADULT RECOVERING ALCOHOLICS IN UASIN GISHU COUNTY

KENYA

BEATRICE CHEROP

A Research Project Submitted to the Graduate School in Partial Fulfilment of the Requirements for the Award of Master of Arts Degree in Guidance and Counselling of Egerton University

EGERTON UNIVERSITY

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DECLARATION AND RECOMMENDATION

Declaration

This Research Project is my original work and has not been previously presented for award of Diploma or Degree in this or any other university.

……. …….

Beatrice Cherop Date
Reg. No. EM16/2648/10

Recommendation

This Research Project has been submitted for examination with my approval as the University Supervisor.

…… ……

Date

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DEDICATION

This work is dedicated to my husband, Benjamin Chesro and children, Levi, Nathan and Joe for their continuous inspiration, patience, encouragement and motivation.

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ABSTRACT

Since the escalation of alcoholism in Kenyan, many families are wrestling to cope with the costs of addiction because addiction is often defined as chronic, relapsing disorder that require comprehensive detoxification and psychosocial intervention. Alcoholism severity and relapse complexity process that involves the mental, physical, emotion and behavioural component of a person disables recovering alcoholics to achieve sobriety. Therefore, this study sought to investigate the influence of counselling services on behaviour change among adult recovering alcoholics in Uasin Gishu County. The study used descriptive survey design. Purposive sampling was used to select three rehabilitation centres for recovering alcoholics and accessible sample size 70 from these rehabilitation centres. The questionnaire was administered by the researcher to collect data. It was a self report measure consisting of 25 items scored on a likert five point scale which measured the following broad domains; counselling services, physical health, psychological well being and social functioning. The pilot study on identified subjects of similar treatment was done to find the accuracy of items. The data obtained was analyzed by Statistical Package for Social Sciences (SPSS) version 22.0 for windows. Kuder- Richardson was used to estimate the reliability. Reliability coefficient of 0.806 was obtained and this was considered acceptable for this study indicating good concurrent validity. The findings demonstrated that counselling services offered among adult recovering alcoholics influences behaviour change and improves general health, psychological well being and social functioning. The result also indicated that recovery and a fulfilling life is possible by taking positive steps towards meaningful goals setting, working on self esteem, empowerment and social support. Often there is inadequate attention placed on how to maintain abstinence in the weeks, months or even years following treatment. Given this reason, the researcher recommends for enhancement of aftercare structured counselling program among rehabilitation centres' which has been shown to make a huge difference between the addict abstaining from his or her addiction and successful relapse management.

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ABBREVIATIONS AND ACRONYMS

AA: Alcoholics Anonymous

ABCT: Alcohol Behavioural Couple Therapy.

ADAPT: Alcohol, Drug Abuse, Prevention and Treatment

AVE: Abstinence Violation Effect

BCI: Brief Counselling Intervention

CBT: Cognitive-Behavioural Therapy

EAP: Employee Assistance Programme

ECBI: Effectiveness of Coping Behaviours' Inventory

EU: European Union.

FRAMES: Feedback, Responsibility, Advice, Menu, Empathy and Self-efficacy

GSRA: Global Status Report on Alcohol

HIV: Human Immunodeficiency Virus

IP: Identified Patient

NACADA: National Agency for Campaign Against Drug Abuse

NIAAA: National Institute on Alcohol Abuse and Alcoholism

NESAR: National Epidemiologic Survey on Alcohol and Related Conditions

MET: Motivational Enhancement Therapy

RPP: Relapse Prevention Plan

STI: Sexual Transmitted Infection

SPSS: Statistical Package for Social Sciences

TPB: Theory of Planned Behaviour

TRA: Theory of Reasoned Action

USA: United States of America

WHA: World Health Assembly

HED: Heavy Episodic Drinking

WHO: World Health Organisation

WHOQOL: World Health Organisation Quality Of Life

WHS: World Health Survey

CHAPTER ONE
INTRODUCTION

1.1 Background Information

Alcohol has been and continues to be most available and abused substance worldwide regardless of age, race, intelligence, education, religion, profession, gender among others. Alcohol consumption has health and social consequences through drunkenness, alcohol dependence, and other related biochemical effects. Alcoholism is a disease that is characterized by the sufferer having a pattern of excessive drinking despite its negative effects on individual's health, work, medical, legal, educational, family, and social life. At this level, the researcher will look at research studies on alcohol prevalence globally, regionally and nationally. Thereafter to find out how these statistics have influenced urgency of intervention to curb the escalating alcohol related problems.

The Global Status Report on Alcohol and health (2014) presents a comprehensive perspective on the global, regional and country consumption of alcohol, patterns of drinking, health consequences and policy responses. The World Health Organization's (WHO) statistics report on Global Status on Alcohol (2011) estimated that there are about 2 billion people worldwide who consume alcoholic beverages and 76.3 million with diagnosable alcohol use disorders. Worldwide per capita consumption of alcoholic beverages in 2005 equalled 6.13 litres of pure alcohol consumed by every person aged 15 years and older per year. A large portion of these consumption 28.6% or 1.76 litres per person was homemade and illegally produced alcohol or, in other words, unrecorded alcohol.

In 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributed to alcohol consumption. There are significant sex differences in the proportion of global deaths attributed to alcohol, for example, in 2012 7.6% of deaths among males and 4.0% of deaths among females (WHO, 2014). In the very year, 5.1% of the global burden of disease and injury were attributable to alcohol consumption. Following the endorsement of the global strategy to reduce the harmful use of alcohol, WHO is committed to continue to monitor, report and disseminate the best available knowledge on alcohol consumption, alcohol-related harm and policy responses at all levels. WHO ensures monitoring progress in implementing the global strategy and regional action plans among its member countries. It has strengthened its actions and activities to prevent and reduce alcohol-related harm at all levels. These

strategies include: leadership, awareness and commitment action, health service response, drinking-driving-countermeasures, regulating availability of alcohol, marketing restriction, pricing, reducing negative consequences of drinking, addressing illicit and informal production, Monitoring and surveillance. Many WHO Member States have demonstrated increased leadership and commitment to reducing harmful use of alcohol over the past years, as proposed by the Global Strategy to Reduce the Harmful use of Alcohol (WHO, 2014). In addition the report shows the need for communities to be engaged in reducing harmful use of alcohol. Through a global network, WHO is supporting countries in their development and implementation of policies to reduce the harmful use of alcohol. The need for intensified action was endorsed in the landmark 2011 of United Nations General Assembly meeting, which identified alcohol as one of the four common risk factors contributing to the Non-Communicable Diseases (NCDs) epidemic.

Europe has the highest level of drinking in the world, with a prevalence of heavy episodic drinking in excess of one fifth of the European population of 15 years old and over (WHO, 2010). A report from the Institute of Studies estimate that every year alcohol is responsible for 115,000 net deaths in Europe up to the age of 70 (Anderson & Baumberg, 2006). Alcohol is the leading contributor to death among young adult men with about 25% mortality. The report also estimated the tangible costs of alcohol to the EU in 2003 to be 125 billion Euros, which is 1.3% of the EU GDP (Anderson & Baumberg, 2006). In collaboration with the Department of Health, the National Institute for Health and Clinical Excellence (NICE) has published national guidelines on management of alcohol use and alcohol disorders in the UK (Drummond, Pilling, & Brown, 2011). Alcohol-use disorders, the NICE guideline on diagnosis, assessment and management of harmful drinking and alcohol dependence, builds on the conceptual framework for alcohol treatment delivery developed by the Institute of Medicine in 1990.

In the United States of America (U.S.A), alcoholic beverages are both legal and socially accepted. The study, published in the Archives of General Psychiatry (2008), postulated that more than 43,000 adults reported in 2007 found that thirty percent of U.S.A. adults have experienced alcohol abuse or alcoholism. They articulated further that fewer are getting treatment for alcohol use disorders than in the past. The recent research done on Health Statistics for U.S.A adults (2011) indicates that overall 52% of adults aged 18 and over were current regular drinkers, 14% were current infrequent drinkers, 6% were former regular

drinkers, 9% were former infrequent drinkers, and 20% were lifetime abstainers. Sixty percent of men were current regular drinkers compared with 44% of women. Men were also more likely to be former regular drinkers than women. Women were more likely to be current or former infrequent drinkers or lifetime abstainers than men. In 2000 National Survey of both rural and urban populations of Mexico age group 20 years and above, the rate of current drinkers was 69.4% (male) and 59.5% (female). In reference to the 2003 World Health Survey (WHS), sample population aged 18 years and over, the rate of lifetime abstinence was 52.7%, (35.6% male and 65.2% female). World Health Survey (2003) indicates that 22,368 sample populations aged 18 years and over, the rate of heavy episodic drinking among the total population was 3% (total), 6.3% (male) and 0.7% (female). Heavy episodic drinking was defined as at least once a week consumption of five or more standard drinks in one sitting.

The treatment of alcohol problems in the United States of America can be traced back to the establishment of Alcoholics Anonymous (AA) in 1935 as Alcoholics Anonymous World Services (National Academy Press, Washington, D.C, 1990). This was recognized quickly by men like Clinton Duffy, the great "reform" warden of San Quentin, who encouraged the establishment of AA groups in his prison in 1942. The Institute of Medicine report (1990) states that Harvard psychiatrist Robert Fleming in 1944 argued that the prolonged institutionalization of alcoholics was no longer necessary instead community-based psychotherapy and AA participation was his new prescription. The growth of AA permitted the first substantial stirrings of community care since the Washingtonian Movement. During the early 1960s, some state hospitals, particularly in Minnesota, incorporated recovering alcoholics and the principles of AA into their treatment programmes. What became known as the Minnesota model of short-term inpatient care. Subsequent AA fellowship and recovery-home living spread slowly among private treatment providers such as the Hazelden Foundation, Minnesota and the Mary Lind Foundation in Los Angeles (Besteman,1991).

The most commonly abused substances in Africa are alcohol, cannabis and khat/miraa (Odejide, 2006). Africa has the second highest growth of beer consumption after Asia, with a compounded annual growth rate of 6.4 per cent over the past five years (Beer Brewer SABMiller's 2009, Annual Report). In South Africa, alcohol consumption rate is 28%, which translates to 8.3 million South Africans 15 years and above. For both men and women the highest levels of current alcohol use were recorded among persons between 35-44 and 45-54

year age groups, and the lowest levels in the 15-24 year group. Risky drinking was defined as drinking five or more standard drinks per day for men and three or more drinks per day for women.

The heavy influence of the alcohol industry on the development of national alcohol policies favourable to alcohol advertising and distribution has recently been documented in several African countries. In South Africa, the established Inter-Ministerial Committee (IMC) reviewed extensive inputs and evidence on alcohol marketing and alcohol-related harm and then mandated the Minister of Health to draft legislation banning all advertising and sponsorships and other marketing on the basis of this evidence (WHO, 2014). The impacts of the Inter-Ministerial Committee are now beginning to be felt. The individual country can plan how best to reduce the impacts of alcohol in society and where all departments can contribute to reducing alcohol-related harm as part of a "whole of government" approach has the potential to reduce alcohol-related harm considerably. A survey conducted in Central and Southern Nigeria indicates that, 52% of male and nearly 40% of female respondents reported heavy episodic drinking in the past year, and among drinkers heavy consumption was common practice (Ibanga, Adetula, Dagona, Karick, & Ojiji 2005). Alcohol consumption in Nigeria was a gender and age based. A similar survey done in Uganda showed that 46% and 17.6% of male and female drinkers respectively engaged in heavy episodic drinking (Tumwesigye & Rogers, 2005).

Uganda is the highest consumer of alcohol per capita in the East African region, according to a newly released report. The Global Status on Alcohol and Health (2014) indicates that 23.7 litres of pure alcohol are consumed per capita by drinkers annually in Uganda. Rwanda and Burundi follow each registering 22.0 litres per capita per year. Kenyans follow with a registered 18.9 litres of alcohol consumed per capita while Tanzania consumes only 18.4 litres per capita. At least 89 per cent of the alcohol consumed in Uganda is unregulated, home brewed and illegally sold, according to the report. In Uganda, a country of more than 32 million people, alcohol dependence is among the main causes of psychiatric morbidity (Ministry of Health in Uganda, 2005). Historically, alcoholic beverages such as beer have often been used to bind different Ugandan cultures together and during celebrations of important events such as marriages (Wolf, Busza, Bufumbo, & Witworth, 2006). Uganda not only lacks a clear national alcohol policy, but has weak and poorly enforced laws, thereby providing a fertile ground for alcohol abuse. It is also evident that there is neither restriction

on advertising alcohol nor sponsorship of national events including youth assemblies. Enforcement of laws on alcohol beverages in government premises, health centres and education institutions is very inadequate despite a ban on them. Similarly, there are no restrictions on opening time of bars. Some bars are open 24 hours and 7 days a week more especially in areas around institutions of higher learning, parks, streets, workplaces among others. The alcohol manufacturers successfully opposed a rise in the tax levy on alcohol introduced in 2012/13 budget. They argued that the government would lose revenue if alcohol prices and smuggling increased. Attempts by the Ministry of Health to regulate the consumption of alcohol have been opposed by the Ministry of Trade which blocked a proposal on the manufacture and consumption of local gin products, Waragi sachets (Ministry of Health in Uganda, 2005).

Alcohol is the most liberally abused substance in Kenya followed by Tobacco, Bhang, Miraa (Khat), inhalants and description drugs (NACADA, 2002). While Kenya has a lower alcohol-consuming population in the region, it has the largest number of beer consumers at 56 per cent of all alcoholic beverages consumed compared to 50 per cent in Ethiopia, Burundi's 25 per cent, 11 per cent in Rwanda and Tanzania and only 9 per cent in Uganda (WHO,2014). All alcoholic beverages contain ethanol, which is considered a drug since it is narcotic, depressive and addictive. It is estimated 13% of people from all provinces in Kenya except North Eastern province are current consumers of alcohol (NACADA, 2011). Disaggregating by province, the lowest use was found in North Eastern (0 %) and Western provinces (6.8%) while the other six provinces were comparable with a range of 13% - 19% (Rift Valley 12.5%, Eastern 14.8%, Nyanza 17.0%, Central 17.7%, Coast 18.6%, Nairobi 18.6%). The three classes of illicit brews in Kenya according to WHO (2004) are: fermented brews (traditional Beer) such as Busaa (a grain beer), Mnazi (palm Wine), Muratina (from a local fruit known as Muratina mixed with sugar cane juice and honey) and Indali (banana beer) from ripe bananas; distilled liquors or spirits such as chang'aa in Kenya which is equivalent to Waragi in Uganda and Konyagi in Tanzania.

Findings from a National Survey on Alcohol and Drug Abuse conducted by NACADA in 2012 shows that 13.3% Kenyans are currently using alcohol. The survey further indicates that 30 % of Kenyans aged 15-65 have ever consumed alcohol in their life. This means that at least 4 million people abuse alcohol. The damage caused by both licit and illicit alcohol abuse to the society, labour force and the entire economy has been of much concern to the Kenyan

government. Alcohol use has led to so many deaths in Kenya although the law penalises those found guilty of adulterating alcoholic drinks. This has however not prevented occurrence of deaths linked to illicit brews. Between April and August 2010, over 50 deaths were reported and dozens of alcohol related blindness (NACADA, 2011). This shows an urgent need to prevent and control alcohol abuse in Kenya. The Kenyan government took an action of instituting policies especially promulgation of various Acts such as; Traditional Liquor Licensing Acts and Narcotic Drugs and psychotropic substance control Act of 1994. The government also resolved to combat the menace through formation of National Agency for the Campaign Against Drug Abuse Authority (NACADA) to complement stated Acts. These Acts and policies on alcohol are purposed to control alcohol production and sales but little has been done to help alcoholics to stop abusing alcohol and other drugs.

Although Nacada has launched a massive campaign to fight alcoholism, the war is undermined by the limited number of affordable rehabilitation facilities for the recovering alcoholics. There are about 75 rehabilitation treatment centres in Kenya, both private and public. While each rehabilitation has specific goals, all rehabilitation centres in Kenya have three similar generalised goals: Reducing substance/ alcohol abuse or achieving alcohol -free life. Maximising multiple aspects of life functioning that is psychological, social and physical well being and preventing the frequency and severity of relapse among recovering alcoholics. The primary goal of counselling in regard to alcohol addiction is attainment and maintenance of abstinence. Until the client or recovering alcoholic accepts that abstinence is necessary, the treatment program usually tries to minimise the effects of continuing use and abuse through education, counselling, and self-help groups that stress reducing risky behaviour, building new relationships with alcohol-free friends, changing recreational activities and lifestyle patterns, with a goal of convincing the client of her or his individual responsibility for becoming abstinent.

For every addiction, there are recovery programmes and support groups in the rehabilitation centres to help those looking forward to change their habits. During the beginning phases of recovery, an alcoholic undergoes the process of drug detoxification to remove any unwanted chemicals from the body, followed by intensive addiction recovery counselling. Once individuals get through the initial detoxification from alcohol, they will continue through rehabilitation because detoxification alone does not address the psychological, social, and behavioural problems associated with addiction. Detoxification should thus be followed

by a formal assessment and referral to psychological therapeutic intervention. This is where the clients get to the core reasons behind their addictions, addressing those issues they can effectively move on with their lives without going back to alcohol or their addictive behaviour. Therefore, counselling begins to open a line of communication during this often difficult time. It allows trained therapists to share helpful information about addiction, relapse prevention, and developing positive, healthy methods of coping to continue living a happy and alcohol-free life. These can be done through individual, group counselling and family counselling.

