CONTRIBUTION OF SELECTED PSYCHOLOGICAL AND SOCIAL FACTORS TO RELAPSE AMONG RECOVERING ALCOHOLICS IN ASUMBI AND JORGS ARK REHABILITATION CENTRES, KENYA

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DECLARATION AND RECOMMENDATION

Declaration

This thesis is my original work and has not been previously presented for the award of a degree in this or any other university.

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Recommendation

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

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DEDICATION

To God the giver of life and wisdom, my loving wife Joyce and children Christian and Jean.

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ABSTRACT

Drug abuse is a major global problem and in Kenya there has been increasing drug and alcohol abuse with serious negative effects. Treatment and rehabilitation of alcoholism is expensive and in many cases non-conclusive. Treatment not only strains the national resources allocated to health but it drives families to poverty. Deaths from alcoholism are also a major loss to families and to society. Thus this study sought to find out the contribution of selected psychological and social factors to relapse among recovering alcoholics of Asumbi and Jorgs Ark rehabilitation centres in Kenya. The study adopted the descriptive survey design. The population of the study comprised of 93 relapsed alcoholics and rehabilitation counsellors in Asumbi and Jorgs Ark rehabilitation centres in Kenya. A sample of 67 recovering alcoholics and 13 counsellors was drawn from the two purposively selected rehabilitation centres and used in the study. The study used two sets of questionnaires to collect data, one for relapsed alcoholics and another for rehabilitation counsellors. The questionnaires were piloted to establish their reliability by use of the Cronbach alfa method. A reliability coefficient of 0.84 was obtained for the questionnaires before the actual data collection. The data was then processed and analyzed using descriptive statistics including frequencies and percentages with the aid of the Statistical Package for Social Sciences (SPSS) version 20.0 for windows. The key findings of this study indicated that the selected psychological factor that mostly contributed to relapse was dwelling on resentment that causes anger due to unresolved conflict. The social factor that mostly contributed to relapse was hanging around alcoholic friends. The conclusion was that in view of the selected psychological factors, dwelling on resentment that causes anger due to unresolved conflict contributed to relapse. In the selected social factors, hanging out with alcoholic friends contributed most to relapse. Based on the major findings of this study, it is recommended that recovering alcoholics should be trained by counsellors on how to deal with anger due to unresolved conflict because it was a major reason for relapse. Rehabilitation centres are encouraged to strengthen individual counselling so as to solve these problems. It is also recommended that recovering alcoholics should be trained by rehabilitation counsellors on how to make and sustain meaningful relationships.

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LIST OF ABBREVIATIONS AND ACRONYMS

AA	Alcoholics Anonymous
APA	American Psychological Association
DALYs	Disability Adjusted Life Years
DSM(IV)	Diagnostic and Statistical Manual Fourth Edition
GYTS	Global Youth Tobacco Survey
KEMRI	Kenya Medical Research Institute
NA	Narcotics Anonymous
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
NACOSTI	National Commission for Science, Technology and Innovations
NHSC	National Health and Social Care
NIDA	National Survey on Drug Use and Health
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NSDUH	National Survey on Drug Use and Health
RP	Relapse Prevention
SPSS	Statistical Package of Social Sciences
UNODC	United Nations Office of Drugs and Crime
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

According to the United Nations Office of Drug Abuse and Crime (UNODC, 2015), drug abuse is on the increase and causes adverse social, health and economic implications. In 2012 alcohol consumption led to about 3.3 million or 5.9 percent of global deaths. The World Drug Report (2013), reports that alcohol abuse is a major global threat with serious consequences on people's security, economic status, heath and cultural welfare. In many parts of the world relapse rates in addiction are still very high and addictions have continued to plague many drug users. For instance the National Survey on Drug Use and Health (NSDUH, 2006) gives relapse rates at 50%-90% in America. Alcohol use has serious health and social effects making its prevention and control a public health priority. According to WHO (2002, 2004), alcohol causes 1.8 million deaths (3.2% of total) one third (600,000) of which result from unintentional injuries. It also causes a loss of which 40% are due to neuro-psychiatric conditions.

Marlatt, Parks and Witkiewitz, (2002) explains that relapse to alcohol addiction is dependent on many factors, some are found within the individual and others found within the social milieu in which the individual lives. Treatment of addictive disorders in the recent years has focused on relapse prevention as an important component in recovery from such addictions. A supportive family is considered the strongest source of identity and social support among all contextual relationships (Beattie, 2001) and hence associated with better prognosis and successful reduction of drug use during treatment. Copello, Velleman and Templeton (2005) argue that the family plays an important role on alcohol abstinence maintenance or relapse and propose that to achieve effectiveness in alcohol treatment the alcoholics' family should be involved.

According to Pierce, Frone, Russell, Cooper and Mudar (2000) substance abuse and alcoholism are seen as symptoms of a dysfunctional family system, and hence the family is considered as part of the solution to the relapse problem without which the individual would not relapse. Saatcioglu, Erim and Cakmak (2006) explain that there is strong evidence to support the effectiveness of family interventions in treatment of

alcoholism, which demonstrates that family therapy for alcoholics is effective in improving overall family relationships and functioning, and which in turn improves overall substance use outcomes, engagement, and retention in therapy. Family treatment also brings about marital satisfaction for alcoholics, improve communication, and improve positive couple functioning which in turn improve prognosis (Antoine, Christophe, & Nandrino, 2009). Family members' involvement in therapy greatly contributes to the individual alcoholic's motivation to change and maintain abstinence (Templeton, Velleman, & Russell, 2010). While involved in a treatment program, family members are a rich source of information about the real life interactions and experiences of the addict that may have a contribution to effective treatment planning and relapse prevention (Saatcioglu, *et al*., 2006).

Acccording to Emmite and Swierzewski, (2008), alcohol consumption and abuse is influenced by multiple factors including gender, family history and parental influence. Men are more likely to use alcohol with some estimates indicating a ratio of 5:1. Men are also at high risk of heavy drinking and intoxication (Gmel, Rehm, & Kuntsche, 2003). However the number of women who drink, abuse, and become dependent on alcohol is rising.

Relapse is a formidable challenge in the treatment of all behaviour disorders (Witkiewitz & Marlatt, 2004). To explain this challenge several authors have described relapse as complex, dynamic and unpredictable (Buhringer, 2000; Donovan, 1996 & Marlatt, 1996). Rasmussen (2000) noted that relapse occurs because of the building up of additional crisis including looking trivially on a certain problem, stress, weak or failed forecast, the pessimistic thinking that all issues cannot be resolved and immature actions. Relapsed addicts are also confused and overreact due to the inability to think clearly, unable to manage feelings and emotions, the difficulty to remember things, unable to control their feelings and easily angered. Moos (2007) contended that psychological factors contribute to relapse among drug addicts after abstinence. Another relapse promoting factor is self-efficacy, defined as a degree to which an individual feels confident and capable of performing a certain behavior in a specific situational context (Bandura, 1977).

Although reports on alcoholism in Africa in general are committed to giving a broad picture on health issues relating to alcohol, there is an underlying impression that relapse rates are still high in these areas. The National Campaign against Drug Abuse Authority (NACADA), in Kenya has shown that relapse rates are very high, however, it is more committed at providing statistics of areas dominated by drug use and the drug of choice in such areas (NACADA 2011). Some available data for four outpatient rehabilitation programs in Kenya from 2007 to the first quarter of 2010 estimated the overall abstinence rates for three drugs: cannabis, alcohol, and heroine as 42%, while that for alcohol and cannabis alone was 46% of users (Deveau, Tengia, Mutua, Njoroge, Dajoh & Singer, 2010).

The United Nations Office of Drug and Crime in its World Drug Report of 2010 (UNODC, 2010) ranked Kenya among the four most notorious African nations with drug problems, and the port of Mombasa as a major transit point. In Kenya, alcohol is the most abused drug with a national abuse rate of 36.3 percent followed by nicotine 17.5 percent, C*annabis Sativa - Bangi* 9.9 percent, heroin 8.0 percent, *Catha edulis – Miraa* 2.7 percent and cocaine at 2.2 percent. According to Ndetei, Mutiso, Khasakhala, Odhiambo, Kokonya, and Sood (2004) alcohol use has been attributed to social dysfunctions and laxity in legal provisions and application. The National Agency for the Campaign against Drug Abuse (NACADA, 2004), report that of the youth population of 5,835,007 in Kenya, 60 percent abuse drugs, mostly alcohol.

The Government of Kenya has endeavored stringent law enforcement together with rehabilitation programmes for drug addicts. Indeed, the government through various agencies for instance NACADA, has put into action strategies to impede drug use parallel to the mission of attaining a drug-free society. According to NACADA (2008) the objectives of the NACADA 2009-2014 Strategic Plan, are: to strengthen the capacity of NACADA to coordinate the campaign against alcohol and drug abuse in Kenya; to develop a comprehensive prevention program for alcohol and drug abuse with a focus on demand reduction; to strengthen control mechanisms for alcohol and drug abuse focusing on supply suppression; to ensure quality treatment and rehabilitation for persons with substance use disorder; to undertake quality research on alcohol and drug abuse in Kenya; to guide policies and programmes; and to strengthen inter-sectoral coordination and collaboration.

A study on the contribution of selected psychological and social factors to relapse among recovering alcoholics in Asumbi and Jorgs Ark, Kenya is timely. Asumbi and Jorgs Ark rehabilitation centres have played a significant role in treatment and receive many relapsees. It was therefore important to get the contribution of factors to relapse from these rehabilitation centres. This study sought to give insights into development of comprehensive prevention, treatment and rehabilitation programmes. Likewise identifying factors that are associated with relapse after alcohol dependence treatment is likely to improve the effectiveness of treatment and prevent relapse.

1.2 Statement of the Problem

In Kenya, alcoholism has had serious negative effects. This has led to the establishment of treatment and rehabilitation services to tackle this problem. NACADA (2014) indicates that while 2.5 million Kenyans are in need of professional intervention in the form of treatment and rehabilitation there are only 77 facilities with an approximate bed capacity of less than 1000. Despite the increase in the number of centres and demand for the services offered in the country, there has been a simultaneous increase in the number of relapse cases. There is therefore a need to study the contribution of selected psychological and social factors to relapse among recovering alcoholics of Asumbi and Jorgs Ark rehabilitation centres, Kenya.

1.3 Purpose of the Study

The purpose of this study was to determine the contribution of selected psychological and social factors on relapse among recovering alcoholics in Asumbi and Jorgs Ark rehabilitation centres, Kenya.

1.4 Objectives of the Study

The study was guided by the following objectives:-

i) To determine the contribution of selected psychological factors on relapse among recovering alcoholics in rehabilitation centers in Kenya

ii) To determine the contribution of selected social factors on relapse among recovering alcoholics in rehabilitation centers in Kenya

iii) To establish the recovering alcoholics' preparedness to cope with risks to alcohol relapse after rehabilitation.

1.5 Research Questions

i) What is the contribution of the selected psychological factors to relapse among recovering alcoholics in rehabilitation centers in Kenya?

ii) What is the contribution of the selected social factors to relapse among recovering alcoholics in rehabilitation centers in Kenya?

iii) What is the recovering alcoholics' preparedness to cope with risks to alcohol relapse after rehabilitation?

1.6 Significance of the Study

In order to rehabilitate alcoholics, detailed studies are needed to assess the factors that contribute to relapse. This study was based on the fact that establishing the contribution of selected psychological and social factors to relapse is important in understanding the success and outcomes of rehabilitation programmes in addressing relapse among alcoholics. It was envisaged that the study may benefit NACADA, Ministry of Public Health, Mental health agencies, psychologists, counsellors, Non-Governmental organizations, policy makers, researchers, alcoholics in the study area and the country at large. NACADA may use these findings to strengthen the operations of rehabilitation centers in reducing relapse cases. The psychologists and counsellors may understand their critical role in the alcohol treatment and rehabilitation and make them more effective in the execution of their duties. The recovering alcoholics may use this study to better understand their alcohol problem, treatment and recovery. The society and country at large may understand their

expected role in the treatment and rehabilitation of alcoholics through enabling social re-integration. This information may be used in the improvement of alcoholism treatment and rehabilitation programmes in Kenya.

1.7 Scope of the Study

The study was confined to Asumbi Treatment Centre, Homabay County and Jorgs Ark rehabilitation centre located in Kiambu County Kenya. Asumbi was selected because it constantly has a high number of alcoholics. Jorgs Ark was also selected because it attracted an urban clientele. This study specifically targeted the available relapse cases and service providers in the centres because of their direct involvement in alcohol treatment and rehabilitation in country. This study concentrated on the selected psychological factors, social factors and the recovering alcoholics' preparedness to cope with risks of alcohol relapse after rehabilitation.

1.8 Assumptions of the Study

The study was carried out under the following assumptions:

i) That the rehabilitation centres will be ready to assist to give information for the study.

ii) That the respondents selected would willingly provide accurate and true information about themselves and the problem under study.

1.9 Limitations of the Study

The study was limited by the fact that some respondents found the study to be sensitive especially due to ethical issues involved and were suspicious as to the purpose of the study. The researcher reassured them of the confidentiality of the information provided and that the information obtained was purely for research purposes.