1.2 Statement of the Problem

Since the escalation of alcoholism in Kenyan, many families are wrestling to cope with the costs of addiction. Alcoholism severity and relapse complexity process that involves the mental, physical, emotion and behavioural component of a person disables recovering alcoholics in Uasin Gishu County to achieve sobriety. This is because addiction is often defined as chronic and relapsing disorder. Recovery from alcohol addiction is a long-term process and frequently requires multiple counselling services or approaches. For alcohol recovering people seeking help, total abstinence has been an ideal goal but given their circumstances and motivation for change, that goal may be unreachable when alcohol addicts first seek counselling services and often leave treatment prematurely, hence unable to fully resolve their alcoholism problems. Therefore there is need to investigate the influence of counselling services on behaviour change among adult recovering alcoholics.

1.3 Purpose of the Study

The purpose of this research was to investigate influence of counselling services on behaviour change among adult recovering alcoholics in Uasin Gishu County.

1.4 Objectives of the Study

The study was guided by the following objectives:

i. To identify counselling services offered to adult recovering alcoholics on behaviour change.
ii. To determine the influence of counselling services on psychological well being among adult recovering alcoholics.

iii. To determine the influence of counselling services on physical wellness among adult recovering alcoholics.
iv. To determine the influence of counselling services on health social lifestyle among recovering adult alcoholics.

1.5 Research Questions

This study answered the following research questions:

i. Do counselling services among adult recovering alcoholics influence behaviour change?
ii. Do counselling services improve psychological well being among adult recovering alcoholics?
iii. Do counselling services improve physical wellness among adult recovering alcoholics?
iv. Do counselling services impact positively on the social lifestyle of recovering alcoholics?

1.6 Significance of the Study

Significance of this study states that the research outcome may help the counselling staff in recovering rehabilitation centres to give time, effort, resources, and compassion for effective counselling demands. The research findings may assist the rehabilitation centres working team, to improve skills and adequate time of counselling options that are tailored towards the needs of each client. The results of this study also may assist the staff members in recovering rehabilitation centres distinguish between effective and ineffective counselling services and find new opportunities for treatment improvement. Finally, the results for this study may create an insight for the individual and community to be engaged and involved in helping recovering alcoholics to go through abstinence process from alcohol misuse to sobriety lifestyle.

1.7 Scope of the Study

This study was carried out to determine the influence of counselling services on behaviour change among adult recovering alcoholics. The study was conducted in Uasin Gishu County, in community based rehabilitation centres. The target population was both male and female above 18 years old admitted in these rehabilitation centres. The study focused on the

influence of counselling services offered to determine the impact on behaviour change among recovering alcoholics.

1.8 Limitations of the Study

This study had the following limitations:

i. The study included small sample size and short duration of treatment for three months without follow-up. Longer duration of follow-up could have predicted the impact of certain treatment-related variables on quality of life.
ii. Some the respondents declined to give information genuinely due to guilt and fear that they would be labelled as alcoholics. This limitation was dealt with through assuring the participants on confidentiality of their information.
iii. The study did not manage to get information from family members and significant others. These family members play an important role in the treatment, care and emotional support.
iv. The finding of this study was only applied to selected rehabilitation centres hence the result would not be generalized to all rehabilitation centres within the County and give comprehensive information on the general population.

1.9 Assumptions of the Study

This study has got the following assumption:

i. This study assumed that findings suggested would contribute to modify effective counselling services, skills, planning and implementations of alcohol community based rehabilitation centres.
ii. The other assumption underlying this research was on identified recovering alcoholics to withstand temptation of falling back to drinking alcohol or abstain completely.
iii. The recovering alcoholics may manage their drinking habits that may result in improvement of individual health, social and psychological well being.
iv. Their general health might be improved and recovering alcoholics may be responsible in taking care of themselves and managing alcoholic triggers.

1.10 Definition of Terms

This study was guided by the following operational and conventional terms. The first statement was referring to operational definition and second statement referring to conventional meaning.

Abstinence: Discontinuance and avoidance of further use of alcohol.

The dictionary definition is any self-restraint or self-denial of something you like most.

Aftercare: Is a service following hospitalisation or rehabilitation, individualized for each patient's need. Aftercare, gradually deter the patient out of treatment while providing follow-up attention to prevent relapse.

Extended support services by a welfare agency or a professional for a person discharged from an institution, such as hospital, prison or rehabilitation centre.

Alcoholism: This term generally taken to refer to chronic continual drinking or periodic Consumption of alcohol which is characterised by impaired control over drinking, frequent episodes of intoxication, and preoccupation with alcohol and the use of alcohol despite adverse consequences.

Scientifically alcoholism is defined as a progressive, potentially fatal disease characterised by the excessive and compulsive consumption of alcoholic beverages and physiological and psychological dependence on alcohol.

Alcohol Abuse: Is when a person's drinking leads to problems, but not physical addiction. Alcohol abusers have some ability to set limits on their drinking. However, their alcohol use is still self-destructive and dangerous to themselves or others.

Alcohol Dependence: It is a chronic disease characterised by the consumption of alcohol at a level that interferes with physical, mental health, with family and social responsibilities.

According to DSM-IV-TR alcohol dependence is understood as a maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by tolerance or withdrawal.

Alcohol Detoxification: Is a medically supervised process of assisting the body to get rid of Alcohol while effectively managing the symptoms associated with withdrawals.

It is where the metabolic process by which toxins are changed into less toxic or more readily excretable substances.

Alcohol Withdrawal: Refers to symptoms that may occur when a person who has been Drinking too much alcohol every day suddenly stops drinking alcohol.

Is a set of symptoms that can occur when an individual reduces or stops alcoholic consumption after long periods of a duration.

Binge Drinking usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk. The World Health Organisation has defined binge drinking as drinking six or more standard drinks (about 3 pints of beer) during one drinking occasion.

Cessation: Refers to total stopping or reduction in alcohol use that has been heavy or prolonged. The process of ending or being brought to an end of something.

Co Morbidity: Means the co-occurrence of one or more diseases or disorders in an individual. These illnesses can be medical or psychiatric conditions as well as drug use disorders, and alcoholism.

It is a state where two or more coexisting medical conditions or disease processes that are additional to an initial diagnosis.

Counselling: Counselling is the application of mental health, psychological or human development principles, through cognitive, affective, behavioural or systematic interventions, strategies that address wellness, personal growth, or career development, as well as pathology. In other words, counselling is a systematic process which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being.

Counselling is a principled relationship characterised by the application of one or more psychological theories and a behaviour set of communication skills, modified by experience, intuition and other interpersonal factors, to clients' intimate concerns, problems or aspirations.

Craving: Having a strong urge or need to drink alcohol.

It is a powerful desire for something for example drinking, or smoking.

Epidemiology: Is the study of the distribution and patterns of health-events, health-characteristics and their causes or influences in well-defined population.

Epidemiology is a branch of medicine that is concerned with the study of the factors determining and influencing the frequency and distribution of disease, injury, and other health-related events and their causes in a defined human population for the purpose of establishing programs to prevent and control their development and spread.

Hazardous Use is a pattern of alcohol consumption carrying that increases the risk of harmful consequences to the drinker.

Hazardous use refers to exposing one to risk as of loss or harm.

Intervention refers to the specific treatment strategies, therapies, or techniques that are used to treat one or more disorders. Interventions may include psychopharmacology, individual or group counselling, cognitive-behavioural therapy, motivational enhancement, family interventions, 12-Step recovery meetings, case management, skills training, or other strategies.

Metabolism: Is the organic and chemical processes inside of organisms that are necessary to maintain life, or how quickly you burn calories or fat in the body.

Metabolism is complete set of chemical reactions that occur in living cells.

Physical Dependence: is a physiological state of adaptation to a substance, the absence of which produces symptoms and signs of withdrawal.

Physical dependence refers to how the body experiences physiological adaptation in response to chronic use of alcohol

Psychotherapy: The treatment of emotional or behavioural problems by psychological means, often in one-to-one interviews or groups.

Is a therapeutic interaction or treatment contracted between a trained professional and a client, patient, family, couple, or group.

Primary Care: Is the provision of integrated, accessible health care services by counsellors who are accountable for developing a sustained partnership with patients, and practicing in the context of family and community.

Is the day-to-day health care given by a health care provider, typically this provider acts as the first contact and principal point of continuing care for patients within a health care system, and coordinates other specialist care that the patient may need.

Quality of Life: An individual's perception of the effects of illness on the physical, mental, and social dimensions of his/her well-being.

It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status have on an individual quality of life.

Recovery: It refers to a voluntarily maintained lifestyle characterised by sobriety, personal or the 'process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life"

Relapse: To fall back into a previous state of drinking after achieving a level of abstinence. It ` is a process that begins when you start slipping back into old behaviour patterns.

Relapse is the state of returning to heavy alcohol use following a period of abstinence or moderate use. To fall or slip back into a former state or practice.

A relapse is when negative thinking and those ways of behaving that were tackled within treatment creep back over a longer period and things start to spiral again making you feel worse.

Self-Help Group: It is a group of individuals with similar problems like alcoholics that meets for the purpose of providing support and information to each other and for mutual problem solving. Parents Anonymous and Alcoholics Anonymous are examples of self-help groups.

It is a group of people who provide mutual support for each other.

Tolerance: Tolerance means that after continued drinking, or consumption of a constant amount of alcohol, produces a lesser effect or increasing amounts of alcohol are necessary to produce the same effect. In other words is the need to drink greater amounts of alcohol in order to feel or to get "high".

It is the ability of willingness to accept feelings, habits, or beliefs that are different from your own.

Treatment: It is a provision of one or more structured interventions designed to manage health and other problems as a consequence of alcohol abuse and to improve personal and social functioning.

Treatment is use of an agent, procedure, or regimen, such as a drug, surgery, or exercise, in an attempt to cure or mitigate a disease, condition, or injury.

Therapy: Is a helping relationship in which a therapist assists client(s) to resolve their issues and cope with diverse situations.

It is a form of psychiatric or psychological treatment for someone with mental illness or emotional problems that involve talking to them or asking them to do things.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter discusses the understanding of alcohol, types of alcohol and its use and misuse. The study further discusses alcoholism treatment especially pharmacotherapy and psychosocial intervention. The study discussed detoxification methods and counselling approaches that include; Cognitive behavioural counselling, motivational enhancement therapy, brief counselling and Alcohol Anonymous (12- step facilitation principle). Most of the literature cited in this research was from the USA and UK, although specific alcohol statistics on effect and campaigns against alcohol discussed herein are from Africa and Kenya in particular. The word alcoholics and alcohol dependence has been used interchangeably referring same meaning.

2.2 Types of Alcohol and Alcoholic Beverages

Alcohol is a psychoactive substance with dependence-producing properties that have been widely used in many cultures for centuries. Many countries define alcohol differently. WHO (2014) report, states that legal definition of alcoholic beverages varies according to countries. World Health Organisation defines alcoholic beverages as anything containing between 1% and 7% or more of pure alcohol. In Kenya NACADA (2010) defines alcohol as a colourless volatile flammable liquid, synthesised or obtained by fermentation of sugars and starches. It is widely used as either pure or denatured, as a solvent and in drugs, cleaning solutions, explosives, and intoxicating beverages. The variety of alcohol types, different brands, and mixing ingredients is sometimes overwhelming.

There are different types of alcohol. Some are used in chemistry laboratories and industry, for example, Isopropyl and methyl alcohol. Isopropyl alcohol is used in industrial processes as well as in home cleaning products and skin lotions. It is also commonly known as “rubbing alcohol”. Methanol, or methyl alcohol or wood alcohol has been used as an industrial solvent and is also commonly available as methylated spirit. It is found in cleaning solvents, paint removers, photocopier developer and anti-freeze solutions. It is similar to ethanol but the end product after it is digested by the body is formaldehyde, which is poisonous. This is responsible for “alcohol poisoning”. Methanol poisoning leading to blindness has been known to occur on consuming even small amounts. Another type of alcohol is ethyl alcohol,

also known as ethanol. This has been consumed by human beings for its intoxicating and mind-altering effects. The term 'alcohol', unless specified otherwise, refers to ethanol or ethyl alcohol.

The most popular consumed alcoholic beverage include: Bear, Cider, Wine and Spirits. Beer is one of the oldest forms of fermented alcoholic beverages. As people across the globe consumed different forms of beer, there are actually many sub types in beer. Ale type of beer is brewed from malted barley by mixing certain amount of yeast. The yeast helps in fermenting the beer and giving a fruit flavour to the beer. Fruit Bee; is a fruit like cherry, raspberry and peach are commonly used in brewing this type of beer. Most of the breweries add a flavour of these fruits instead of fermenting these fruits. Lager; this is another kind of beer that is brewed and stored at low temperatures. It is the most widely brewed and consumed beer in the world. It had its origins in Germany. Sahti is a Finnish Beer and is brewed by mixing different types of malted and unmalted grains such as Barley, Wheat, Oats and Rye. Wheat Beer is a type of beer produced by mixing a larger proportion of Wheat when compared to the malted Barley content. This type of beer had its origins in Austria and Germany and is commonly used in Kenya.

Cider is a fermented alcohol made out of Apple juice. The alcoholic content can vary from 3% to 8%. In United States and Germany, people refer to Cider as Apple. Wine is made from a variety of fruits, such as Grapes, Peaches, Plums or Apricots. The most common wines are produced from Grapes. The Grapes are crushed and fermented in large vats to produce wine. Spirit is an alcoholic beverage produced by distilling ethanol by fermentation of grains, fruits or vegetables. It is also referred to as hard liquor. These include Gin, Rum, Vodka, Tequila and Whiskey.

Alcoholic beverages in Kenya include: Beer, Wine, Spirit and locally made alcohol. Among various types of beer, Beer is the most commonly produced and consumed though other types of beers are also available in the market. A variety of wines are consumed in Kenya mainly from South Africa, France, Italy, Spain, Germany, Austria, Chile and America. There is also local production of wine mainly from the Naivasha area and other regions of the country. Chang'aa is a distilled beverage consumed in much of the Kenya communities. Chang'aa can be made from a variety of grains, malted millet and maize being the most common. Its alcoholic content ranges from 20% to 50%. This illegal liquor is produced in clandestine

distilleries (both in rural and urban areas) and is consumed by people who cannot afford Beer or those who want to experience the effect of alcohol more quickly and at a lesser cost. Busaa is a traditional beer made from Finger Millet malt and is consumed in many parts of the country though rampant in the Western region. Palm Wine (Mnazi) is consumed especially along the coastal region. Muratina is an alcoholic drink made from sugarcane and sun dried Muratina fruit. The fruit is added to a small amount of sugar-cane juice and incubated in a warm place. It is removed from the juice after 24 hours and sun-dried. The fruit is then added to a barrel of sugar-cane juice which is allowed to ferment between one and four days. The final product has a sour alcoholic taste. Banana beer is made from ripe bananas, mixed with cereal flour (often sorghum flour) and fermented to an orange, alcoholic beverage. It is sweet and slightly hazy with a shelf life of several days under correct storage conditions. Urwaga banana beer is made from bananas and sorghum or millet.

National survey by NACADA (2012) showed that alcohol is now the most abused substance in the country and of the different types of alcoholic drink. Traditional liquor is the most easily accessible, followed by wines and Spirits and last but not least Chang'aa. Among the different types of alcoholic drinks, traditional liquor is the most easily accessible type of alcohol followed by Wines and Spirits and lastly Chang'aa.

2.3 Use and Misuse of Alcohol

Since time immemorial, people have been drinking alcohol. Its consumption was considered normal, especially when drunk without outright intoxication in African context and other parts of the globe. Wine, Beer, Spirit and other fermented alcoholic beverages were drunk in traditional societies and some of these beverages are still used in this modern era for different purposes. Though alcoholic beverages have been consumed for hundreds of years, the pattern and purpose of consumption vary considerably among societies and even within communities. Excess consumption was not widely tolerated in many African societies while few communities permitted it. Alcohol consumption was not a daily affair.

Alcohol use was reserved for adult men and played a crucial role in political, religious and socio economic relationships (Oshodin, 1995.) In this era, alcohol played complex roles in religious and communities' rituals and served as a conduit for social cohesion as people drank locally brewed beverages together in groups. Because of these ceremonial functions, adult

male were expected to drink being served by the women. Alcohol was a key requirement for a bridal price to be paid in order to consummate marriages in many villages. It was consumed at almost all ceremonies including cultural festivals, chieftaincy enthronements, child dedications and even funerals. Even on these occasions, excess consumption among adults was culturally controlled partly because traditional wine cups were served based on age and title hierarchies. Indeed the indigenous society for most part regarded drunkenness as a disgrace. During modern industrialisation in Europe as a continent, the influx of new beverages, new modes of production, distribution and promotion emerged vigorously into African continent (Jernigan, 2000). As distilled spirits became available and transportation improved, alcoholic beverages became a market commodity which was available in all seasons of the year, and at any time during the week. This increased supply and availability often proved disastrous to all age groups and genders. In recent decades, the pattern, quantity and reasons for consumption are changing rapidly, especially among youths.

Alcohol abuse is determined by the volume of alcohol consumed, the pattern of drinking and the quality of alcohol consumed. As shown by the most recent WHO data, globally, individuals above 15 years of age drink on average 6.2 litres of pure alcohol per year, which translates into 13.5 grams of pure alcohol per day (WHO, 2014). However, there is a wide variation in total alcohol consumption across WHO regions and Member States. Globally, 50.1% of total recorded alcohol is consumed in the form of Spirits, which are also the most consumed beverage type in the WHO South-East Asia and Western Pacific regions (WHO, 2014). The second most consumed beverage type is Beer, which accounts for 34.8% of all recorded alcohol consumed in the world. Only 8.0% of total recorded alcohol is consumed in the form of Wine. However, consumption of Wine represents one fourth of total consumption in the WHO European region. Unrecorded beverages only represent 7.1% of all consumption, but constitute the most popular beverage type in the African region (51.6% of total recorded consumption). The World Health Organisation say that in 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributed to alcohol consumption (WHO, 2014).