1.10 Operational Definition of terms

Alcoholism: a chronic, a progressive, potentially fatal disorder marked by excessive and usually compulsive drinking of alcohol leading to psychological and physical dependence or addiction (www.merriam-webster.com). In the study, it is the excessive, compulsive consumption of alcohol leading to addiction.

Alcohol relapse: This term refers to return to alcoholism after a period of abstinence.

Psychological factors: Psychological factors refer to thoughts, feelings and other cognitive characteristics that affect the attitude, behavior and functions of the human mind. (www.reference.com). In the study, it refers to aspects relating to behaviour or mental activity of the individual that contributes to alcohol relapse. The selected factors are, dwelling on resentments that provoke anger due to unresolved conflict, loss of a loved one, belief that alcohol gives relief for stress and feeling overwhelmed, confused and useless.

Rehabilitation centre: This refers to an authorized institution for the reception, maintenance, treatment and rehabilitation of drug abuse cases.

Recovering alcoholics: This refers to people who have earlier undergone treatment for alcoholism in a rehabilitation center and have been readmitted after going back to drinking.

Relapse: The return of ill health after an apparent or partial recovery (www.collinsdictionary.com). In the study, it means return to heavy alcohol use following a period of abstinence after alcoholism treatment.

Social factors: These are the factors that affect our thought and behaviour in social situations (www.psychologydictionary.org). In the study they are aspects relating to social interactions of a recovering alcoholic that contribute to relapse. The selected factors are, unsupportive family environment, spouse or family member who uses alcohol, isolation and not attending Alcoholic Anonymous meetings and hanging around alcoholic friends influencing relapse.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter focused on major aspects of concern, based on the research problem. The concepts examined in this chapter included alcoholism in Kenya, effects of alcohol abuse, relapse among alcoholics, factors contributing to relapse and alcohol relapse prevention. Finally psychoanalytic theory, social learning theory and conceptual frameworks to be used in this study have been examined.

2.2 Global Status Report on Alcohol and Health by World Health Organisation

According to World Health Organisation's global status report on alcohol and health published in 2011, hazardous and harmful use of alcohol is a major global contributing factor to death, disease and injury. It affects the drinker through serious negative effects such as alcohol dependence, liver cirrhosis, cancers and injuries and to the others through the dangerous actions of intoxicated people such as drunk driving and violence. The harmful use of alcohol results in 2.5 million deaths each year globally (WHO, 2011). According to World Health Organisation's global status report on alcohol and health published in 2011, hazardous and harmful use of alcohol is a major global contributing factor to death, disease and injury. It affects the drinker through serious negative effects such as alcohol dependence, liver cirrhosis, cancers and injuries and to the others through the dangerous actions of intoxicated people such as drunk driving and violence. The harmful use of alcohol results in 2.5 million deaths each year globally (WHO, 2011).

2.3 Alcoholism in Kenya

Alcoholism is a disease characterised by the repetitive and compulsive ingestion of alcohol in such a way as to result in interference with some aspect of the interpersonal relationships or other required societal adaptations. In this study relapse refers to going back to drinking after treatment for alcoholism in a rehabilitation center. Globally, the UNODC (2008) estimates that between 155 and 250 million people globally (3.5% - 5.7% of the population aged 15-64) used illicit substances. In Africa, except where alcohol is banned for religious reasons, large quantities are still being

brewed (Obot, 2000). However, regardless of improvement in technology, large amounts of unprocessed and unhygienic alcohol are still being consumed, especially by the poor World Health Organisation (WHO, 2004). In East Africa, Uganda has the highest per capita consumption of alcohol with 19.5 litres of absolute in the world (McKean, 2005) which is attributed to homemade alcohol. This is higher than Luxembourg with 17.54 litres of absolute alcohol, a country reputed to have a high prevalence of conventional alcohol in the world.

Kenya is described as a low-income developing country and drug use has not stabilized but is increasing as compared to the developed world. Studies on drugs and substance abuse did not provoke much concern in Kenya until the early 1990's. This may have been as a result of the perception that drug abuse was not a major problem among Kenya's populace. An assessment study by Mwenesi (1995) indicated an increasing trend of drug abuse. Alcohol was the most liberally used drug in Kenya followed by tobacco, bhang, miraa (khat), inhalants and description drugs (NACADA, 2002). According to a study done by NACADA, (2007) 14.2% of the Kenyan population aged 15-65 was consuming alcohol, miraa (5.5%), bhang (1%), cocaine (0.2%) and heroin (0.1%). In the Agricultural sector, alcohol (41%) was the most consumed drug followed by cigarettes (28.7%), local brews (17.9%) and bhang (6.5%) in both rural and urban areas.

According to WHO (2004), there are three classes of illicit brews in Kenya; fermented brews (traditional beer) such as busaa (a grain beer), mnazi (palm wine), muratina (from a local fruit known as muratina, sugar cane juice and honey) and indali (banana beer) from ripe bananas; distilled liquors or spirits such as chang'aa in Kenya and methylated brews, which are made by mixing non-beverage alcohols such as methanol, butanol, and propanol with other ingredients.

2.4 Effects of Alcohol Abuse

Traditionally, consumption of alcohol and use of tobacco and other drugs was a privilege for elders, especially male elders. Drug abuse did not exist in pre-colonial Africa because of the traditional rules and values of most African cultures which strictly prescribed the circumstances under which drugs and intoxicants could be obtained and consumed. The actual existence of drug abuse as a social problem was

rare because of the strong social structures that existed in form of traditions and taboos which were held to discourage the misuse of drugs and other substances.

In works written by Mwenesi, (1995) drug and substance abuse is rampant especially among the urban populations and this has resulted in social and economic strife. Findings showed that drugs have had serious negative effects especially on health, relationships with friends and family, academic progression, a significant cause of morbidity, mortality and poverty. Alcohol consumption was locally and internationally gaining recognition as a major risk factor for non-communicable diseases, infectious diseases and injury, disability and mortality caused by accidents, violence and crime. According to Brown and Tapert (2004), excessive drinking accounted for substantial cognitive impairment, many of them irreversible. Apart from such health consequences, alcohol consumption was also been linked with various negative social and economic outcomes.

Alcohol consumption was associated with gender-based violence, crime, poverty, child abuse and neglect. Alcohol abuse was regarded as a threat to family stability as it makes violent situations worse. According to Barlow (2000), alcohol was a threat to family life and to harmonious interpersonal relations. Jellinek (1969) observed that once a person becomes alcoholic, he or she no longer chooses how much to drink, and cannot predict the outcome because of an overwhelming compulsion to drink regardless of financial state and health condition in the family. He further stated that alcohol abuse makes the drinker lead a poor quality of life which impacts negatively on the family. In the United States, studies reveal that 11-52% of all assaults occur in domestic settings, 12-18% of the murders annually are committed by spouses, and domestic violence calls were among the most frequent and dangerous for police officers (NACADA, 2007). Alcohol abuse and domestic violence are major social problems in Kenya today. The abuse results from a breakdown of family values evident in traditional societies. Women whose partners abuse drugs often suffer injuries and even death.

There were several media reports of alcohol related deaths in Kenya as well as reports about women in parts of Kenya protesting about neglected sex roles by their alcoholic spouses (NACADA, 2011). Children living in violent families faced not only the risk of violence from parents, siblings or extended family members, but were also

subjected to emotional abuse and neglect as a result. Children living with parents who abuse alcohol lacked the natural interactions with them because the parents are either not there or the mood at home was not conducive for such interaction.

2.5 Relapse among Alcoholics

Relapse is the return to heavy alcohol use following a period of abstinence after alcoholism treatment. It is commonly accepted amongst workers in the field of alcoholism that the relapse rate among patients treated for alcoholism is extremely high. Research has found that approximately 35% and 58% of persons relapse at two weeks and three months respectively following treatment for alcoholism, and as high as 90% when relapse has been defined as the consumption of a single drink after treatment. Connors, Maisto and Donovan (1996) and Miller, Westerberg, Harris and Tonigan, (1996). Sheeran, (2012) explaned that occurrence of relapse was so prevalent that some clinicians accept relapse as an inevitable part of the disease of alcoholism.

According to recent studies by Kuria (2013), Factors associated with relapse and remission of alcohol dependent persons after community based treatment, it was likely for persons with more alcohol related problems to resume drinking in an attempt to avoid looking for solutions to their problems or reducing the tension associated with the presence of such problems. This was supported by findings that individuals who lack coping skills and self efficacy were more likely to relapse after alcohol treatment. Rehm *et al*. (2004) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) (2000).

In work done by Laudet, Stanick and Sands, (2009) research could investigate the users' perspective by examinations of psychosocial factors of potential relevance for how patients perceive the quality of the provided health services. The user perspective was often overlooked in addiction research. Service user satisfaction and perceptions of treatment and recovery processes were likely to be significant quality indicators of health services (Finney & Moos, 1984; Jones, Power & Dale, 1994). Perceptions related to the qualities of social processes and the information flow at the treatment facilities may have been associated with patient satisfaction (Jørgensen, Rømma & Rundmo, 2009). Such satisfaction may have related to treatment outcomes. (Carlson & Gabriel, 2001). McLellan and Hunkeler (1998) argued that patients' perceptions of

treatment were an important performance parameter for programme developers and clinicians. Therefore, it was of interest to obtain a further elaboration of which psychological factors, social factors and relapsed alcoholics preparedness to cope with risks to alcohol relapse after rehabilitation were important for patients' perceptions of treatment and recovery processes.

Relapse rates in addiction were high in many parts of the world and addictions continued to plague many drug users. In their research Dawson, Goldstein, and Grant, (2007) discovered that in America, prevalence of relapse in the general U.S. population was 51.0% across all ages. They did a study on adults 18 years and over in Maryland, USA, with individuals who met the Diagnostic and Statistical Manual fourth edition (DSM-IV) criteria of alcohol dependence with a focus on rates of relapse. Relapse was defined as recurrence of any alcohol use disorder symptoms and recurrence of Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) alcohol dependence. However, it was not clear from this study whether participants were treated for alcoholism or not, but it gave the general percentages.

Moos and Moos (2006) did a study in the Department of Veteran Affairs Health Services Research in the United States of America and found out that in treated samples, estimated long-term relapse rates varied between 20 and 80%, while short-term remission rates in the same samples were lower. The National Survey on Drug Use and Health (NSDUH, 2006) gave relapse rates at 50-90% in America, while the National Institute of Drug Abuse (NIDA, 2008) gave relapse rates of 41.4% of all admissions which involved alcohol use, and 40-60 % of drug addicted patients in America. These percentages for NIDA included all admissions in publicly funded substance abuse treatment programs, in which 23.1% were alcoholics. These statistics however did not give specific information on alcohol on its own but included relapse for substances of abuse in general. Moreover, it was not known whether or not the substance abusers were involved in inpatient or outpatient treatment programs.

Reports on alcoholism in England were committed to giving a broad picture on health issues relating to alcohol, such as the gender statistics on alcohol use, as well as effects on the body after extended alcohol use. According to National Health and Social Care (NHSC, 2009), 33% of men and 16% women in the general population were hazardous drinkers in 2007. Among adults aged 16 to 74, 9% of men and 4 % of

women showed some signs of alcohol dependence in the general population. This report did not give the criterion used to classify alcohol dependence or abuse and did not give relapse rates that would offer comparison to the findings of the study. Majority of this data was committed to discuss the general prevalence of alcoholism in these countries with the majority populations while none gave the alcohol relapse rates of treated alcoholics in inpatient rehabilitation programs.

Studies in Africa were mainly on prevalence of drug use in different geographical regions. A report by National Campaign against Drug Abuse Authority (NACADA, 2011) in Kenya was committed to presenting prevalence of alcohol in various parts of the country, but there were no reports available on relapse rates among individuals that had been treated of alcoholism. For instance, NACADA (2011) demonstrated that Central Province had the highest alcohol use rates (30 %) among the general population in the province. Community members reported that alcohol consumption in their areas was high and that *chang'aa* (a local brew) as well as traditional liquor were reported to be the most available and accessible types of alcohol (NACADA, 2011). Though the report indicated that dependency of alcohol consumption was higher in Central Kenya, the criterion for dependency was not provided for, and no relapse rates were given for the province.

In a study by Deveau, Tengia, Mutua, Njoroge, Dajoh and Singer (2010) in four outpatient rehabilitation programmes in Kenya from 2007 to the first quarter of 2010, one sample estimated the overall abstinence rates for three drugs: cannabis, alcohol, and heroine was estimated at 42%, while that for alcohol and cannabis alone was 46% of users. A second sample provided information about clients who attended an inpatient treatment services in addition to outpatient treatment. One of the four rehabilitation programs used for the study had the highest overall abstinence rate at 48% and highest abstinence rate among heroin users at 49%. Though the data provided information on relapse and combined effect of main drugs used in Kenya, there was no known source of data for relapse rates for alcohol alone in the country.

To add to the current literature on relapse in Kenya, the present study hoped to elucidate the prevalence rates in the country, more so on alcoholics who relapsed and were re-admitted in rehabilitation programs.