2.4 Factors and Causes that Influence Alcohol Abuse

There are a huge number of factors that may influence an individual's chances of developing an alcohol addiction, and while some of them may be genetic factors that cannot be changed. Other factors can be environmental, psychological, and socio-cultural factors that play a part in alcoholism. There is a strong link between alcohol abuse with dependence and genetics. It

has long been recognized that alcoholism runs in families. A family history of alcoholism is a well-established risk factor for the development of alcoholism. Genes that may be involved in alcoholism have not been identified. However, a number of studies of twins and adoptions support the idea that genetics may be involved in alcoholism. In one study, identical male twins, raised in separate environments, shared patterns of alcohol use, including dependence. Another study showed a continued likelihood of alcoholism in male siblings born into alcoholic families but adopted into non alcoholic families (Schuckit, Edenberg, Kalmijn Flung, & Smith, 2001). Public health experts and practitioners in Kenya have learned that the environment in which people live and work heavily affects their attitudes and behaviour around drinking. Environmental influences on alcohol use include: acceptance of alcohol use by society; availability (including price, number of outlets, advertising and marketing both nationally and locally) and public policies regarding alcohol and enforcement of those policies (WHO, 2004). Despite anti-drinking campaigns and education through NACADA, environmental factors may play a part in alcoholism when a community is threatened by drinking temptations within and outside home. It can be difficult for people to stay away from bad drinking habits when surrounded by an atmosphere of drinking neighbourhood or community. Adults can develop a pattern of drinking in bars and parties within the community that promotes drinking. Although occasional drinking may be harmless for many people, others can be led to excessive drinking.

The environment in which people live and work heavily affects their attitudes and behaviour towards drinking. An impoverished environment can increase the likelihood of alcohol abuse. Poverty can affect generations of family members due to lack of education and limited access to employment or healthcare. Poverty-stricken environments leave many experiencing lifestyles including incarceration, homelessness and poor health. Those who drop out of school, are unemployed or live in unsafe areas are at higher risk, especially if their home environment has already exposed them to alcohol. Exposure to these elements early in life leads many young adults down the same paths and can be difficult to escape. Acceptance of dangerous drinking is encouraged through mass media, peer attitudes, role models, and the attitude of the society in general. Alcohol is part of the social fabric of our society and the western society in general. This social endorsement ideology of alcohol consumption creates a lope hole for alcohol manufacturers to market their product with no consideration of side effect of it. Mass media reports and advertisement of alcohol products through radio, television shows, movies, normalize drinking in the society. Marketers in most cases

associate their product with appropriate target masculine and feminine images influencing social attitude by normalizing consumption pattern. Alcohol marketers are heavily involved in sponsoring most populated sporting activities (Like Olympic Games, Common Wealth Sports, World Cup) and other local sponsorship activities for example Tusker Project Fame Competition, Church-Chill Show, Beauty Context among others. The fact is that such marketing trends and services have opportunities to reach out to the remotest areas you can imagine in the country**.**

The physical compulsion and mental obsession to abuse alcohol can remain with someone for years. Research shows that heavy alcohol consumption can lead to periods of depression. A number of studies have shown that alcohol abuse increases the risk for depression. Among alcoholics in the general population, higher volume of consumption is associated with more symptoms of depression (Mehrabian, 2001). Among patients in treatment for alcohol abuse and dependence, the prevalence of major depression is higher than in the general population (Lynskey, 1998). This connection may be because of the direct neurotoxin effects of heavy alcohol exposure to the brain. Alcohol abuse also can have serious repercussions on a person's life, leading to financial and legal troubles, impaired thinking and judgment, as well as marital stress. In addition, trauma related to poverty, social isolation, and the experience of living in distressed environment, difficulties with housing, income, and employment tend to precipitate emotional distress and relapse into alcohol abuse among recovering alcohol consumers (Marlatt & Gordon, 1985). Although the RP model considers the high-risk situation the immediate relapse trigger, it is actually the person’s response to the situation that determines whether he or she will experience a lapse.

The harmful use of alcohol is a component cause of more than 200 disease and injury conditions in individuals. Most notably alcohol dependence are; liver cirrhosis, cancers and injuries as described in Statistical Classification of Diseases and Related Health Problems (ICD) 10^{th}. revision, (WHO, 1992). There is a strong association that exists between alcohol abuse and sexually transmitted infections. When a person is under alcohol influence, there are general risk behaviour impacts on both alcohol consumption and increased risk of unsafe sexes (Rehm, Shield, Joharchi & Shuper. 2012). In addition, there is a clear causal effect of alcohol consumption on HIV/AIDS patients’ adherence to antiretroviral treatment, which can be quantified (Gmel, Shield, & Rehm. 2011). The harms done by people’s drinking to others involve both socioeconomic consequences and substantial health problems. No matter the

type, when alcohol consumption is taken too far, the user's family feels the effects. Neglect, misuse of funds and increased domestic violence are all too common results. In this case women and children are the most affected family members. Measures of problems from alcohol consumption have primarily focused on harm to the drinker's health and have placed limited emphasis on the harm to the health and welfare of others around the drinker. People who are alcohol dependent are unable to reduce the amount they drink or to stop drinking, though they often try. Mostly, alcohol use takes over more and more of the person's life, and he or she may deny the complications it causes. Early intervention among adult recovering person's development can curb the effect of risk factors and serves to boost protective factors to combat the cloud created by negative influences towards abusing alcohol.

The cycle of addiction is created by changes produced in brain chemistry from substance abuse. It is perpetuated by physiological, psychological and emotional dependency. This cycle of addiction continues unrestrained, until some type of intervention occur. Alcohol abuse alters the way the brain and certain neurotransmitters function. These changes in brain chemistry create addiction, tolerance and withdrawal symptoms, which all lead to cravings.
Drug and alcohol addiction research has clearly demonstrated that the addicted brain is chemically and physiologically different from a normal brain. The idea of addiction being a neurological disorder is critical to understanding its development and the recovery process (Kolb & Whishaw, 2011). The neurotransmitters serotonin and dopamine send messages to the brain and the rest of the body. The altered brain chemistry essentially requires constant, repetitive exposure to the substance or action to function psychologically and physiologically.

Addiction develops over time and usually begins with misuse, moving toward abuse and resulting in addiction. Addiction alters the brain chemistry affecting the process of thought and decision-making. The definition of addiction also includes strong references to denial, minimization and justification, all of which are primitive internal defence mechanisms. After the addiction is acknowledged, the addict may ultimately be forced to decide to stop using chemicals, thus breaking the cycle of addiction. The abnormal, addicted brain cannot tolerate that decision. The cycle of addiction is powerful, usually requiring outside interventions that include alcohol detoxification and psychosocial treatment.

2.5 Treatment of Alcoholism

The spectrum of alcohol use disorder severity is from hazardous and harmful use of alcohol through to severe alcohol dependence. The range of interventions appropriate to address this range of severity is from primary prevention for people not yet addicted to alcohol problems through to more intensive specialist treatment for those with alcohol dependence. Across Europe, there is a clear gap in realising the potential contribution of the health sector to reducing the alcohol related harm. In primary health care settings, commonly fewer than 10% of people are at risk of becoming hazardous and harmful drinkers. In regard to Needs Assessment Study (2004) in England found that only 1 in 18 (5.6%) alcohol-dependent drinkers actually accessed treatment each year, with regional variations ranging from 1 in 102 to 1 in 12.

An inpatient centres require the patient to live at a facility for 24 hours a day. Clients usually live with other recovering addicts and have the opportunity to attend daily therapy sessions and support groups. Inpatient treatment generally last for 30 to 90 days, although some centres may last for as long as a year depending on the client's severity of alcoholism. Residential rehabilitation provides room and board in addition to the alcohol detoxification, one-on-one therapy, group counselling, and aftercare. With outpatient care, the individual goes home at the end of each day and is free to do whatever they wish with their time. The specific types of therapy available in an outpatient setting include the following: cognitive behavioral therapy, motivational incentives, motivational interviewing and not limited to multidimensional family therapy. In Kenya, the vast majority of addicts have at one time or another sought treatment at a rehabilitation centre, from established ones (residential) like Asumbi in Kisumu County to the new one at Redhill, supported by the Wilson Foundation. In Nairobi, newcomers are supplementing established institutions like the Chiromo Lane Medical Centre (CLMC) among others. Chiromo Lane medical centre is a psychiatric in-patient hospital. It is specialized in diagnosis, treatment and management of mental disorders. It caters for detoxification needs and counselling services. Asumbi Treatment Centre is a programme that offers residential treatment for drug and alcohol abusers. It focuses on spiritual and personal growth as peer pressure, role modelling, self-pity, personal responsibility, reality confrontations and levelling. To achieve above it uses individual and group counselling and family therapy. Treatment can reduce the harm caused by alcohol misuse to individuals' well-being, to public health and to community safety.

There are many options for treatment for alcohol use disorders. They depend in part on the severity of the patient's drinking. Alcohol addiction or dependence treatment can include medications, behavioural therapies, or both combinations. Pharmacotherapy generally targeted at a narrow spectrum of symptoms or psychological problems and is usually insufficient to constitute a treatment package when given alone. Psychological interventions are based on behavioural therapies that addiction is a learned maladaptive behaviour and can therefore be "unlearned". A wide range of behavioural techniques has been applied on this basis in the treatment of alcohol addiction. (Woody, 2003) support the argument that psychosocial interventions and pharmaceutics' agents, when suitably combined, consistently improve addiction outcomes. Because they work on different aspects of addiction, combinations of behavioural therapies and medications (when available) generally appear to be more effective than either approach used alone. After-care and work therapy uses services to help maintain sobriety. For example, in some cities, sober-living houses provide residences for people who are trying to stay sober. They do not offer formal treatment services, but the people living there offer each other support and maintain an abstinent environment.

2.5.1 Pharmacotherapy

Detoxification is the process of rapidly achieving an alcohol free state. Detoxification should be viewed as the gateway to ongoing treatment. Planned detoxification is commonly undertaken in the early part of the action stage of change. Detoxification services generally are available under a medical model or a social model. Medical model programs range from hospital-based inpatient programmes to free-standing medically based residential programme in hospitals or in community facilities that can draw on various medical resources. Social model program that provide detoxification should have reliable and routine access to medical services to manage medical and psychiatric complications of their patients' withdrawal. Community-based detoxification can be delivered in the home, on an outpatient or day patient basis, or within a supported residential facility where specialized services are provided by medical staff under the direction of a qualified physician with knowledge and skills in addiction treatment.

Many treatment plans begin with a detoxification programme to help break an alcoholic body's physical addiction to alcohol. Medicines can be used to help treat alcohol abuse and dependence. Some medicines reduce withdrawal symptoms during detoxification. Other

medicines help you stay sober during the long process of recovery. According to the National Institute on Drug Abuse, there are several types of medication that have been approved for use during alcohol treatment. Medicines approved by the Food and Drug Administration (FDA) to treat alcohol dependence include disulfiram (Antabuse), naltrexone (Vivitrol), and acamprosate (Campral) (Krishnan-Sarin, O'Malley, & Krystal, 2008). The first drug therapy to be developed for alcohol dependence was disulfiram (brand name Antabuse), which prevents the metabolism of alcohol and makes the experience of drinking unpleasant due to the excess of acetaldehyde (American College of Surgeons, 2000). Disulfiram works by deterring alcoholics from drinking by causing unpleasant physical reactions if he/she drinks alcohol. These can include: nausea, chest pain, vomiting, dizziness among others. In many ways, dilsulfiram is an anti-harm reduction medication. The only treatment goal is abstinence, and, if individuals attempt to drink moderately (non-harmfully), they will still experience harmful consequences.

Naltrexone is an opioid antagonist, which is thought to be effective by blocking endogenous opioid pathways stimulated by alcohol use (Sinclair, 2001). Naltrexone is believed to reduce the reinforcing effects of alcohol and, thus reduce the behavioural response to drink a lot of alcohol more frequently. The efficacy of Naltrexone is partially determined by medication compliance. Poor compliance has been shown to greatly reduce the effectiveness of Naltrexone (Bouza, Angeles, Munoz, & Amate, 2004). The theory behind this treatment is that the repeated absence of the desired effects and the perceived futility of abusing alcohol will gradually diminish craving and addiction. Consistent with a harm reduction approach, a long-acting Naltrexone formulation that releases the drug for one month per injection was developed and tested in a multi-centre, randomised, double-blind placebo-controlled study (Garbutt, Kranzler, O'Malley, Gastfried, Pettinati, & Silverman, 2005). Compared to placebo, the long-acting Naltrexone resulted in a significant decrease in heavy drinking days over 6 months. Combining Naltrexone with a psychosocial treatment, (Monterosso, Flannery, Pettinati, Oslin, Rukstalis, & O'Brien, (2001), achieved a low attrition rate, 18 per cent, and significantly fewer heavy drinking days, five per cent for Naltrexone against nine per cent for controls. Sinclair (2001) showed progressive decreases in craving which persisted after finishing medication.

Acamprosate (brand name Campral) is used to help prevent a relapse in people who have successfully achieved abstinence from alcohol. It is usually used in combination with

counselling. Acamprosate affect two neurotransmitter systems involved in maintaining alcohol dependence, the glutamate system and the gamma-amino-butyric acid system. While chronic alcohol exposure disrupts both systems, causing changes that may persist for many months following withdrawal, Acamprosate may act by restoring normal activity in these. The course will usually start as soon as you begin withdrawal from alcohol and can last for up to six months. Acamprosate has been shown to help dependent drinkers maintain abstinence for several weeks to months, and it may be more effective in patients with severe dependence. The nature of treatment depends on the severity of an individual's alcoholism and the resources that are available in his or her community. Recovery is understood as an ongoing process in which treatment can play a critical role in recovery initiation (Hser, Longshore & Anglin, 2007).

White and Kurtz (2006) reviewed available literature on the point of recovery stability and concluded that such stability is not reached until 5 to 7 years of sustained remission, which is consistent with the idea of recovery as a developmental process of growth and change. In assessing pathways to recovery, Stanick, Laudet, and Sands (2007) reported that higher commitment to abstinence at intake increases the odds of treatment completion that in turn increases the likelihood of sustaining abstinence for a full year after the end of treatment.

Counselling is an important part of treating recovering alcohol dependence. Despite different treatment among alcohol users, little research has been done on counselling influence on behaviour change of recovering alcohol consumers towards abstinence. This research undertakes psychological and social support through consideration of behavioural counselling interventions to stop alcohol misuse or total abstinence. The research will systematically examine various behavioural counselling services as applied among recovering alcohol dependence. These include: cognitive-behavioural therapy, motivational enhancement therapy, twelve step facilitation, brief counselling intervention, couple and family counselling.

2.5.2 Psychosocial Interventions

The most typical form of psychosocial treatment for alcohol dependence is a supportive therapeutic relationship that combines elements from different therapeutic orientations (Emmelkamp, & Vedel, 2012). Combined behavioural intervention (CBI) is a current form of therapy that uses special counselling techniques to help motivate people with alcoholism to

change their drinking behaviour. CBI combines elements from other psychotherapy treatments such as cognitive behavioural therapy, motivational enhancement therapy, brief counselling intervention and 12-step programme (Longabaugh, 2007). Behavioural counselling vary in their focus and may involve addressing a client's motivation to change, providing incentives for abstinence, building skills to resist alcohol use, replacing alcohol using activities with constructive and rewarding activities, improving problem solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy or counselling and other peer support programmes, during follow up treatment can help maintain abstinence

2.6 Cognitive Behavioural Therapy (CBT)

Cognitive-behavioural therapy is among the most extensively evaluated interventions for alcohol- or illicit-drug-use disorders. Based primarily on Marlatt and Donovan (2005) model of relapse prevention, these treatments target cognitive, affective, and situational triggers for substance use and provide skills training specific to coping alternatives. CBT treatment for alcohol use often includes the following strategies: (1) social skills training which identify intrapersonal and interpersonal triggers for relapse, (2) functional analysis of substance use (3) coping-skills training, (4) relapse prevention plan (alcohol refusal skills training). CBT is an intervention that improves the patient's cognitive and behavioural skills for changing his or her problematic drinking behaviour. CBT is based on the principles of social learning theory and views drinking behaviour as functionally related to major problems in a person's life (Miller, & Wilbourne, 2002). It posits that addressing this broad spectrum of problems will prove more effective than focusing on drinking alone. Emphasis is placed on overcoming skill deficits and increasing the person's ability to cope with high-risk situations that commonly precipitate relapse, including both interpersonal difficulties and intrapersonal discomfort such as anger or depression.

The rationale of cognitive therapy on outpatient treatment offers considerable opportunity for interaction between the treatment from the programme and the realities of each client's daily existence. The events of client's daily life can be described in counselling sessions and used as bases for problem solving exercise, role play and homework assignments. An outpatient has an advantage of being able to practice new skills in a variety of problem situations. This enhances generalisation of new behaviour of various aspects of client's natural environment.