2.6 Factors that Contribute to Relapse

There are several factors that contribute to alcoholism. There are genetic, social and psychological factors such as anxiety, depression, or low self-esteem, unresolved conflicts in a relationship, and social factors such as alcohol availability, promotion of alcohol use and social acceptance, peer pressure and a demanding lifestyle. Alcohol dependence often has a general pattern, and it is estimated that 40-60% of the variance of risk is explained by genetic factors and 30-40% by environmental factors American Psychological Association (APA, 2013). According to Gossop, (1993) factors that played a role in relapse were numerous; however, these fell under three categories: medication intake and biological changes, responses, and variations, personal and psychological factors and social factors. For purposes of this study psychological and social factors were discussed.

2.6.1 Psychological Factors Contributing to Relapse

In the study by Kuria (2012), The Association between Alcohol Dependence and Depression before and after Treatment for Alcohol Dependence. There was a high prevalence rate (63.8%) of major depression among the alcohol-dependent persons. This was close to a higher limit (68%) of the estimated prevalence of co occurrence of depression and alcohol dependence (Halikas, Herzog, Mirassou & Lyttle, 1981). Mammo and Weinbaum (1993), assert that lack of services contributed to relapse. Conflicting work schedules, state of sobriety and distance to the treatment hospital were identified as significant factors that influenced treatment continuation. Formal investigations and clinical anecdotes consistently indicated poor outcome in the treatment of alcohol-related problems. The evidence indicated that no matter which philosophy assumed or which treatment method employed, high relapse rates were the norm. This observation prompted Litman (1979) to declare problem drinking a relapsing condition. The findings of the study showed that lack of services in the community led to relapse. Anyone who works with the alcoholic patients, whether providing counselling or medication services, requires a particular blend of professional and personal characteristics. Even though medication and counselling were beneficial in the treatment of alcoholic patients, there were limitations to the extent of available alcohol rehabilitation services in the community.

Heynman (1996) noted that rebellion, peer pressure, and portrayal of alcohol use as absolutely normal by the media, advertising agencies, and the sports industry were the major reasons for relapse. Usually teens started using alcohol because of curiosity and for experimentation. They wanted to know what alcohol does and to feel what it was like to be under the influence of alcohol. Unfortunately, this experimentation led to a psychological addiction. Some of the signs of alcohol abuse in teenagers were mood swings, appearing to be out of touch with their environment, being very intense and angry at times, changes in school and job performance, and overall changes in their behaviour, personality and physical appearance. For some alcohol abusers, psychological traits such as impulsiveness, low self-esteem and a need for approval prompted inappropriate drinking. Others drank alcohol so as to cope with emotional pain. Once people began drinking excessively, the problem perpetuated itself. Heavy drinking causes psychological changes that make more drinking the only way to avoid discomfort.

Freud provided a view on how personality develops through a series of five psychosocial stages. Failure to resolve conflicts at a particular stage can result in fixations, conflicts or concerns that persist beyond the developmental period in which they first occur. Fixation at the oral stage might produce an adult who was unusually interested in oral activities- eating, talking, smoking, and drinking. This leads to alcoholism. In this study the selected psychological factors were; dwelling on resentments that provoke anger and frustrations due to unresolved conflict, loss of a loved one, belief that alcohol gives relief for stress and feeling overwhelmed, confused and useless.

2.6.2 Social Factors Contributing to Relapse

According to Witkiewitz and Marlatt, (2004), few studies on relapse prevention focused on the individual factors, most studies, including research done by Copello, Velleman and Templeton, (2005) and Saatcioglu, Erim and Cakmak, (2006) recognized that the social context in which the alcoholic lived and recognized its significance to whether they remained abstinent from alcohol drinking or relapsed after treatment. Saatcioglu, Erim and Cakmak (2006) explain that social environment and especially the family context in which an alcoholic lived might be the main contributing factor to relapse.

Walitzer and Dearling, (2006) studies on gender differences in substance abuse relapse showed that for men, marriage could be a protective factor; for women, however, this status could act as an additional risk factor. In their study, Gender Differences in Alcohol and Substance Abuse Relapse, marriage was protective for men up to 15 months post-treatment, but was a contributory factor to relapse in women at 3 months, post-treatment These authors also cited a study indicating that men maybe more likely to relapse before a 3 month post-treatment follow up when living alone, than women living alone.

Arteaga, Chen and Reynolds, (2010) identify that fear of social isolation and peer rejection has a significant influence on drug and alcohol use by young people especially in circumstances where substance misuse is normative within youth culture. According to Reece (2007) research showed that contextual factors, such as occupational activities were relevant when considering relapse risk and substance use among individuals with substance use disorders. Lader (1995) referred to social factors as social rejection, social isolation and major life events such as unemployment and poverty. Social influences for the individual to drink alcohol were prevalent from family, peers and friends, and were included as risk factors in problem behaviour theory. Successfully maintaining a change in alcohol using behaviour was clearly influenced by the environment within which individuals operated. Alcohol abuse is a drinking pattern that results in adverse consequences that are both significant and recurrent.

Nurnberger (1990), observe that abstention and heavy drinking were more common among the unemployed than among the employed. Aimlessness, lack of structure for the day and loss of self-esteem led to increased drinking and the need to replace work; social networks also drew people to the pub. On the other hand economic studies showed that alcohol purchases were income sensitive and that when their income fell people tended to buy less alcohol. This led people to reduce consumption when they became unemployed. The association of heavy drinking and unemployment reflected a causal connection between lack of job and drinking or vice versa. Unemployment had a multitude of negative effects and the detrimental effect of unemployment was widespread. According to Broman, Hamilton and Hoffman (1990), unemployment was a social problem, and social problems occur when some piece of social behaviour

causes misery and needs collective action to solve it. In general, unemployment caused unhappiness, loneliness, a sense of helplessness and alcoholism.

There is evidence that family member's involvement in relapse prevention improves outcomes of the patients with alcohol dependence. According to Guerin (1976), the family was the primary and most powerful emotional system individuals belongs to, which shapes and continues to determine the course and outcome of our lives. As in any system, relationships and functioning (physical, social and emotional) are inter-dependent, and change in one system was followed by a compensatory change in other parts of the system. Such primary impact makes the family our greatest potential source of stress. In view of the fact that the family is a system whereby a change in one part of the system will bring about change in all of the other parts and in the system as a whole as subscribed by the systems theory, relapse is inevitable under stressful situations.

Work by Salmoiraghi and Salmoiraghi (1995) indicated that Peer pressure or Social influences for the individual to drink alcohol was prevalent from family, peers and friends, and were included as risk factors in problem behaviour theory. Perceptions that drinking alcohol is standard practice among peers and friends can promote drinking. Results of work by Donna and Colello, (1996) specified Hanging out with friends who still use alcohol as the number one relapse trap. Living with someone who is an active abuser of alcohol was another common trap.

In this study the selected social factors were; unsupportive family environment, having spouse or family member who still uses alcohol, isolating/not attending AA/NA meetings and hanging around old drinking friends.