The outpatient counsellor can provide session by session while monitoring progress in applying new skills and supervise problem solving to deal with difficulties as they arise. In the treatment for alcohol, the goal of cognitive behavioural therapy is to teach the person to recognise the situation in which they are most likely to drink. They have to avoid these circumstances if possible and cope with other problems and behaviours which may lead to their alcohol abuse. Psychological factors such as attributions and coping skills and social cultural factors such as family history, peer influence, advertisement are determinant actions to alcohol abuse (Velleman, 2001). Numerous effective cognitive behavioural therapies have been developed that can bring the treatment to the patient rather than bringing the patient to treatment. These cognitive behavioural therapy techniques which can provide effective treatment across the spectrum of severity of alcohol abuse and prevention include; social skill training, functional analysis, coping skills and relapse prevention.

2.6.1 Social Skills Training

The common trait of much alcohol abusing person's experience is the problem of interacting with people in social situations. Social skills training can teach alcoholics better ways to deal with these situations. Social skills training focus on helping an alcoholic addict on how to interact with friends, family members, and co-workers, how to interact in social situations, especially when alcohol is present and alcohol refusal skills. Social Skill Training is a type of behavioural counselling model used by counsellors to help recovering alcoholics to maintain sobriety lifestyle and avoid backsliding (Kadden, 1997). This approach sees a person's ability to change primarily as a matter of personal commitment and community support. Social skill training consists of how to interact with friends, family members or co-workers. In outpatient rehab, recovering alcoholics interact with former friends and colleagues can learn social skill so as to achieve better interpersonal relationship.

Recovering alcoholics are exceptionally vulnerable to social isolation, repeated patterns of involvement in traumatic or abusive relationships and ongoing difficulties with low self confidence and self esteem. Their immediate environment has a direct impact on their choices and mood. They need to be taught on listening carefully as well as talking and understanding unspoken sign such as body language. This will assist them not to be taken advantage of the situation. They are also obligated to learn refusal strategies that allow them to enter social situation without giving into the temptation of drinking. They can practice techniques for

refusing drinking offers. For example being assertive and clear about what they say. His or her "no" must be insisted without hesitation. Below is adapted skill training table to enhance social interaction for recovering alcohol user.

Emotional Management	**(Dealing with Others)**
Managing compulsive thoughts	Refusing alcohol
Problem solving	Assertiveness training
Decision-making	Expressing needs constructively
Relaxation techniques	Accepting feedback
Managing anger	Giving criticism
Reversing negative thinking	Expressing emotions
Emergency contingency planning	Building support networks

Figure 1: Cognitive Behavioural Skills Training for Recovering Alcoholics

Source; Peter Monti, David Abrams, Ronald Kadden and Ned Cooney (1989)

Interpersonal skill training in figure 1, involved learning how to recognize social signs; development of the ability to start, maintain and change conversations with friends and strangers. This can be done through strengthening of assertive behaviours such as "saying no" or "asking for changes in other people's behaviours." Intrapersonal skills are associated with learning muscle and respiratory relaxation strategies, anger management and cognitive restructuring to reduce anxiety and/or depressive mood states. Interpersonal skills building exercises may target repairing relationship difficulties, increasing the ability to use social support, and effective communication. This skill was performed in a controlled inpatient setting. The long-term effectiveness of cue exposure for diminishing craving after discharge remains to be demonstrated (Chaney, O'leary, & Marlatt, 1987). Chaney and colleagues investigated the effectiveness of skills-training intervention to help recovering alcoholics cope with relapse risk. Recovering alcoholics learned problem-solving skills and rehearsed alternative behaviours for specific high-risk situations. The investigators suggested that skills training may be a useful component of behavioural cognitive approach to prevent relapse among recovering alcoholics. The primary goal in skill training is to assist clients to master skills that will help them to maintain abstinence from alcohol.

2.6.2 Functional Analysis of Alcohol Consumption

For each instance of alcohol use during treatment, the therapist and patient do a functional analysis, that is, they identify the patient's thoughts, feelings, and circumstances before and after the alcohol use (Heather & Stockwell, 2004). Functional analysis can help an alcoholic avoid relapse and replace negative behaviours with positive habits. However, the only problem is his or her use of alcohol to meet those needs. So the community based counsellors will identify needs that are likely to trigger a desire to use alcohol and having done so, the counsellor will develop alternative ways of meeting those needs. This helps the recovering alcoholics determine the risks that are likely to lead to excessive alcohol drinking and likelihood of relapses. Functional analysis can also give the person an insight into why he or she drinks or use drugs in the first place and identify situations in which the person has coping difficulties.

Heather and colleague (2004) articulates that functional analysis identifies triggers or high risk situation, examine dysfunctional thoughts and emotions. It helps clients take a proactive and rational approach to alcoholism, understanding its triggers and identifying its enablers. It can also help recovering alcoholic to avoid relapse and replace negative behaviours with positive habits. The result is an overall healthier lifestyle when used effectively as part of a comprehensive treatment. The therapist works with the client to develop strategies to change the most important triggers on the client list of high risk situation. Jarvis and colleagues (2005) argued that to achieve change of behaviour requires self management planning exercise, an example is planning ways for coping with crisis situation such as social separation(e.g. divorce, death, children moving away), health problems, work related changes and even financial difficulties. The counsellor explores other factors that make a client more susceptible to excessive drinking behaviour. The counsellor asks clients questions to give common type of drinking episode.

2.6.3 Coping Skills Training

After conducting the functional analysis, the next step is to institute skills training. Heavy drinkers often use alcohol to cope with certain or most of the problems in their lives. Drinking may become the preferred way of coping especially in the absence of other skills. If alcoholism is the only way a person has to cope with certain things, then he or she has become psychologically dependent upon it. For such a person, coping skills deficit are major

obstacles to his or her recovery from alcohol dependence. Think of skills training as a way for patients to unlearn old habits and learn new and healthier behaviours to replace them. Therefore, coping skills training is essential to enable alcohol dependent to manage high risk situations without relapsing. In the context of an alcohol rehab centre, this will be a targeted training programme that focuses on unlearning old habits and replacing them with new ones. Ideally, habits that lead to alcohol abuse are replaced with positive activities and thought patterns. It requires a person to deal with the normal obstacles of life without turning to alcohol.

Coping skills training is of major importance since it develops alternative ways of meeting needs and thereby modifying the psychological dependence factor (Heather & Stockwell, 2004). One way to build coping skills is to set goals. An example of a recovery-oriented goal might be committing to abstinence from alcohol for the day. With the goal of abstinence comes the need for a coping skill to deal with the stress of the day. For example, to cope with stressful situations an alcoholic has to apply relaxation skills to reduce anxiety and tension when facing troubles (Parks *et al,* 2004). Other skills such as communication skills, assertive training, creating and maintaining social support networks and vocational training are very vital. These do more than merely avert relapse. They have the potential to improve interpersonal skills, encourage better emotional copping behaviours and enhance the person's social support network. In an outpatient environment, the client has to be very assertive, innovative and proactive in order to manage alcohol cues without segregating himself from others. Hence, the goal of cognitive behaviour therapy is to get the person to learn or relearn better coping skills.

The clients enjoy the empowerment that comes with positive coping skills and a reduced likelihood of relapse. One segment of it identifies past, current and potential future to enhance positive rein-forcers particularly in areas of the client's life that includes relationships, job and recreational activities (Best *et al*, 2012). These positive rein-forcers are aimed at increasing the likelihood that sober behaviour will be achieved. Punishing consequences has been also used to maintain positive behaviour change. An example is providing tangible positive rewards; such as credit card that can be exchanged for calling, for a desired behaviour of abstinence from alcohol. In case of implementing other negative consequences; provide negative reports to interest other parties, such as family members or a spouse.

2.6.4 Relapse Prevention Plan

Marlatt and Gordon's (1985) RP model is based on social-cognitive psychology and incorporates both a conceptual model of relapse and a set of cognitive and behavioural strategies to prevent or limit relapse episode. There are a number of key principles that guide the relapse prevention approach (Addy & Ritter, 2000) which include: the need for the client to develop coping skills to manage high risk situations, to make lifestyle changes to decrease the need for alcohol use, to undertake healthy activities, to prepare for interrupting lapses so that they do not lead to relapse and to prepare for managing relapse so that potential harms may be minimised. Marlatt and Gordon (1985) defined relapse prevention as (RP) "a self management program designed to enhance the maintenance stage of the habit change process". Relapse prevention forms a cognitive behavioural approach that is aimed at reducing the symptoms that influence relapse to alcoholism, (Heather & Stockwell, 2004). RP model for recovering alcoholics emphasizes a strategy that helps each individual develop a profile of past drinking behaviour and current expectations about high-risk situations. The counsellor promotes use of coping strategies and behavioural change by engaging the patient in performance-based homework assignments related to high-risk situations.

A quality alcohol (RP) programme helps the recovering alcohol addict discover his or her unique triggers and teach him/her how to manage emotional challenges while in recovery. In alcohol dependence treatment one will develop a relapse prevention plan which will help him or her cope with the stresses of life and identify triggers that could lead to a relapse. The RP model developed by (Marlatt & Gordon, 1985) provides both a conceptual framework for understanding relapse and a set of treatment strategies designed to limit relapse likelihood and severity. Researchers of RP model postulates that high-risk serve as the immediate influence of initial alcohol use after abstinence (Heather & Stockwelll, 2004). According to the model, a person who has initiated a behaviour change, such as alcohol abstinence, should begin experiencing increased self-efficacy or mastery over his or her behaviour, which should grow as he or she continues to maintain the graph change. The concept of self efficacy or self control refers to individual's capacity to cope effectively with specific cues to the person's sense of control. The RP model predicts that if a person fails to effectively cope with high risk situation, she or he is likely to create decreased self efficacy and possibility of helpless and powerless to cope with threats. On other hand, people with low self-efficacy perceive themselves as lacking the motivation or ability to resist drinking in high-risk situations. For

example, when they pass by a brewing home where people are drinking local beer, joins others without invitation due to driving urges.

Research among college students was done and the results indicated that those who drink alcohol most tend to have higher expectations regarding the positive effects of alcohol that is outcome expectancies and may anticipate only the immediate positive effects while ignoring long tern negative consequences of excessive drinking. Such positive outcome expectancies may become particularly relevant in high-risk situations, when the person expects alcohol use to help him or her cope with negative emotions or conflict, then drinking serves as "self-medication". In these situations, the drinker focuses primarily on the anticipation of immediate gratification, such as stress reduction, neglecting possible delayed negative consequences. After a lapse of alcohol use, clients may experience the Abstinence Violation Effect (AVE) that involves a loss of perceived control experienced after the client's failure to adhere to his or her self imposed rules of conduct regarding alcohol drinking (Heather & Stockwell, 2004). On an emotional level, the AVE increases the probability of relapse because, once a lapse has occurred, the shame, guilt, self blame and other negative feelings influences further drinking or using drugs. In addition, the AVE affects the likelihood of relapse on a cognitive level because a lapse is also followed by an internal conflict over the inconsistency of one's efforts to abstain from alcohol combined with the reality of just using alcohol. Finally, the AVE also leads the client to attribute their "failure" to stay sober, to stable internal factors within their character that demonstrate that they are beyond redemption. Thus increases probability of relapse whereby the person continues to drink.

Relapse prevention is the utmost important process in helping recovering clients with alcoholic and other substance addictive behaviour especially given the long term course of a problem. Relapse prevention model helps in balancing the client's lifestyle and develop positive attitude and perception on relapse process. The client will employ stimulus control and urge- management techniques. Counsellors can assist clients with developing relapse road maps through analyses of high-risk situations, emphasize the different choices available to clients for avoiding or coping with these situations as well as their consequences.

2.7 Brief Counselling Intervention (BCI)

Substance abuse treatment programmes frequently use brief intervention approach. BCI can be used with clients before, during and after alcohol abuse treatment. Brief interventions are short-term counselling sessions that are aimed at addressing problems associated with hazardous and harmful drinking (Moyer & Finney, 2004). The intervention is a component of the journey towards recovery and can be integral steps in the process. As the name suggests, acts as a first step to determine if recovering alcoholic has made his or her mind to enter into treatment, change behaviour or think differently (Centre for Substance Abuse Treatment, 1999). This intervention acts as a way of improving client's motivation for treatment. A brief intervention consists of five basic steps that incorporate FRAMES (Miller & Sanchez, 1993). These include: feedback given to the individual about personal risk or impairment, responsibility for change is placed to the client, advice to change is given by the counsellor. Menu of alternative self-help or treatment options is offered to the client. Empathic style is used in counselling. Self-efficacy or optimistic empowerment is engendered to the client. At the onset of counselling, the client requires brief motivation to encourage him or her to persist for more advanced support.

In reference to Prochaska and DiClemente (1986) stages-of-change model can be used to tailor brief interventions to clients' needs. Clients need motivational support appropriate to their stages of change. The model is primarily concerned with motivation to change and the processes that lead to change. Effective brief interventionists quickly assess the client's stage of readiness, plan a corresponding strategy to assist him in progressing to the next stage, and implement that strategy without succumbing to alcoholism. The counsellor can use brief interventions to motivate particular behavioural changes at each stage of this process (Centre for Substance Abuse Treatment, 1999). For example, in the contemplation stage; a brief intervention could help the client weigh the costs and benefits of change. In the preparation stage; a similar brief intervention could address the costs and benefits of various change strategies for example; self-change, brief treatment, intensive treatment, self-help group attendance. In the action stage; brief interventions can help maintain motivation to continue on the course of change by reinforcing personal decisions made at earlier stages.

This approach focuses on the individual patient, but also takes into account the patient's family and social networks in the community. To integrate the use of brief interventions into

specialized treatment, counsellors and other therapeutic providers should be trained to provide this service. It is also extremely important for alcohol abuse treatment personnel to collaborate with primary care providers, Employee Assistance Programme (EAP) personnel, referral clinic staff, and other community based service providers in developing long term plans (Babor & Biddle, 2001). Such plans may include both brief interventions and more intensive care to help keep the client focused on treatment and recovery. The effectiveness of this approach has been demonstrated in numerous studies. For example, Fleming and colleagues (2000) found that brief advice, delivered across two therapist visits and two follow-up phone calls, resulted in a significant reduction in alcohol use and binge-drinking episodes for up to 4 years following the intervention. More recently, a study found that brief interventions were equally effective for alcohol-dependent and nondependent participants (Guth, Lindberg & Badger, 2008).

2.8 Motivational Enhancement Therapy

Motivational Enhancement Therapy (MET) is designed to enhance motivation to change addictive behaviours especially for recovering alcoholics. Poor motivation for change is a particular problem in the field of alcoholism, where client ambivalence has been troublesome. Motivational Enhancement Therapy was developed by (Miller & Rollnick, 2002). MET employs a variation of Motivational Interviewing (MI) to analyze feedback gained from client(s) sessions. MET focuses on re-patterning client behaviour that is the result of uncertain and undefined thoughts. This form of therapy is presented in a direct approach and client's behaviours are targeted that strives to transform undesired behaviours. The client is helped to explore the reasons that are likely to sustain the behaviour and assist him or her shift the decisional balance of pros and cons into the direction of change. The counsellor applies the technique of empathy and respect to persuade the client to change. Also the counsellor will apply reflective listening technique to convey understanding of client's point of view and underlying drives. The counsellor supports self efficacy by building the client's confidence that change can happen (Burke, Arkowitz & Menchola, 2003).

Lack of progressive development about alcohol treatment, has been attributed to the client failing to adhere to motivation training. The successful implementation of MET may depend on therapist's skills in general, or skill with certain patients, in creating the type of technique that is central to the theory of this form of therapy. An unlike client-centred therapy, MET

employs techniques and strategies to motivate clients to achieve specific behaviour change, values and goals. Some of these counselling techniques of MET are borrowed from client-centred therapy as described in motivational enhancement manual (Rollick & Allison, 2004). These techniques include a focus on listening to the client and the importance of therapist empathy, acceptance, respect, reflection and positive regard for the client. For example, therapists actively focus the client's attention on discrepancies between where they are and where they want to be, and to channel these discrepancies toward behaviour change (Miller *et al*, 1995). In addition, therapists ask questions and reflectively listen to clients to specifically support client statements that favour change (Miller & Rollick, 2002). Overall, MET is a more directive approach than client-centred therapy.

In MET, the belief that the individual can reform the behaviour is a requirement for change. The heart of this treatment is the attempt to engage the client into a constructive discussion about change in which the client drives the process. The counsellor actively explores opportunities available about values and issues that are important in the client's drinking behaviours that are likely problematic. Even when individuals admit to have drinking problems, movement towards change is most likely to occur if the client believes that success is possible. It is essential that the client should be more optimistic about the possibility of changing his or her behaviours. The therapist works with the client to create positive affirmations and a sense of inner willingness to facilitate change. Once that is achieved, the client becomes receptive to the healing process and progresses towards wellness. Through a gradual application of this process, the client is made aware of problems, ramifications and their relationship to drinking. The process moved forward by application of behaviour shaping to reinforce client verbalisation that indicates increased awareness of problems and of need to change. The goal of MET is to help the client in clarifying his or her own perceptions and beliefs about alcohol consumption in order to direct him or her in a more decisive way. Most people who respond to this type of treatment have struggled for many years to stop alcohol misuse but are unable to succeed on their own. Such people welcome the opportunity to have vision and focus in changing alcohol dependence behaviour in live.

2.9 Alcoholics Anonymous (12- Step Facilitation Principles)

Alcoholics Anonymous (AA) is the oldest and best-known "twelve-step" programme of self-help for alcoholics who wish to abstain from drinking alcohol. Founded in 1935 by Bill Wilson and Dr. Bob Smith and its philosophy based on a religious movement of the time; Alcoholics Anonymous (AA), (2004). The basic principles of A.A., as they are known today, were borrowed mainly from the fields of religion and medicine, though some ideas upon which success finally depended on the result of noting the behaviour and needs of the fellowship itself. The theoretical rationale is based in the 12 steps of AA and the need to accept that willpower alone is not sufficient to achieve sustained sobriety, that self-centeredness must be replaced by surrender to the group conscience, and that long-term recovery which consists of a process of spiritual renewal ((Heather et al, 2004).). The primary mechanism action is active participation and a willingness to accept a higher power as the focus of change in one's life.

The most common formula among AA facilitation is counselling based on the 12-step principles. During the session, participants typically report on their current status as well as their progress towards working the 12 steps (Mckay, Lynch, Shepard & Etal, 2004). The members are expected to follow the Twelve Steps philosophy to fit the particular needs of a mutual-help group. Twelve-Step programmes emphasize treatment activities such as attending Twelve Step meetings in the community and participating in psychotherapy groups that cover topics such as working the steps using the Big Book and writing an autobiography. Outcomes desired in Twelve Step treatment include acceptance of an alcoholic/addict identity, acknowledgment of a loss of control or powerlessness over the abused substance and adherence to abstinence as a treatment goal. The 12 step recovery process may be slightly modified depending on the type of addiction being treated and the treatment program that a client attends. Other organizations who have adopted 12 step recovery programmes have often changed the 12 step wording and focused little to religious language. As much as there is modification, the 12 step programmes still emphasize that belief in a higher power (God) as what is important. The A.A.'s twelve steps apply to the life of the fellowship itself. They outline the means by which A.A. maintains its unity and relates itself to the world about it, the way it lives and grows.

Twelve-Step Facilitation (TSF) consists of a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse/alcoholism and other drug abuse/addiction. The following are the 12-Step principles originally published by Alcoholics Anonymous: Step 1; "We admitted we were powerless over alcohol that our lives had become unmanageable*"*. The first step of AA programme is to admit that you have a problem. Those who are not ready to admit to a problem may not be able to seek the help they need, and they may likely return to drinking. Admission of powerlessness is the first step in liberation. They discover fatal nature of their situation. Then they become open minded to conviction and willing to listen to anything which will lift merciless obsession of drinking. Step 2; "Came to believe that a power greater than ourselves could restore us to sanity". Alcohol Anonymous does not demand that you believe in anything. All of its Steps are suggestions. What matters is a truly open mind which can lead alcohol recovering to faith. The AA meetings assure individuals that God will restore them to sanity. Step 3; "Made a decision to turn our will and our lives over to the care of God as we understood Him". This step calls for affirmative action. It is only by action that one can cut away self will which has always blocked the entry of God or Higher Power into one's life. The whole of AA program base its support upon the commitment of each member to make a decision to turn his or her will and depend on God.

Step 4; "A searching and fearless moral inventory of ourselves". Step four is an effort to discover oneself. What happens after admitting a problem is admitting to your faults. Each participant in the programme has to look at his past and present situations and determine any faults that he has. By admitting to these problems, the group and the individual can try to help him fix them. Step 5; "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs". Knowing what you have done wrong and admitting it are two different things. Admitting past errors and wrongs to a group and receiving support to change your life is a part of AA that all participants go through. Step 6; "Were entirely ready to have God remove all these defects of character" in this step is all about accepting character defects exactly as they are and becoming entirely willing to let them go and accept that it is time to change. Accepting responsibility for the change is part of this step. Step 7; "Humbly asked Him to remove our shortcomings." The spiritual focus of this step is humility, asking a higher power to do something that cannot be done by self-will or mere determination.

Step 8; "Made a list of all persons we had harmed and became willing to make amends to them all". Sometimes, people come to AA thinking there is no way back from their current

situations. But, that is not always the case. By making a list of all the people harmed by alcoholism and being willing to try to make reconciliation, a participant is accepting responsibility and understanding what has been wrong in his life. This step is more about the planning and acceptance of making amends rather than completing the task. Step 9; "Made direct amends to such people wherever possible, except when to do so would injure them or others". In many cases, admitting you are wrong, apologizing and informing a person that you are getting help is enough to have that person's support. However, sometimes people have been seriously hurt or are in a position where an apology or trying to make amends would make a situation worse. Through the group, decisions can be made as to who will be best served by trying to make amends and who may be more hurt by it than anything else. For instance, drunken driving accidents may be something a person wants to apologize for, but not all people will be ready to hear an apology.

Step 10; "Continued to take personal inventory and when we were wrong promptly admitted it". The major concern of the programme is being responsible for clients' actions. If you (an alcoholic) fall back into drinking, it is important to stop and admit it. Relapses are normal, and the group can be supportive while you are healing. Admitting trouble with quitting, or trouble with other parts of your life, are not signs of weakness. It is meant to help keep participants on track to a healthier lifestyle. Step 11; "Sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will for us and the power to carry that out". Whether or not a person is religious, this allows him to have quiet time where he can reflect on the day, what has happened recently and the things he needs to do to make his life better. **S**tep 12; "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs". Another serious aspect of the 12 step programme is giving back to the community that has helped you to receive the treatment you needed. The main point of this is to help others seek help when they need it and sometimes to give a person someone else to feel responsible for, as this can help them focus on more positive aspects of life. Community service, aiding others and working with future AA groups are all normal choices for this step (Alcoholics Anonymous, the Big Book; 2001).

Most addicts have difficulty in sharing their emotions, partly because they are afraid nobody will understand them and they will be criticized. So they bottle everything up inside, which makes them want to use even more. The people at a 12 step group would not judge alcohol

addict because they have heard and done it all before. They know that person is not crazy because of the things he does when drunkard. The people who recovered did not do anything special. They just followed the few simple principles of 12 step groups. If you follow those principles, you can recover too. The 12 steps approach gives one the chance to reach out and ask for help. In this approach one has to believe that recovery is possible**.** One sees that other people have recovered from addiction, and she/he develops confidence that one can change his behaviour.

2.10 Theoretical Framework

This study presented a review of literature relating to theories and models of human behaviour and change. These theories and model focused on the individual as the locus of behaviour change.

2.10.1 The Theory of Reasoned Action (TRA)

In the theories of reasoned action and planned behaviour, the intention to engage in behaviour is governed by attitudes toward the behaviour and by subjective norms (Ajzen & Fishbein, 1980). The TRA stresses the role of cognitive factors in motivating actions for behaviour change (Fisbein & Ajzen, 1975). This theory states that individual performance of a given behaviour is primarily determined by a person's intention to work on that behaviour. This intention is determined by two major factors: the person's attitude towards the behaviour that is, beliefs about the outcomes of the behaviour and the value of these outcomes. The concept of perceived behavioural control is similar to the concept of self-efficacy; a person's perception of his or her ability to perform certain behaviour. Perceived behavioural control over opportunities, resources, and skills necessary to perform behaviour is believed to be a critical aspect of behavioural change processes.

These theories are applicable to recovering alcoholics. For example, behaviour is based on attitudes that rest on personal beliefs and it is reasonable to suggest that alcohol users' attitudes and beliefs about 12-step groups play a critical role in whether they choose to participate in AA group meetings and counselling sessions or not. Despite the wide application of the TRA & TPB these theories have been criticised. TRA was criticised for neglecting the importance of social factors that in real life could be a determinant for individual behaviour (Grandon, Peter & Mykytyn, 2004). Social factors mean all the

influences of the environment surrounding the individual (such as norms) which may influence the individual behaviour. For example, during cultural festival seasons, alcohol cannot be avoided. Traditional occasions of naming of children and during engagements, alcohol is a requirement which acts as a symbol of fellowship. Hence probability of drinking is likely to happen.

2.10.2 Social Learning Theory (SLT)

Social Cognitive Theory is explicitly about behaviour change. Bandura states that altering our standards and goal setting is essential for "self-directed change" (Bandura, 1991). Bandura proposed that behavioural change is affected by environmental influences, personal factors and attributes of the behaviour itself. Each may affect or be affected by either of the other two. A central principle of social cognitive theory is the concept of self-efficacy. A person must believe in his or her capability to work on his/her drinking behaviours. The person must possess self-efficacy and must perceive an incentive to do so (the person's positive expectations from performing the behaviour must outweigh the negative expectations). This theory has been criticized with various scholars. Ajzen and Fishbein (2005) articulated that social cognitive theory largely ignores the influence of hormones on one's behaviour. According to them hormones can affect one's decision making abilities and therefore change ones behaviour. The SCT is relevant to recovering alcoholic because it deals with cognitive, emotional aspects and aspects of behaviour for understanding alcoholism behavioural change. This Theory is relevant for designing a programme geared towards health lifestyle and behaviour change. The theory also explains how people acquire and maintain certain behavioural patterns which are likely to impact their positive attitude towards alcohol abstinence.

2.10.3 Trans-Theoretical Model

A well-known theory in the addictions area is Trans-Theoretical theory of behaviour change commonly referred to as the "Stages of Change" Model (Prochaska & Di Clemente 1992). The Trans-theoretical model of Change is a model that allows an individual to view human intentional behaviour change (Di Clemente, 2007). The model incorporates elements of various theories of therapy, learning, and behaviour change, hence the term 'Trans-theoretical'. It looks at what an individual experiences and participates in creating new

behaviours, modify existing behaviours, or stop problematic patterns of behaviour. The stages described in this model include pre-contemplation, contemplation, preparation, action and maintenance. Within each stage there is a constellation of tasks that create the foundation for movement forward in the process of change as they build upon each other (DiClemente, 2007). The path to successful behaviour change is to accomplish the tasks well enough to be successful in creating a new pattern of behaviours which promotes engagement with the targets in the subsequent phase.

The model was originally developed by Prochaska and Di Clement (1992) through an examination of the stages and process of self-change in smokers, and suggested that individuals attempting to change behaviour move through a sequence of stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. Clients do not necessarily go through the stages in an orderly way instead linear fashion. Progression may take a process of spiralling through the various stages. For example, a client may start the day at the stage of action but may then spiral back to the stage of contemplation following the onset of their withdrawals and their subsequent decision to go and apply the method. In addition, most people make several attempts at changing their behaviour before they succeed, and they learn from each attempt.

Pre-contemplation is the stage in which people are not intending to make a change in the near future. People at this stage of change often use psychological mechanisms, such as rationalisation, in order to allow themselves to believe that drinking is not a problem, or to minimise the problem. Contemplation is the stage where people intend to change. People in this stage are aware of the pros of changing but also can identify the cons. Preparation represents the stage where people have a plan of action and intend to take action in the near future. Action is the stage in which people make sound decision about behavioural change. After an alcoholic has realized the effect and consequences of consuming alcohol, he or she starts to work on how to change his or her drinking behaviours. Maintenance represents the stage where people work to prevent relapse. This model intends to understand behavioural change by defining the tasks, steps, experiences, contexts and main processes of which it is composed and that differentiate between success and failure. In each phase of the change success is associated with task accomplishment which promotes engagement.

The review of model and theories of change suggests some intervention techniques which may prove effective for particular behaviours, but more fundamentally, it shows how best to approach the task of behaviour change. Most of the recovering alcohol dependence progresses through stages at varying rates. They often slip back and forth as they encounter lapse and relapses a number of times before attaining the goal of maintenance. Efficient self-change thus depends on adhering to the process at the right time (stages) and personal commitment. Behaviour change theory in particular highlights the role of deliberation and elaboration in achieving change. Change is considered more likely to occur and to be sustained as the amount of reflection about specific behaviours or issues increases.

2.11 Conceptual Framework

The conceptual framework of the study was drawn from reviewed literature and the theoretical frame work. The independent variable was the influence of counselling services on behaviour change which includes four counselling approaches; cognitive-behavioural therapy, motivational enhancement counselling, brief counselling and the Twelve Steps facilitation. Conceptual framework of this study was based on the concept that counselling services had an influence on behaviour change among adult recovering alcoholics to minimize the severity of alcohol misuse and optimistic abstinence that results to quality life. Dependent variables are physiological, psychological, social well being and alcohol abstinence influenced by counselling services offered to recovering alcoholics. Identifying client's high-risk situations for relapse and using cognitive and behavioural techniques to help clients cope with risky situations. The social pressure, negative life events and environmental factors are likely to affect recovering alcoholics in making the right decision on behavioural change as an intervening variable whereby motivational enhancement comes in. The alcohol recovering clients are being rehabilitated within the community thus its social environment in terms of alcohol availability and peer pressure may likely influence the client to go back for drinking.

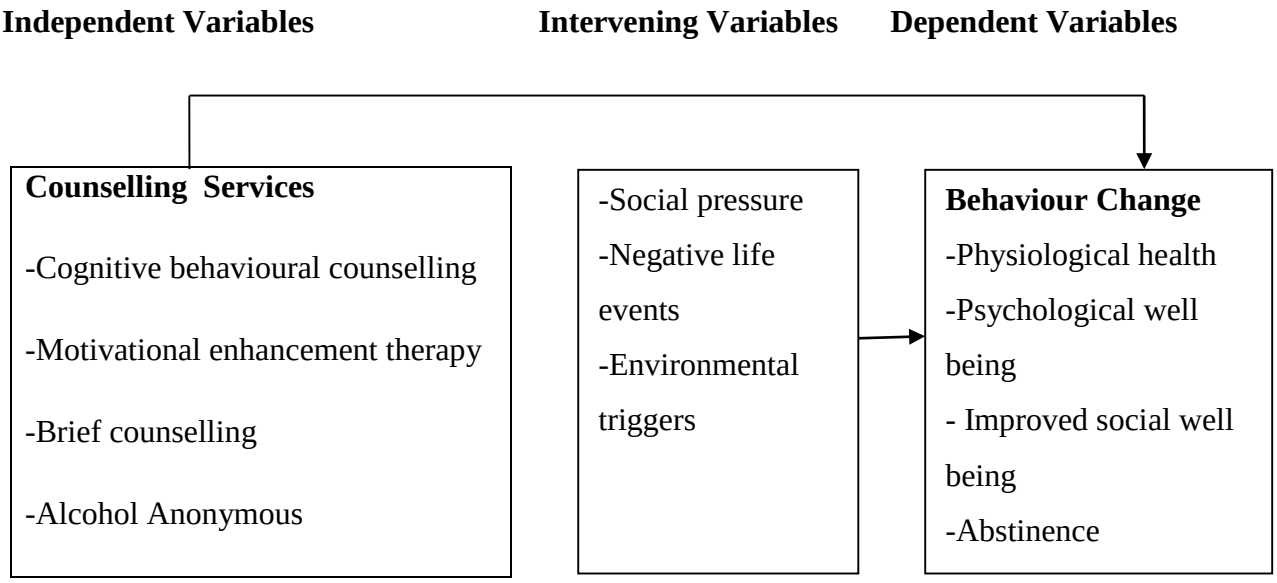

Figure 2: Behavioural Counselling Services that Influence Behaviour Change

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

This was a case study, which attempted to investigate the influence of counselling services on behaviour change among adult recovering alcoholics. The comprehensive methodological approach described and analyzed the design, location and target population, sample size and sampling procedures, research instruments (reliability and validity), the data procedures and analysis.

3.2 Research Design

The intention of research design is to obtain information relevant to the purposes of the survey. This study investigated the influence of counselling services on behaviour change among adult recovering alcoholics. This study used the descriptive survey design to obtain information from adult recovering alcoholics on current status of recovery concerning their behaviour change. Kothari (2004) asserts that in a descriptive survey, the researcher describes the state of affairs as it exists at present and does not manipulate the variables as they are.

3.3 Location of the Study

This research was conducted in Uasin Gishu County; Kenya. The research was conducted in three inpatient rehabilitation centres within the County which are actively engaged in counselling recovering alcoholics. These include; Haven, Re-awake and Kipkaren rehabilitation centre. These rehabilitation centres are the only one that are actively operating and recognized by the County Government. There are other rehabilitation centres but much involved in outreach services than inpatient services.

3.4 Population of the Study

The target population was 105 all adult recovering alcoholics within Uasin Gishu County among three rehabilitation centres; Kipkaren, Re-awake and Haven. The sample size was 70 adult recovering alcoholics for the study from these different rehabilitation centres. The study focused on adult recovering alcoholics who were on ongoing counselling services for not less

than three months after admission. Table 1 shows the total population and the number of respondents according to their gender.

Table 1

Population of Recovering Alcoholics

Name of rehab centre	No. of Recovering Alcoholics	Male	Female
Haven Rehab Centre	56	42	14
Re-Awake Rehab Centre	12	10	2
Kipkaren Rehab Centre	37	32	5
Total	**105**	**84**	**21**

3.5 Sampling Procedures and Sample Size

This study used purposive sampling to select rehabilitation centres and participating respondents because rehabilitation centres were very few and the sample size was too small for random sampling. This was achieved through checking admission number in the clients' register and the file that showed the admission date and ongoing sessions. The clients selected must have been in the session for at least three months. The counsellors assisted so much in sorting the clients as stated. Table 2 indicates the sample size and their gender.

Table 2

Sample Size of Recovering Alcoholics

Name of Rehab Centre	Sample Size	Male	Female
Haven Rehab Centre	40	34	6
Re-Awake Rehab Centre	7	7	0
Kipkaren Rehab Centre	23	20	3
Total	**70**	**61**	**9**

3.6 Instrumentation

The data for the study was collected from the respondents by use of self scoring questions developed by the writer. The questionnaire was developed based on the objectives of the study. The items were used to collect data on demographic background and counselling influence on behaviour change to enhance quality life of adult recovering alcoholics. Items were based on Likert scale to examine respondents' feelings or attitude about alcoholism behaviour change. The respondents were asked to indicate how closely their degree of agreement was or satisfaction to match the statement on a rating scale.