2.7 Alcohol Relapse Prevention Programme

According to Larimer *et al,* (1999), alcohol relapse prevention is an important component of alcoholism treatment. Various treatments are available to help people with drug and alcohol problems. Depending on the circumstances, treatment involves an evaluation, a brief intervention, an outpatient programme or counseling, or a residential inpatient stay. Most programmes provide counseling, behavioral therapy, lectures, group therapy, discussion groups and other types of services to persons with drug and alcohol abuse disorders. Many various behavioral drug alcohol rehabilitation

programmes and centers have been shown to help patients achieve and maintain prolonged abstinence.

Marlatt, (1985) notes that alcohol relapse is a threat to any person who has suffered from alcoholism in their lifetime. Alcoholism is a disease and its hold on the body is extremely powerful. According to Brownell, Marlatt and Lichtenstein, (1986) and Marlatt, (1985) recovery from alcohol is a lifelong process. This is attributed to the changes that it produces in the brain of the client. The brains have been programmed such that pleasure has been associated primarily with alcohol. Therefore, contrary to many beliefs, once a person goes through alcohol detoxification and rehabilitation the fight doesn't end there. The individual who has suffered from alcoholism will face a life-long battle to remain sober. Fortunately with the right education and quality relapse treatment and prevention programme life-long sobriety is attainable.

It can be very easy for a recovering alcoholic to experience an episode of alcohol relapse. After rehabilitation, the individual will often return home to familiar settings, hang out with the same friends and associate in behavior that may have been part of the problem in the first place. Alcohol relapse treatment can provide the individual with the education they need to recognize the triggers that threaten all the hard work put in while in rehabilitation. Alcohol relapse prevention will give the individual the tools and the techniques they can use to combat the cravings and help avoid peer pressure (Brink, 2001; Marlatt, 1985)

According to Urell (2008), the primary goal of an alcohol relapse prevention programme was to educate people so that they could easily identify the triggers for relapse. A quality alcohol relapse prevention programme could help one limit the threat of these actions affecting recovery. Alcoholism and drug addiction was influenced by social, environmental, psychological and medical factors. There was no specific method of preventing relapse, but there were certain guidelines, that when followed, greatly increased the odds of achieving and maintaining long term recovery (Rollins, O'Neill & Davis, 2005; Hodgson, 1979).

Barrick and Connors, (2002) in their study on relapse prevention and maintaining abstinence in older adults with alcohol use disorders in 2002 noted that psychological treatment such as cognitive-behavioral therapy, group and family therapy and self-help groups were very effective in preventing relapses in older adults. These therapies

were of particular benefit to older adults because of emphasis on social support (Barrick & Connors, 2002).

Urell. (2008) Marlatt and Gordon, (1985) and Cummings, Gordon and Marlatt, (1980) observed that the following were the main signs and symptoms of relapse for recovering alcoholics and addicts, experiencing post-acute withdrawal, return to denial, avoidance and defensive behavior, starting to crisis build, becoming depressed, compulsive and impulsive behaviours, cravings, and loss of control

2.8 Theoretical Framework

The Psychoanalytic Theory and Social Learning Theory were used to explain the variables in this study.

2.8.1 Psychoanalytic Theory

Psychoanalytic theory by Sigmund Freud in the early 1900s identified three main sources of maladaptive behaviour; seeking sensuous satisfaction, conflict among the components of the self and fixation in the infantile past. According to psychoanalytic theory, ego performs several tasks that enable the individual to adapt to the world. As a result, people react differently to the same stressor- they may change or adapt. According to the psychoanalytic model of alcoholism, at each stage of our development appropriate defense emerges. According to Nash (1990), if those developed during childhood persist into adult life, they can cripple the individual, hinder career development, limit satisfying relationships and leave the individual vulnerable to breakdown in times of stress.

All the psychological theories of drug dependence assume that alcohol satisfies some important need. One early psychoanalytic theory (Psychoanalytic), suggested that children who are fixated at the oral stage are more prone to abuse alcohol later in life. Psychoanalysts theorize that oral fixation results when children are either frustrated in their oral dependent needs (unloving mother) or too easily satisfied by oral stimulation (overprotective mother). When stressed as adults, oral-dependent people are more likely to turn to alcohol to cope. Adams (1995) suggests that it is not deprived infants who develop oral traits but rather children (particularly boys) with overprotective mothers. Later in life such men will have a strong need to remain dependent on either their mother or another woman. When their needs become

frustrated, they become angry. Unable to deal with anger assertively, these people find that alcohol provides an effective way to reduce aggressive impulses. It has the additional advantage of hurting those people around them. Psychoanalytic theories make some intuitive sense since many alcoholics have immature social skills. They often turn to alcohol to help cope with life stresses. An alcohol dependent person may exhibit dependent traits; however, these traits are just as likely to lead to or result from chronic alcohol use. This theory makes us understand the contribution of selected psychological factors to relapse and enable appropriate interpretation of findings.

Cramer, (2000) in his study propounds evidence of many of the major defense mechanisms. Baumeister, Dale and Sommer, (1998) and Marcus-Newhall *et al*., (2000) as quoted by Wade, (2003) explained that reaction formation, projection and denial seemed to operate unconsciously to protect self esteem and reduce anxiety, and that people regularly displaced aggressive feelings onto innocent bystanders. This gave an insight into the contribution of psychological factors to relapse among recovering alcoholics in Kenya.

2.8.2 Social Learning Theory

People learn through observing others' behavior, attitudes, and outcomes of those behaviors. Most human behavior is learned through observation and modeling: from observing others, one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action (Bandura, 1977). Social learning theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences.

According to Bandura (1977), human beings are full of attitudes, beliefs and expectations that affect the way they acquire information, make decisions, reason and solve problems. These mental processes affect what individuals will do at any given moment and also more generally the personality traits they develop. Because people differ in their attitudes, expectations and perceptions, they can live through the same event and come away with entirely different lessons from it.

Several models of relapse that are based on social-cognitive or behavioral theories emphasized relapse as a transitional process. Annis (1986); Marlatt and Gordon,

(1985). According to these models, the relapse process began prior to the first post treatment alcohol use and continued after the initial use. Marlatt and Gordon's relapse model was based on social-cognitive psychology and incorporated both a conceptual model of relapse and a set of cognitive and behavioral strategies to prevent or limit relapse episodes. A central aspect of the model was the detailed classification of factors or situations that could precipitate or contribute to relapse episodes.

According to Meltzoff and Gopnik, (1993) as quoted by Wade (2003), behaviorists have always acknowledged the importance of observational learning, and have tried to explain it in stimulus response terms. Social-cognitive theorists believe that in human beings, observational learning cannot be fully understood without taking into account the thought processes of the learner. This guided this study in investigating the contribution of selected psychological and social factors to relapse among recovering alcoholics in Kenya.