3.6.1 Validity

Validity is often defined as the extent to which an instrument measures what it purports to measure (Mugenda, 2008). Kuthari and Pals (1993) observed that piloting of instruments improve their validity. Piloting of instruments was done at Promises Recovery Centre in Webuye, Bungoma County among adult recovering alcoholics that shared similar characteristics with the research studied. Content validity of the existing instrument was established by reviewing literature and any additional information so as to ensure that the items adequately cover the objectives of the study. The researcher scrutinised and reversed some questions with the assistance and advice from the expert at the Department of Psychology, Counselling and Educational Foundations, Egerton University.

3.6.2 Reliability

Reliability is a term that refers to the degree of consistency with which a measuring instrument measures what it is supposed to measure. It can also be said that reliability of a research instrument concerns the extent to which the instrument yields the same results on repeated trial (Mugenda, 2008). The reliability test was conducted on the research instruments during the pilot study among 8 recovering alcoholics and the reliability statistics (Cronbach's Alpha) was obtained as 0.806. The generally accepted standard of >0.70 for reliability coefficients was required for sufficient internal consistency. Test-retest reliability was assessed to determine the stability of scores over a brief time period. Most psychometric tests have a reliability statistic that falls within the range of 0.75 to 0.83, (Nunnally, 1978; page 245–246).

3.7 Data Collection Procedures

After the project had been approved and signed by the supervisor and the chair of the graduate school of Psychology, and Educational foundation, the researcher obtained a permit from the Ministry of Education, Science and Technology. The researcher sought permission from the directors of all studied rehabilitation centres. Data was collected from these rehabilitation centres respectively. The researcher explained to both directors and respondents the purpose of the research as well as their role in the study. The questionnaire was administered to the respondents by researcher. The respondents answered questions on their own and the researcher was with them to clarify unclear questions. It took about one hour for respondents to finish filling questions and submitted to the researcher immediately.

3.8 Data Analysis

Once the instruments were collected and checked, coding was done. To tabulate the data collected, Statistical Package for the Social Sciences (SPSS) computed programme 22.0 was used. The data was organized into frequencies, percentages, means and standard deviations for analysis.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the results of the data collected, analysis and discussion of the implications of the data. The study was designed to investigate influence of counselling services among adult recovering alcoholics on behaviour change in order to live a quality life. The findings of the research presented based on the research objectives:

i. To identify counselling services offered to adult recovering alcoholics on behaviour change.
ii. To determine the influence of counselling services on psychological well being among adult recovering alcoholics.
iii. To determine the influence of counselling services on physiological health among adult recovering alcoholics.
iv. To determine the influence of counselling services on health social lifestyle among recovering adult alcoholics.

4.2 Demographic Data of the Respondents

A self report questionnaire sought basic demographic information. Participants were asked to provide their gender, age, current grade level in school, marital status and estimated income range.

4.2.1 Gender of the Respondents

The study interviewed 70 respondents who were recovering alcoholics. Out of the seventy recovering alcoholics interviewed, 61 (87.14%) were male and only 9 (12.86%) were female. This research suggested that women with alcohol abuse problems were less likely to seek help than men with similar problem severity. According to Kenyan cultural context women are less likely than men to use illicit alcohol and to develop alcohol related problems, although they are the key players in brewing illicit alcohol. The family and society often put more pressure on alcohol abusing women to get treatment than they do on men, so usually women will enter treatment sooner after onset of abuse than men. The social norms permit men to be worried that the society will look down on a man who can't "tough it out" on his own, and that seeking or even needing help is not "normal" male behaviour. Even men who

do seek counselling may worry about what others think of their choice. Literature on gender differences among those entering rehabilitation centres for treatment is limited. Once in treatment, however, gender is not a significant predictor of counselling retention, completion or outcome.

4.2.2 Age Bracket of the Recovering Alcoholics

According to the NACADA Strategic Plan 2009 – 2014, alcohol and drug abuse (ADA) is estimated to be the highest among young adults of age's between15-29 and lowest among adults of ages 65 and older. The study established that most of the recovering alcoholics were in the 30-39 years. This was followed closely by those aged between 20-29 years who numbered 21 (30.0%). Those aged between 40-49 years were 15 (21.4%) and only 9 (12.9%) were in the advanced age bracket of 50-59 years. Research done indicated that younger age, with high education, male gender and being employed are consistently associated with better functioning on all quality of life dimensions, while other general population are held constant (Donovan et al., 2005).

4.2.3 Marital Status of Recovering Alcoholics

The most of the recovering alcoholics in table 2, 36 (51.4 %) are married and following closely are the single casualties being 20 (28.6%). Those who are separated, perhaps, because of their drinking problem are 11 (15.7%) and only 3 (4.3%) are divorced. The divorced could also be alluded to the drinking vice. Meta-analytic reviews of randomized studies show more abstinence with family involved treatment than with individual treatment in alcohol abuse and reduces social costs, domestic violence, and emotional problems of the spouse and children (O'Farrell *et al.* 2001). Recent studies have found that both couples counselling and family counselling are related to better outcomes following treatment than individual counselling (McCrady *et al.* 2009; O'Farrell *et al.* 2010). Skills training, contingency management, and behavioural contracting often are primary components of these counselling services. The results showed improved outcomes for individuals whose partners were involved in counselling, with individuals assigned to BCT or spouse-involved alcohol-focused counselling, reporting fewer heavy drinking days and more abstinent.

Table 3

Age and Marital Status of Recovering Alcoholics

Age of Recovering alcoholics	Married	Single	Separated	Divorced	Total
20-29 Years	1	17	3	0	**21**
	1.4%	24.3%	4.3%	0.0%	**30.0%**
30-39 Years	17	2	6	0	**25**
	24.3%	2.9%	8.6%	0.0%	**35.7%**
40-49 Year	9	1	2	3	**15**
	12.9%	1.4%	2.9%	4.3%	**21.4%**
50-59 Years	9	0	0	0	**9**
	12.9%	0.0%	0.0%	0.0%	**12.9%**
Total	**36**	**20**	**11**	**3**	**70**
	51.4%	**28.6%**	**15.7%**	**4.3%**	**100.0%**

4.2.4 Employment Status of Recovering Alcoholics

One of the most significant risk factors for people who suffer the effects of poverty and alcohol abuse is access to appropriate health services. For people with adequate money or health insurance, and time available, join a multitude of private alcohol treatment centres that can be afforded. For those who do not have the resources available to them, treatments and detoxification can be difficult to find and to utilize. This study at table 3 indicates that out of the seventy respondents sampled, 22 (31.4%) are employed. This forms the highest percentage. It is followed closely by those who are casually employed (20, 28.6%). Unemployed, accounts for 15 (21.4%) of the total number of the recovering alcoholics. Those employed on part time basis were 8 (11.4%), while 4 (5.7%) and only 1 (1.4%) are retrenched and retired respectively.

Table 4

Employment Status of Recovering Alcoholics

	Frequency	Percent	Cumulative Percent
Unemployed full time	15	21.4	21.4
Employed part time	8	11.4	32.9
Retrenched	4	5.7	38.6
Employed	22	31.4	70.0
Retired	1	1.4	71.4
Casual	20	28.6	100.0
Total	**70**	**100.0**	

4.2.5 Estimate Income of the Recovering Alcoholics

Alcohol use also affects the social and economic prospects of individuals and households. Most of the recovering alcoholics, 46 (65.7%) earn approximately Ksh. 1 to Ksh. 12,000. It can be clearly seen that only 9 (12.9%) percent have an estimated income of Ksh. 13,000 to Ksh. 25,000. Only 6 (8.6%) are the highest paid recovering alcoholics.

4.3 Counselling Services Offered During Alcohol Recovery Process

Counselling services offered in this study referred to objective one, focused on alcohol problems based on research evidence include; motivational enhancement therapy, motivational interviewing, coping-skills therapy, cognitive behavioural therapy (CBT), cue-exposure interventions, the contingency management approach, and Alcoholics Anonymous or 12-step approaches. Of these, there is most consistent evidence for the effectiveness of motivational enhancement therapy, motivational interviewing (Vasilaki *et al.*, 2006), and for coping-skills therapy or CBT (Magill & Ray, 2009).

Brief interventions sometimes adopt the techniques of theoretical approaches to counselling. Strong motives can change specific behaviours and level of motivation has been consistently identified as an important factor in the treatment of alcohol problems (Cox and Klinger, 2004). For instance, in the case of hazardous drinking, identifying the harmful effects of drinking alcohol can instil the motivation to change. Instead of using a direct confrontational

strategy to treat alcohol problems, proposed an alternative method called motivational interviewing (MI). Miller and Rollnick (2002, p. 25) defined MI as 'a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. As they discussed, five key principles underlay MI. First, it emphasises the individual's present interests and problems. Second, it involves selective response to the client's speech in a way that resolves ambivalence and motivates the person to change. Third, it is a method of communication rather than a set of techniques. Fourth, it focuses on intrinsic motivation for change. Fifth, within this approach, change occurs because of its relevance to the person's own values. Table 5 shows interviewed recovering alcoholics when they were asked whether attending training and counselling sessions had been helpful in their alcoholic behaviour change.

More generally, the study emphasized on the role of therapists as actively persuading, shaping, rewarding, and training a client from without versus supporting, facilitating, or catalysing change from within. The findings indicate that in counselling relationships, motivational implications are empirically associated with positive outcomes. Counselling services help recovering alcoholics to identify their alcohol-related problems and make a commitment to change, help clients to follow the course of treatment and reinforce their achievements. They can also have a role in supporting family members and creating a network to help facilitate the recovery process.

Table 5

Training Skills for Recovering Alcoholics

Response	Frequency	Percent
Not Sure	1	1.4
Agree	44	62.9
Strongly Agree	25	35.7
Total	**70**	**100.0**

Most of the respondents were of the opinion that attending training and counselling sessions had been helpful in their alcoholic behaviour change. With 44 (62.9%) of the recovering alcoholics agreeing to this fact while 25 (35.7%) strongly agree that the training and

counselling sessions have been helpful. Only 1 (1.4%) of the respondents was not sure whether training and counselling sessions have been helpful in their alcoholic behaviour change. If recovering addicts are not taught life-coping skills, the first time they encounter a stressful situation or have to make a life decision they will retreat into the only coping mechanism they have left that is relapse. The results indicated that developing healthy life skills is essential to successful sobriety. Social coping skills training for an alcoholic addict consists of: how to interact with friends, family members, and co-workers; how to interact in social situations, especially when alcohol will be present and alcohol refusal skills.

Social skills training often take place in group therapy. The respondents were asked to indicate the types of the counselling services that they received during the recovery process. The question was whether they received the counselling services listed in figure 2. They were to give a 'Yes' or 'No' responses if they respectively received or did not receive the indicated types of counselling services. The responses are as indicated in figure 2.

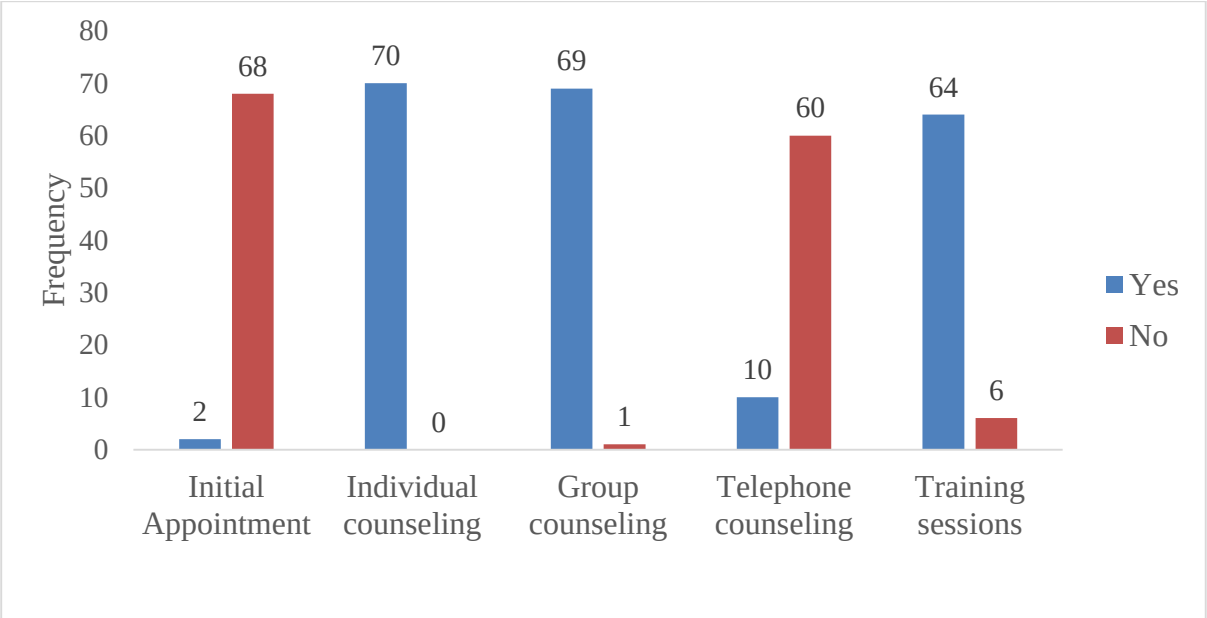

Figure 2: Counselling Services for Recovering Alcoholics

From figure 2 can clearly be seen that individual counselling was the most popular among the respondents with 70 (100%) of the respondents receiving this type of counselling service. Group counselling was also very popular; as it was received by 69 (98.6%) of the respondents. 64 (91.4%) of the respondents attended training sessions as a type of

counselling. This was the third most commonly used counselling service among the recovering alcoholics. Initial appointment was the least popular with only 2 (2.9%) of the respondents receiving the service. Telephone counselling followed in the list of the counselling services received by few respondents as only 10 (14.3) recovering alcoholics received it in their recovering process. The result suggests that recovery from alcoholism is an individualized process. Each alcoholic has unique personal circumstances that led to his or her alcohol addiction issues. Individual counselling at least at the beginning of the recovery process is the best way to ensure that a recovering alcoholic understands why he or she became addicted and how to best overcome addiction. Group counselling encourages empathy, altruism and interpersonal skill development which are often lacking in alcohol dependent people. The road to recovery can be a very personal and emotional experience. However, findings suggested that being able to share information with a group is an important step in the recovery process. Diversity is another important benefit of group therapy. People have different personalities and backgrounds, and they look at situations in different ways. By seeing how other people tackle problems and make positive changes, you can discover a whole range of strategies for facing your own concerns.

The clients were asked whether the counselling services have helped them to cope better with drinking concerns that brought them to the recovery centre, 5 (7.1%) agreed that the counselling services have helped them a little, 23 (32.9%) said that the services have moderately helped them, 39 (55.7%) were happy that the services have helped very much while 3 (4.3%) accept that counselling services have mostly helped them to cope better with their drinking concerns that brought them to the recovery centre. Again, it can clearly be seen from figure 3 that 38 (54.3%) of the respondents have knowledge about the counselling techniques and skills on alcohol recovery while 27 (38.6%) have a little knowledge about the counselling techniques. Only 5 (7.1%) are very much knowledgeable about the available counselling techniques and skills on alcohol recovery. Counselling sessions can help the individual commit to continued development in recovery. Putting down drink is usually not enough by itself to make life fully satisfying.

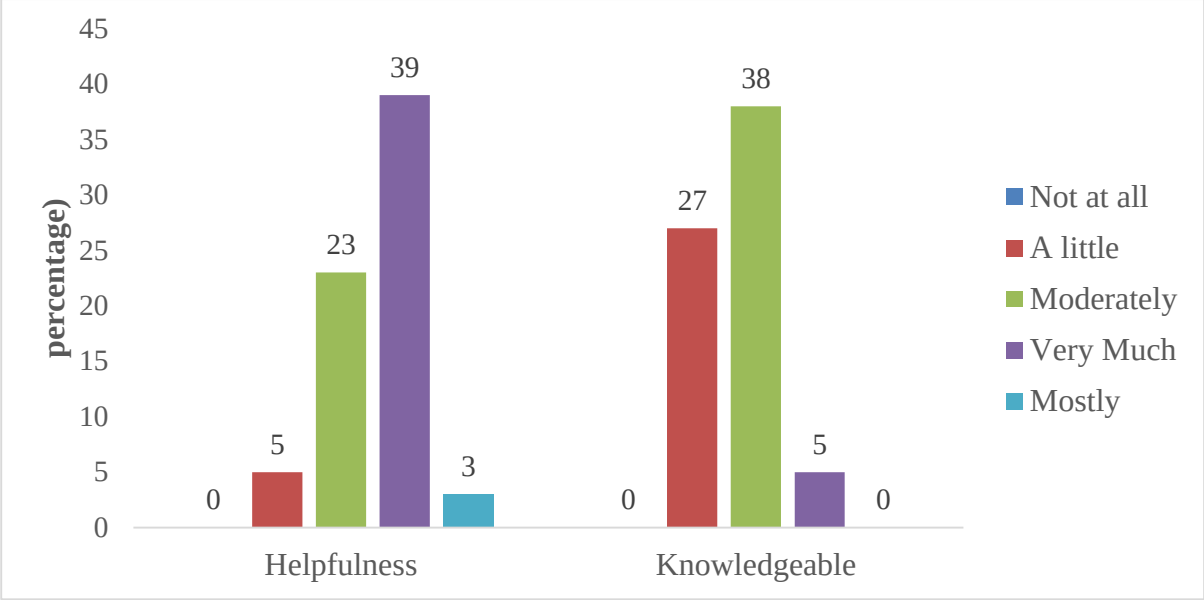

Figure 3: Importance and Knowledge in Counselling Services

The respondents were also asked to indicate how much they were satisfied with the different counselling techniques and skills on alcohol recovery that they received. Table 6 shows their satisfaction with the counselling techniques.

Table 6

Satisfaction of Recovering Alcoholics with the Counselling Techniques

	Frequency	**Percent**
Dissatisfied	4	5.7
Not sure	16	22.9
Satisfied	43	61.4
Very satisfied	7	10.0
Total	**70**	**100.0**

As can be clearly seen from Table 6, the highest percentage 43 (61.4%) were satisfied with the counselling techniques and skills on alcohol recovery while 7 (10.0%) were very satisfied with the counselling techniques that they had so far received. Only 4 (5.7%) of the recovering alcoholics were dissatisfied with the alcohol recovery counselling techniques with a

considerable percentage, 16(22.9%) not being sure whether they were satisfied with the counselling techniques or not. Counselling techniques with certain common attributes have been shown to be most effective in positive change from addiction behaviours.

Establishing trust between the counsellor and therapist is the foundation upon which any process of counselling technique can move forward. Once trust is established, the identification of substance abuse as destructive with a need for change is the next step. Also recently reported research indicated that the level of QOL satisfaction at the end of outpatient treatment is a significant predictor of commitment to abstinence, which in turn is a strong predictor of sustained abstinence (Laudet & Stanick, 2010). The longest study of QOL components among individuals with alcohol abuse disorder reassessed alcoholics 2 and 10 years after their initial treatment episode (Moos, Finney, & Cronkite, 1990). At both follow ups, participants whose drinking remitted (49 percent at 2 years and 57 percent at 10 years) had significantly higher levels of physical, psychological, social, and occupational functioning than did the relapsed group.

4.4 Psychological Well Being of Recovering Alcoholic

Individuals want alcohol counselling services to address the full range of problems that prevent them from living fully quality life free of alcohol. Quality of life improvement is particularly an important goal in treating conditions that cannot be cured. Counselling services is based on person-centred strength to take initiative responsibility for his or her health, wellness and recovery from alcohol dependence.

The respondents were asked some questions about their psychological well-being, 29 (41.4%) of the respondents agree that they felt that their life had been ruined by their drinking behaviour while 33 (47.1%) of the respondents strongly agree to this fact. 10 (14.3%) strongly agree while 32 (45.7%) agree to the fact that they don't feel good about themselves if they don't get some help from a psychotherapist. There are many connected factors when clients enter into treatment. Client personality, socioeconomic status, culture, family history, gender and forces impinging on the client, such as family pressure, legal pressure, and medical problems. Clients' attitude on the choice to enter treatment matters a lot and contributes a lot to recovery progress. The findings indicated that majority of recovering clients willingly acknowledged that they have a problem and admitted to be helped. This

usually happens after they have messed up particularly badly and feel full of remorse. They can see how quitting alcohol abuse might benefit their life.

Out of the seventy recovering alcoholics sampled, 8 (11.4%) strongly agree that they surround themselves with positive experiences when they have difficult feelings with the highest percentage of the respondents, 49 (70.0%) agreeing to this fact. 10 (14.3%) of the respondents are not sure whether they surround themselves with positive experiences when they have difficult feelings with only 3 (4.3%) disagreeing with this fact. Out of the recovering alcoholics sampled, 31 (44.3%) strongly agree that they maintain positive attitude in every step they grow or relapse while 36 (51.4%) of the respondents agree to this fact. Only 3 (4.3%) of the respondents are not sure whether they maintain a positive attitude in every step they grow or relapse.

In recovery centres, clients learn the ability of the individual to assess and control the emotions of themselves and others. As pointed out by Woydyłło (1992), alcoholics are prone to unrealistic expectations about sobriety and may break their abstinence in a clash with reality. Furthermore, as Beck and colleagues (2007) explained that many addicts have a low tolerance for frustration, and focus only on the present. It seems that such recovering alcoholics found it difficult to stay sober in situations where they expect changes for example, concerning improved relations with the spouse but which do not occur despite participating in treatment and maintaining abstinence. So counsellors should work on clients' expectations in relation to sobriety appears to be much needed. The finding indicates that an individual is able to control the impulses, behaviours, and feelings. The individual is able to recognize his own emotions and understands how this can impact his thoughts and behaviour. Thus, result suggested that recovering alcoholics are able to confidently resolve any conflicts in a positive manner.

The respondents were also interviewed on how often they manage their alcoholism behaviour to stand alone and the extent to which they feel that their life is meaningful. Among cognitive variables, several forms of motivation have been associated with good substance use outcomes (Downey, 2000). Maladaptive cognitions represent problems in beliefs or self-statements that may interfere with recovery.

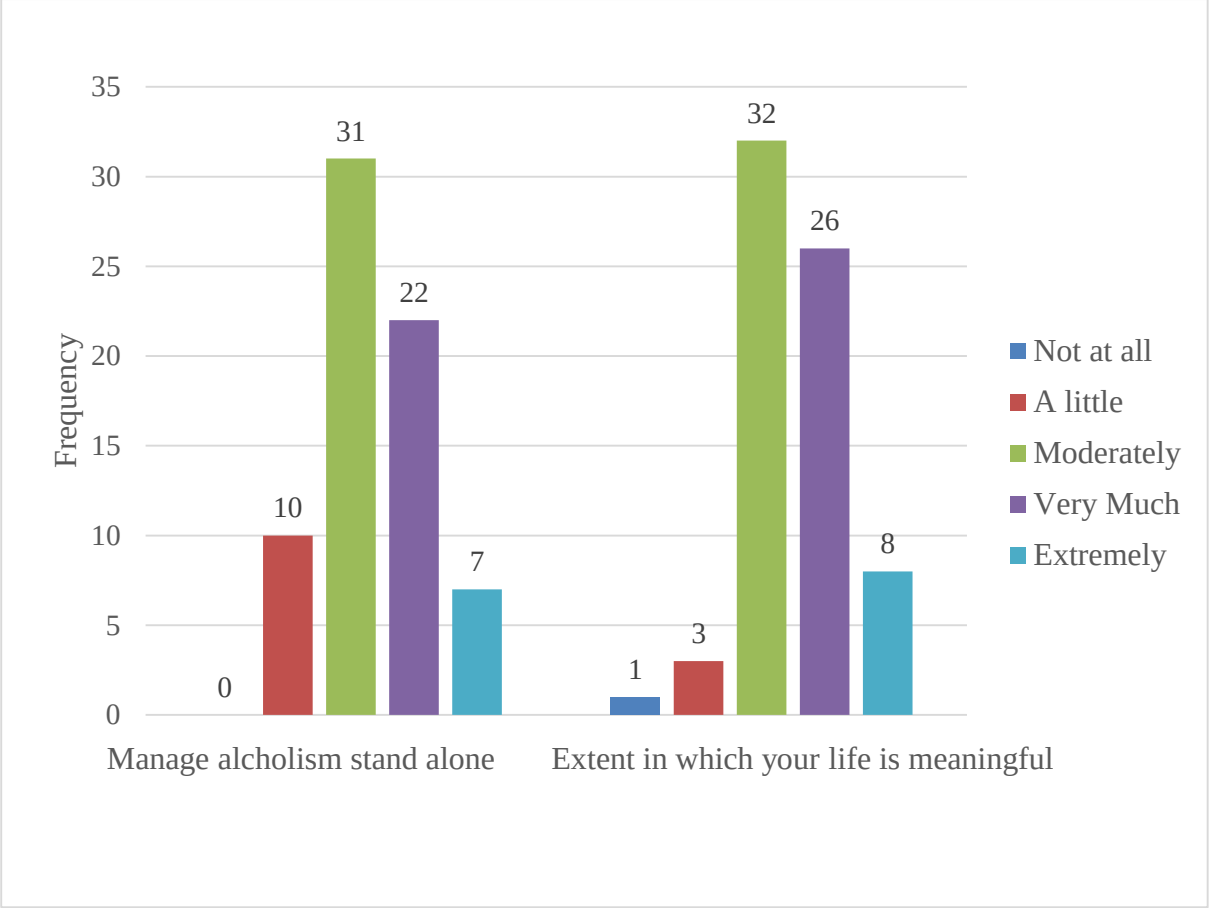

Figure 4: Managing Alcoholism and Meaningful Life

Figure 4 clearly indicates that most of the respondents, 31 (44.3%) moderately manage their alcoholism behaviour change 'stand alone'. This indicated that motivational enhancement counselling helped recovering alcoholics. The findings also showed that 22 (31.4%) of the recovering alcoholics who can manage their alcoholism behaviour very much. Those who could manage their alcoholism behaviour changed a little were 10 (14.3%). Only 7 (10.0%) of the respondents can extremely manage their alcoholism behaviour change 'stand alone'.

The findings indicate that most of the alcohol recovering clients had mastered managing skills of relapse when they are alone. Relapse Prevention plan is a behavioural self-control program that teaches individuals with alcohol addiction how to anticipate and cope with the potential for relapse. RPT can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial alcohol counselling. Through relapse management strategies, ultimately the journey of habit change can still be made. Since addictive behaviour habit change is a cyclical process, most people will not be

completely successful on their first attempt to change an addictive behaviour. The lessons learned from each lapse or relapse may bring the person closer to stable maintenance.

On the extent to which the life of the respondents is meaningful, 32 (45.7) of the recovering alcoholics felt that their life was moderately meaningful, 26 (37.1%) felt their life was very much meaningful, 8 (11.4%) felt that their life was extremely meaningful while only 3 (4.3%) admitted that their life was a little meaningful and only 1 (1.4%) indicated their life was not meaningful at all. The result suggest that life meaning enhance coping, give hope for the future, provide a heightened sense of control, security and stability. They confer support and strength to resist the opportunity to abuse alcohol or other substances. All of which are very much needed to initiate and maintain recovery. The respondents were also asked on how they felt when people or family members treat them differently after admission for alcoholism treatment and recovery progress. Table 7 shows the frequency and percentage of alcoholics' feelings about family member relationship of their respondents.

Table 7

Alcoholics Feelings about Family Members' Relationship

Response	Frequency	Percent
Terrible	14	20.0
Most dissatisfied	8	11.4
Dissatisfied	29	41.4
Satisfied	15	21.4
Very satisfied	4	5.7
Total	**70**	**100.0**

From the table 7, it reveals that 29 (41.4%) of the recovering alcoholics were dissatisfied with treatment they got from family members and people after admission for alcoholism treatment. The 8 (11.4%) felt most dissatisfied with the treatment they received. Those who felt terrible about the treatment they received from family and friends after admission for alcoholism treatment were 14 (20.0%). On a positive note, 15 (21.4%) of the recovering alcoholics felt satisfied with the treatment they received while only 4 (5.7%) felt very satisfied with the

relationship and treatment from family and friends after admission for alcoholism treatment. Spouses and families labour under the heavy emotional burdens of resentment, fear, and hopelessness due to the addictions of family members or loved ones. But family and friends also play an important role in helping their loved ones get the help they need to move forward in recovery.

4.5 Physical Well Being of Recovering Alcoholics

Every recovering person will experience physical changes, and these changes depend on the type of alcohol beverages and length of time used. These changes can be mild or severe. Alcoholics become addicted because their bodies are physiologically incapable of processing alcohol normally. Maintaining sobriety is undoubtedly the most important health goal for individuals recovering from alcoholism. The study was also interested on the physical well-being of the recovering alcoholics. As such, the respondents were asked to indicate the level of their satisfaction with their physical health and their physical ability to perform their daily living activities. Figure 5 shows the frequency of the responses as regards to these questions.

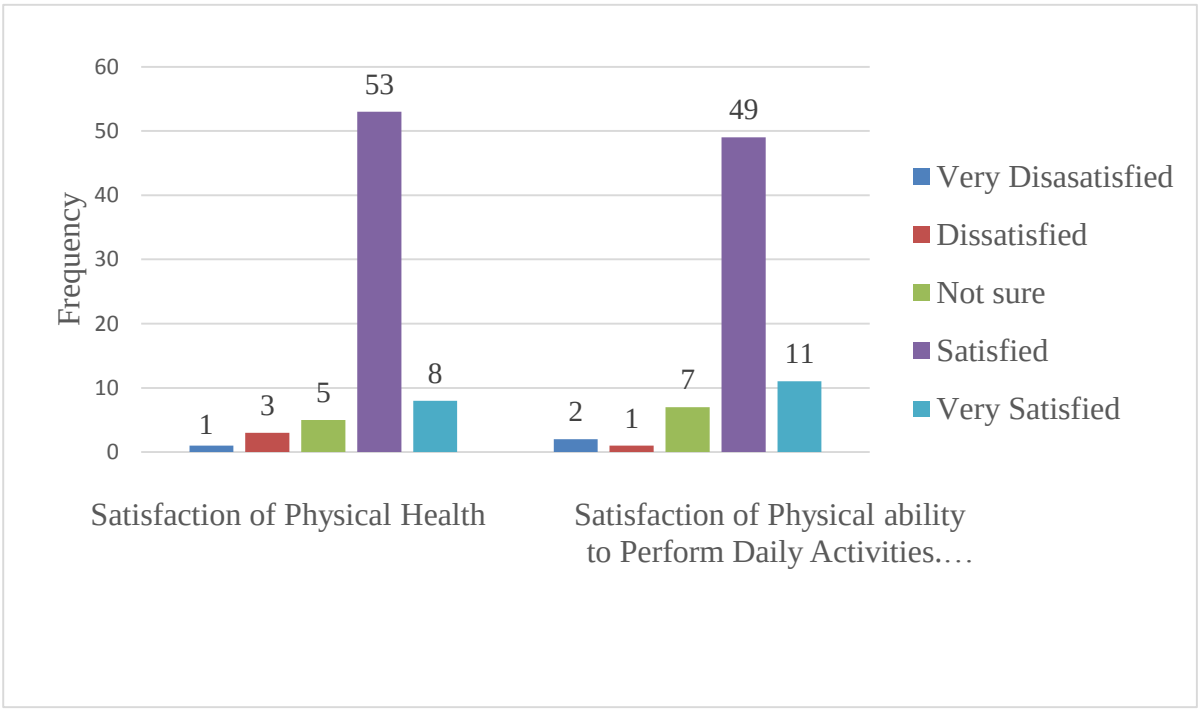

Figure 5: Physical Well-Being of Recovering Alcoholics

The findings indicated a greater percentage of the recovering alcoholics 75.7% were satisfied with their physical health. While 8 (11.4%) being very satisfied about their physical condition. 5 (4.3%) were not sure about their physical health, 3 (4.3%) were dissatisfied while only 1 (1.4%) were very dissatisfied with their physical stability. In recovery, clients experience withdrawal symptoms caused by detoxification. These feelings can all meld together and be difficult to manage. Exercise is a great defense against the mood swings that come with early sobriety. Exercise increases endorphins, or "good feelings," and improves the person's sense of well-being while also improving self-esteem and self-confidence, which in turn can help the person to make better choices in all aspects of life.

On the extent to which the recovering alcoholics are satisfied with their physical ability to perform daily activities, figure 5 shows that most of the recovering alcoholics, 49 (70.0%) were satisfied with their ability to perform daily activities, 11 (15.7%) were very satisfied, 7 (10.0%) were not sure, 1 (1.4%) was dissatisfied and only 2 (2.9%) were very dissatisfied with their physical ability to perform their daily living activities. The finding shows that Even as sufferers of alcoholism are still kicking the negative symptoms of withdrawal, their bodies are already getting back into gear. Though the long-term effects of alcohol can be devastating, people who forego alcohol for as little as one month can already see the immediate benefits of quitting drinking.

The recovering alcoholic clients were also asked to what extent their physical well-being interferes with their daily functioning and attending training and participating in counselling sessions. The physical well-being of most of the recovering alcoholics, 33 (47.1%) do not at all interfere with their daily functioning while 22 (31.4) of the recovering alcoholics felt that their physical well-being slightly interferes with their day today functioning. Those who felt that their physical well-being moderately interferes with their daily functioning were 9 (12.9%) while 5 (7.1%) felt that their physical well-being very much interferes with their daily functioning. Only one of the recovering alcoholic felt that physical well-being extremely interferes with his/her day today functioning.

About physical health hindrance to attending training and counselling sessions, 39 (55.7%) of the respondents indicated that their general health do not at all hinder them from attending training and counselling sessions. This was followed by 20 (28.6%) of the recovering alcoholics who felt that their general health slightly hinders them from attending training and

participating in counselling sessions. Those who are moderately hindered from attending training and counselling sessions by their general health were 6(8.6%), while 3 (4.3%) and 2 (2.9%) were respectively very much and extremely hindered by their general health to attend the training and counselling sessions. The result suggests that most recovering alcoholics' health had improved due to a well-structured fitness programme for addiction rehabilitation provided many benefits such as improved cardiovascular health, better strength, improved sense of well being, and better self-esteem. Maintaining a physical wellness and exercise program post-treatment is equally important to achieving long-term sobriety.

The respondents were also asked whether their physical involvement in self-help activities has been helpful in their recovery and half of the respondents, 35 (50.0%) as can be seen from Table 7 agree that their physical involvement in self-help activities has mostly helped them in their recovery. Maintaining a physical wellness and exercise program post-treatment is equally important to achieving long-term sobriety. While 9 (12.9%) feel that their involvement in self-help activities has extremely helped them in their recovery process. Those who feel that self-help activities has moderately helped them in their recovery are 11(15.7%) while 12 (17.1%) feel that they have been helped a little in their recovery process by self-help activities. Only 3 (4.3%) of the recovering alcoholics, felt that self-help activities have not at all helped them in their recovery process.