2.9 Conceptual Framework

The conceptual framework in the present study illuminated the understanding of relapse variations predicted by contribution of psychological and social factors. Key variables for this study were categorized as independent variables, intervening variables and dependent variables.

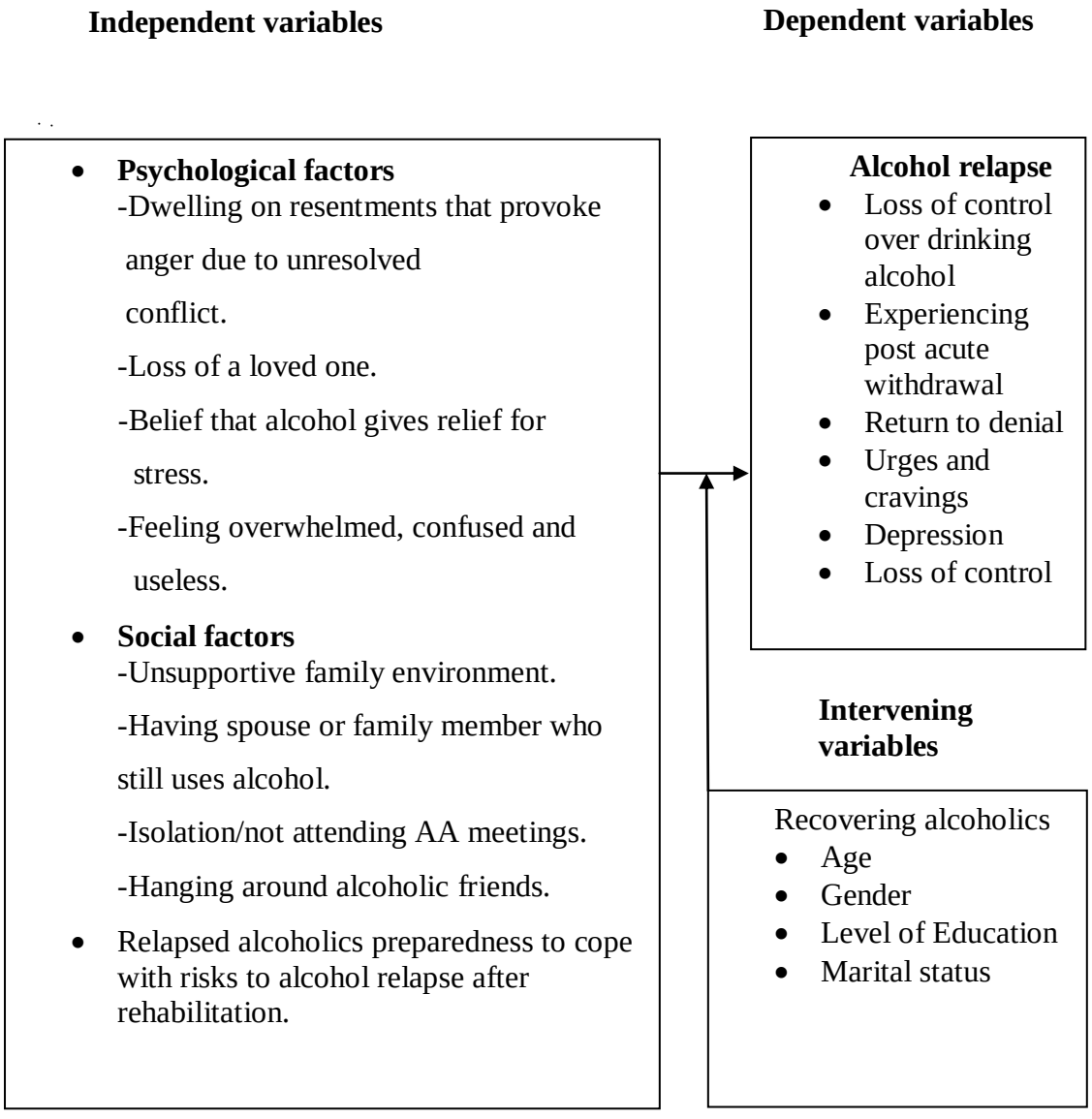

Figure 1: The Contribution of Selected Psychological and Social Factors to Relapse Among Recovering Alcoholics

Figure 1 illustrates the contribution of selected factors, which in this case is the independent variables (psychological, social factors and relapsed alcoholics preparedness to cope with risks to alcohol relapse), to the dependent variables, which

in this case refers to alcohol relapse. Moreover intervening variables influence the dependent variable. For example an intervening variable such as marital status may affect the relapsed alcoholics' depression. Intervening variables were studied alongside the other variables in the study. The intervening variables were, however, a limitation to the study and therefore generalization based on them should be made with caution.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research design, location of the study, population of the study, sampling procedure and sample size, instrumentation, data collection and data analysis methods.

3.2 Research Design

This study used the descriptive survey design in which opinions of recovering alcoholics and rehabilitation counselors were collected. A descriptive research determines and reports the way things are. This type of research attempts to describe such things as possible behavior, attitudes, values and characteristic (Mugenda & Mugenda, 1999). The design was chosen because it is an efficient method of collecting descriptive data regarding characteristic of a sample of a population, current practices and conditions or needs. The design also allows the researcher to gather information regarding the respondent's opinions and perceptions. Questionnaires were used to solicit the desired information related to contribution selected psychological and social factors to relapse among recovering alcoholics of Asumbi and Jorgs Ark Rehabilitation centres.

3.3 Location of the Study

The proposed study was undertaken at Asumbi Treatment Center and Jorgs Ark Rehabilitation Centre. Asumbi Treatment Center is located inside Asumbi Teachers College in Rangwe Division, Homabay County approximately 24 kilometers from Kisii town and 25 kilometers from Homabay Town. Jorgs Ark Rehabilitation Center is located at Tigoni in Limuru, Kiambu County approximately 25 kilometers from Nairobi City. These rehabilitation centres were selected due to the high prevalence of alcoholism in both Central and Western Kenya.

3.4 Target Population

In this study, the target population was 93, 80 recovering alcoholics and 13 rehabilitation counsellors in Asumbi and Jorgs Ark rehabilitation centres in Kenya.

The relapsed alcoholics were selected from both rehabilitation centres. The available recovering alcoholics and counsellors were used because they were in a better position to provide information relevant to investigating the contribution of selected psychological and social factors to relapse among recovering alcoholics in Asumbi and Jorgs Ark rehabilitation centres.

3.5 Sampling Procedure and Sample Size

Two rehabilitation centres, Asumbi and Jorgs Ark were purposively sampled. A deliberate selection of particular units of the universe for constituting a sample which represents the universe is supported by scholars such as Miller and Yang (2008) and Kothari (2004). Asumbi was chosen as it is in a rural area and has a large number of recovering alcoholics. Jorgs Ark rehabilitation centre was selected because unlike Asumbi it is located in an urban area and has fewer recovering alcoholics.

In order to determine a representative sample size of recovering alcoholics to be drawn from an estimated 58, this study adopted the formula of Israel (1992) for estimating a sample size, n, from known population size, N.

$$n = \frac{N}{1 + N(e)^2}$$

Where:

n = required sample size

N = the given population size of potential recovering alcoholics

e = the desired precision (e.g., 0.05 for 95% confidence level)

Substituting these values in the equation, estimated sample size (n) was:

$$n = \frac{80}{1 + 80(0.05)^2} = 67$$

Stratified sampling was used to ensure that the sample was proportionately and adequately distributed among the two centres according to the population of each

centre. Because of the manageable number of counselors, all 13 counsellors were selected, recovering alcoholics were 67. The final sample size was 80.

Table 1: Number of Recovering Alcoholics in the Rehabilitation Centers of Study

Rehabilitation Center	Target population	Sample size
Asumbi Treatment Center	63	51
Jorgs Ark Rehabilitation Center	17	16
Total	**80**	**67**

Source: Jorgs Ark and Asumbi Treatment Centre (2014)

Table 2: Number of Counsellors in the Rehabilitation Centers of Study

Rehabilitation Center	Target population	Sample size
Asumbi Treatment Center	9	9
Jorgs Ark Rehabilitation Center	4	4
Total	**13**	**13**

Source: Jorgs Ark and Asumbi Treatment Centre (2014)

3.6 Instrumentation

This study used questionnaires to obtain data for analysis. The research instruments (Appendix A and B) had sections I, II and III. Section I had the recovering alcoholics and counsellors personal details, section II had items on Psychological contribution, section III had items on social contribution and section IV had items on effectiveness of rehabilitation. The questions had a 5-point Likert scale to measure the objectives of the study. Chimi and Russel (2009) suggested that Likert scale is used in nearly all fields of scholarly and business research and in a wide variety of circumstances The 5-point Likert scale in this study ranged from ‘strongly agree’ to ‘strongly disagree’ and from ‘very good’ to ‘very poor’.

In view of the advantages, the study used two sets of questionnaires (recovering

alcoholics and rehabilitation counselors). The two questionnaires consisted of closed ended items. The questionnaires got information on personal background, alcohol relapse and rehabilitation history, contribution of selected psychological and social factors to relapse, and the level of preparedness achieved prior to completion of previous treatment. Both questionnaires had items seeking information from the respondents so as to gauge their opinions and perceptions on the contribution of selected psychological and social factors to relapse among recovering alcoholics.

3.6.1 Validity of Research Instruments

Validity is the degree to which results obtained from the analysis of data actually represent the phenomenon under study (Mugenda & Mugenda, 2003). Content validity of the research instruments was established in order to make sure that they reflect the content of the concepts (contribution of selected psychological and social factors to relapse) in question. Face validity was established by ensuring that items seem to be reasonably related to the perceived purpose of the test. Construct validity was done by defining the word relapse and testing it accordingly.

The researcher corrected the instruments and compared them with the set objectives. It was ensured that they contained all the information that answer the set of questions and address the objectives. Experts from the Department of Psychology, Counselling and Educational Foundations and supervisors were consulted to scrutinize the relevance of the questionnaire items against the set of objectives of the study. The instruments were then taken for piloting on a population that is similar to the target population

3.6.2 Reliability of Research Instrument

A pilot study was undertaken at Eden Village rehabilitation centre, Kiambu County which was not among those included in the actual study. Eight Samples of recovering alcoholics and counsellors were randomly selected. Piloting was aimed at estimating the reliability coefficient of the research instruments. In determining the internal consistency of the items, Cronbach coefficient alpha which is a general form of Kuder-Richardson (K-R) 20 formula was used. The piloting results indicated that the items on the questionnaire yielded a reliability of 0.58. These figures were relatively low and therefore considered undesirable measures of consistency levels. This was the

case because items could only have been considered desirable as a measure of consistency levels if they yielded a reliability consistency of 0.7 and above (Mugenda & Mugenda, 1999). Consequently the researcher modified the items by rephrasing to make them more reliable. This yielded a coefficient of 0.84 when piloting was repeated at Asumbi Karen rehabilitation centre. This coefficient was considered acceptable and reflecting the consistency levels. The higher coefficients implied that the items correlated highly among themselves, that is, there was consistency among the items in measuring the concept of interest. Thus the instrument was considered reliable.

3.7 Data Collection Procedure

Data collection is the gathering of information to serve or prove some facts (Kombo & Tromp, 2009). The researcher went to collect data after receiving permission from the Graduate school of Egerton University and National Commission for Science, Technology and Innovations (NACOSTI). Appointments were sought from the management of Asumbi and Jorgs Ark rehabilitation centres. The researcher then visited the selected centres before actual data collection for familiarization with the management. During the visit, the researcher informed management about the purpose of the intended study and booked appointments for data collection. On the data collection date the researcher administered the questionnaires to the recovering alcoholics and the rehabilitations' counsellors. Collection of data was done on one day for each rehabilitation centre and the respondents filled the questionnaires for themselves.

3.8 Data Analysis

Once data was collected and coding was done before analysis. Zikmund, Babin, Carr and Griffin, (2012) suggested that data analysis need to apply reasoning in order to understand the gathered information with the aim of determining consistent patterns and summarising the relevant details revealed in the investigation. The data collected was coded, keyed into Statistical Package for Social Science (SPSS) version 20.0 for windows computer software database, organised and checked for any errors that may have occurred during data collection. The data was analysed descriptively using the SPSS computer software and the results were presented in frequencies, percentages and tables.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents results on the contribution of selected psychological and social factors on relapse among recovering alcoholics of Asumbi and Jorgs Ark rehabilitation centres in Kenya. Data was collected from both recovering alcoholics and counsellors of both rehabilitation centres. The data obtained from the respondents was analysed using SPSS version 20.0 for windows.

4.2 Demographic Characteristics of Respondents

This section focuses on the demographic characteristics of the respondents in the study area. Such background information is essential in understanding the respondents of the study and also aids in analysing the study findings. Analysis of the respondents was done on the basis of their age, gender, marital status, and number of admissions to rehabilitation centres.

Table 3: Distribution of Recovering Alcoholics by Age

Age	Frequency	Percent
15-24 years	8	11.9
25-34 years	27	40.3
35-44 years	17	25.4
45-55 years	10	14.9
56 and above	5	7.5
Total