Table 8

Physical Involvement of Recovering Alcoholics in Self Help Activities

Response	Frequency	Percent
Not at all	3	4.3
A little	12	17.1
Moderate	11	15.7
Mostly	35	50.0
Extremely	9	12.9
Total	**70**	**100.0**

A question on how well the recovering alcoholics were able to walk around was also poised and the responses clearly indicated that half 35 (50%) of the respondents interviewed were able to walk around well while 34 (48.6%) were able to walk around very well. Only 1 (1.4%0 of the recovering alcoholics was not able to walk around well. Long-term alcohol misuse can weaken your immune system, making you more vulnerable to serious infections. It can also weaken your bones, placing you at greater risk of fracturing or breaking them.

4.6 Social Well Being of Recovering Alcoholics

The process of recovery is supported through relationships and social networks. This often involves family members who become the champions of their loved one's recovery. They provide essential support to their family member journey of recovery and similarly experience the moments of positive healing as well as the difficult challenges. In order to ascertain the social well-being of the recovering alcoholics, they were asked to indicate how they rate their social well-being. Table 9 shows the responses and frequencies.

Table 9

Social Quality Life of Recovering Alcoholics

Response	Frequency	Percent
Very Poor	1	1.4
Poor	5	7.1
Unsure	8	11.4
Good	49	70.0
Very good	7	10.0
Total	**70**	**100.0**

It can be seen from table 9 that 49 (70.0%) of the recovering alcoholics was the greatest percentage rate their social quality of life as good, 8(11.4%) were not sure on how they can rate their social well-being, 7 (10.0%) rate their social well-being as very good while 5 (7.1%) of the respondents indicated that their social life is poor and only 1 (1.4%) considered their social well-being as very poor. The findings give the best chance of a good outcome. If

the alcoholic is surrounded by others who have achieved sobriety, they will be encouraged to do the same. People with serious drinking problems need to develop positive social network support for change. Good social network help recovering alcohol clients to deal with shame related to alcohol abuse and remove stigma and put a positive face on recovery.

The respondents were also asked about how satisfied they were with their personal relationships with their families and the support they get from friends, family and neighbours. Figure 6 below indicates the findings.

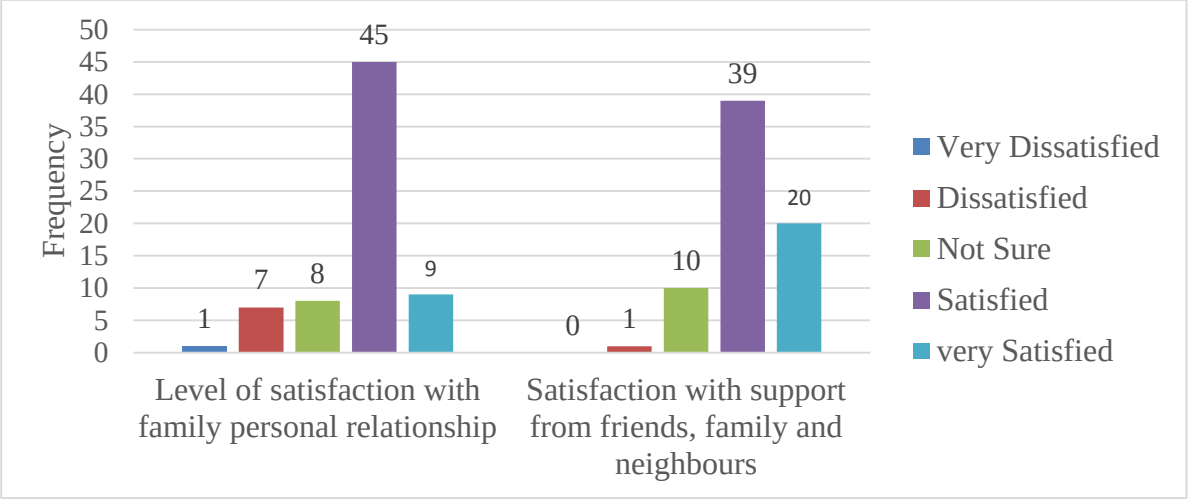

Figure 6: Family Support and Relationship

As indicated on figure 6, it can be seen that a greater percentage of the respondents, 45 (54.3%) were satisfied with their personal relationship with their family while 9 (12.9%) very satisfied with the personal relationship that they have with their family. 8 (11.4%) of the recovering alcoholics were not sure of their level of satisfaction with their family members while 7 (10.0%) were dissatisfied with personal relationship that they had with their family while only 1 (1.4%) of the recovering alcoholics was very dissatisfied with his/her personal family relationship. On the level of satisfaction of the respondents with the support they get from friends, family and neighbours, 39 (55.7%) of the recovering alcoholics were satisfied, 20 (28.6%) were very satisfied, 10 (14.3%) were not sure with the support they got from friends, family and neighbours while only 1 (1.4%) was dissatisfied with the support she/he received. Evidence clearly indicates that relatives and friends can be helpful in engaging the alcohol misuse in treatment (Barber & Crisp, 1995; Miller, Meyers & Tonigan, 1999) and in

bringing about a more favourable outcome of treatment (Epstein & McCrady, 1998). A supportive network is a key element of 12-Step programmes that encourages attendance at AA meetings, because it is the most effective means of eliminating heavy drinking friends and acquaintances from the social.

Perceived social support is defined as the individual's cognitive and subjective assessment of the degree of accessibility to friend support, of his or her coping abilities and the degree of his or her confidence in being able to rely on others. Some researchers maintain that perceived social support influences the individual's health and his or her sense of well-being (Adams & Bezner, 2000; & Hampton, 2004). Researchers refer to perceived social support as a personality trait based on previous life experiences (Kitamura *et al.,* 2002). Individuals with low perceived social support have a low sense of well-being, a tendency to interpret actions as unsupportive and a tendency to interpret social conditions in a negative manner. These characteristics are compatible with those found in the alcohol addict population. Alcohol dependents perceive themselves as lacking personal resources to cope with stress and typically exhibit high levels of anxiety, dysfunctional development of object relations and negative attachment and emotional detachment (Schmitz *et al.,* 2000).

The respondents were also interviewed on the extent of positive difference in their participation in peer support groups was making on their recovery process. Their response was, 31 (44.3%) of the recovering alcoholics indicated that their participation in peer support groups had mostly made a positive difference in their recovery progress, 25 (35.7%) felt that the peer support groups had made a moderate positive difference in their recovery progress while 7 (10.0%) had seen a little positive difference contributed by their participation in peer support groups. 6 (8.6%) of the recovering alcoholics indicated that their participation in peer support groups had resulted to extreme positive difference in their recovery process. Only 1 (1.4%) of the respondents' felt that participation in peer support groups had not at all contributed a positive difference in his/her recovery progress. In the addiction field, recovery-oriented support may foster greater self-efficacy toward ongoing abstinence because recovering persons can acquire effective coping strategies from their peers. Many former recovering persons report that being in the company of other recovering individuals is helpful (Granfield & Cloud, 2001; Margolis *et al.,* 2000).

The respondents were asked on how often their former drinking friends interfere with their recovery progress and the results indicate that the former drinking friends of 28 (40.0%) of the recovering alcoholic rarely interferes with their recovery progress. 20 (28.6%) of the respondents indicated that their former drinking friends do not interfere with their recovery progress at all. On the contrary, 19 (27.1%) of the recovering alcoholics indicated that their former drinking friends sometimes interfere with their recovery progress, 2 (2.9%) revealed that their former drinking friends often interfere with their recovery progress and only 1 (1.4%) of the recovering alcoholics indicated that her/his former drinking friends always interfere with his/her recovery progress. The results of this study also indicate that, due to alcohol dependence, patients often have high resistance to changing their problematic behaviours, so the treatment period should be long enough to achieve more permanent results. When sober individuals spend time with former friends, they will experience pressure to relapse. These friends will see this attempt at sobriety to be a threat to them, it is pointing out their own failings. This may tempt them to try to sabotage the recovering clients in their efforts to build a life away from addiction. These friends are likely to be pessimistic about the individual's chances of building a good life away from addiction.

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of the Findings

The main purpose of the study was to investigate influence of counselling services on behaviour change among adult recovering alcoholics. The study considered four main domains: counselling services, physical health, psychological well being and social stability of recovering alcoholics. The literature review was quite consistent regarding the negative impact of alcohol dependence on many domains of health functioning of alcohol abusers. Alcohol dependence seems to be related to poorer mental health, physical functioning and social wellness.

i. There was sufficient amount of scientific literature supporting that pharmacological interventions combined with psychosocial counselling improved quality of life and gave best results in alcohol abstinence. Palet *et al. (*2008) reported significant improvement across many drinking and QOL parameters in both the Brief intervention and Simple advice groups. Significant differences were noticed across both the interventions, with a decrease in severity of dependence over three months.

ii. Psychological well being of recovering alcoholics to achieve satisfaction with their lives they must develop a sense of meaning and purpose in life. The bottom line here indicated that people nearly always need to make decisions for them-selves.

iii. Regarding the objective of physical well being, respondents demonstrated quite improvement. Self-help recovery programmes often take the form of 12-step programs, which are provided within the framework of support groups. Finding indicated that the recovering alcoholics were greatest percentage which rated their quality of life as physical wellness being good.

iv. Positive social support is the indicator for living a healthy lifestyle. Group counselling is often used in addition to individual counselling to provide social reinforcement for pursuit of recovery. The findings indicate that peer support, family support, self-care, and other counselling approaches are key component of recovery. Recovery support services help recovering clients enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice

5.3 Conclusions

Behavioural health among adult recovering alcoholics is a critical aspect of maintaining physical health, psychological functioning and social well being. Recovery is characterized by continual growth and improvement in one's health in particular recovering alcoholics and wellness that may involve setbacks.

i. Matching treatment settings, interventions, and counselling services to an individual's particular problems and needs is paramount to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
ii. The finding indicates that individuals are able to control their impulses, behaviours, feelings and better self-esteem.
iii. The result suggested that most recovering alcoholics' health had improved due to a well-structured fitness programme in addiction to rehabilitation centres provided many benefits such as improved cardiovascular health, better strength, improved sense of well being and better self-esteem.
iv. Good social network helps recovering alcohol clients to deal with shame related to alcohol abuse and remove stigma and put a positive face on recovery process.

5.4 Recommendations

The following are gap based evidence recommendation for offering counselling services among adult recovering alcoholics:

i. An alcohol recovering individual treatment and counselling services plan must be assessed continually and modified as necessary to ensure that it meets client's changing needs. It is evident that pharmacotherapy is effective when combined with psychosocial counselling.
ii. Counsellors in rehabilitation centres must assist recovering individuals to make a conscious effort to not only resolve the immediate problems of alcohol addiction, but also actively make changes on how they operate and function in life so that they build a much stronger future.
iii. Often there is inadequate attention placed on how to maintain abstinence in the weeks, months or even years following treatment. Given this reason, the researcher recommends for enhancement of aftercare structured program among rehabilitation

centres' intervention which has been shown to make a huge difference between the addict abstaining from his or her addiction or relapsing behaviours.

iv. Moreover, a recovery measure is needed for researchers to elucidate recovery processes, patterns and their determinants, as well as to guide services and to begin identifying recovery 'milestones' that provide realistic expectations to counsellors, persons in recovery, their families and to society at large.

5.5 Suggestions for Further Research

Further research is needed for the following areas:

i. Further research is needed to evaluate the effect of combined pharmacotherapy and psychosocial counselling among adult alcohol dependent people.

ii. More attention and research should be paid to a broader set of positive outcomes from treatment centres in addition to abstinence or reductions in alcohol use, including effects on the family and the wider social context.

iii. There is need for thorough assessment of the extent of impairments in all key areas of functioning among recovering alcoholics including out-of-treatment active abusers and persons in successive stages of recovery.

iv. Further research is needed to determine the effectiveness of existing counselling approaches among rehabilitation centres as well as to develop new strategies to enhance clients' treatment.

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APENDIX A: LETTER OF INTRODUCTION

BEATRICE CHEROP.

P.O BOX 99,

ELDORET.

Dear Sir/Madam,

RE: LETTER OF INTRODUCTION

My name is Beatrice Cherop a student at Egerton University (Njoro), undertaking a Masters of Arts Degree in Guidance and Counselling. The Course requires that I carry out a research project in my area of study. My research topic is; the influence of counselling services on behaviour change among adult recovering alcoholics Uasin-Gishu County, Kenya". You have been selected as one of the research respondents. The information given is for academic purpose only and will be treated in utmost confidentiality. Please fill in the questionnaire according to the instructions given.

Yours faithfully,

Beatrice Cherop.

APPENDIX B: QUESTIONNAIRE FOR RECOVERING ALCOHOLICS

Today Date…….....

Respondent No……

Part A: Demography

Your answers are completely private and confidential.

Tick in the box√ the answer of your choice

1 Gender

Female ☐

Male ☐

2. Indicate Your Age..... Years

3. Marital status

Married ☐

Single ☐

Separated ☐

Divorced ☐

Widowed ☐

4. Education level

Primary ☐

Secondary ☐

Tertiary ☐

University ☐

Never went school ☐

5. What is your employment status?

Employed full time ☐

Employed part time ☐

Retrenched ☐

Unemployed ☐

Retired ☐

Casual ☐

6. Estimate Income Status per month (Kshs.)

0-12,000 ☐

13,000-25,000 ☐

26,000-37,000 ☐

38,000- 49,000 ☐

Above 50,000 ☐

Part B

Please read each question, assess your feelings, and circle the number on the scale that gives the best answer for you for each question.

The following questions ask about counselling services received during your alcohol recovery process;

1. Attending training and counselling sessions has been helpful in my alcoholic behaviour change?

Strongly Disagree	1
Disagree	2
Not sure	3
Agree	4
Strongly Agree	5

2. Counselling services has helped me to cope better with drinking concerns that brought me herein

Not at all	1
A little	2
Moderately	3
Very much	4
Mostly	5

3. How satisfied are you about counselling techniques and skills about alcohol recovery?

Very dissatisfied	1
Dissatisfied	2
Not sure	3
Satisfied	4
Very satisfied	5

4. How knowledgeable are you about counselling techniques and skills about alcohol recovery?

Not at all	1
A little	2
Moderately	3
Very much	4
Mostly	5

5. Please tell us what type of support did you receive from counselling services you had ?

Initial appointment	1
Individual counselling (face to face)	2
Group counselling	3
Telephone counselling	4
Training sessions	5

6. Please select counselling support that most helped you in your recovery progress?

Initial appointment	1
Individual counselling (face to face)	2

Group counselling	3
Telephone counselling	4
Training sessions	5

7. How has the counselling services you received been effective in addressing your drinking difficulties?

Very Ineffective	1
Quite Ineffective	2
It had no impact	3
Quite effective	4
Very effective	5

The following questions ask about your psychological well being. Please circle the number

8. I don't feel good about myself and I need to get some help from a psychotherapist?

Strongly Disagree	1
Disagree	2
Not sure	3
Agree	4
Strongly Agree	5

9. I don't feel good about myself if I don't get some help from psychotherapies?

Strongly Disagree	1
Disagree	2
Not sure	3
Agree	4
Strongly Agree	5

10. How often do you manage your alcoholism behaviour change stand alone?

Not at all	1
A little	2
A moderately	3
Very much	4
An extreme amount	5

11. How do you feel when people or family members treat you differently after admission for alcoholism treatment and recovery progress?

Terrible	1
Most dissatisfied	2
Dissatisfied	3
Satisfied	4
Very satisfied	5

12. I surround myself with positive experiences when I have difficult feeling?

Strongly Disagree	1
Disagree	2
Unsure	3
Agree	4
Strongly Agree	5

13. I maintain positive attitude in every step I grow or relapse?

Strongly Disagree	1
Disagree	2
Unsure	3
Agree	4
Strongly Agree	5

14. To what extent do you feel your life is meaningful?

Not at all	1
A little	2
A moderate amount	3
Very much	4
An extreme amount	5

The following questions ask you about your physical well being. Please circle the number

15. To what extent do you feel about your physical health?

Very dissatisfied	1
Dissatisfied	2
Not sure	3
Satisfied	4

Very satisfied 5

16. . My physical well being interferes with my day today functioning?

Not at all 1

Slightly 2

Moderately 3

Very much 4

Extremely 5

17. How satisfied are you with your physical ability to perform your daily living activities?

Very dissatisfied 1

Dissatisfied 2

Not sure 3

Satisfied 4

Very satisfied 5

18. How often does your general health hinders you from attending training and participating in counselling sessions

Not at all 1

Slightly 2

Moderately 3

Very much 4

Extremely 5

19. My physical involvement in self help activities has been helpful for my recovery

Not at all 1

A little 2

Moderately 3

Mostly 4

Completely 5

20. How well are you able to physically walk around?

Very poor 1

Poor 2

A little 3

Well 4

Very well 5

The following questions ask you about your social well being. Please circle the number

21. How would you rate your social quality of life?

Very poor	1
Poor	2
Unsure	3
Good	4
Very good	5

22. How satisfied are you with your personal relationships with your family?

Very dissatisfied	1
Dissatisfied	2
Not sure	3
Satisfied	4
Very satisfied	5

23. My participations in peer support groups is making positive differences in my recovery progress and my social life.

Not at all	1
A little	2
Moderately	3
Mostly	4
Completely	5

24. How satisfied are you with the support you get from your friends, family and neighbours?

Very dissatisfied	1
Dissatisfied	2
Not sure	3
Satisfied	4
Very satisfied	5

25. How often do your former drinking friends interfere with your recovery progress?

Not at all	1
Rarely	2
Sometimes	3
Often	4
Always	5

Thank you very much for completing this questionnaire. Your input is significantly important and more so confidential.

APPENDIX C: PERMIT FROM MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY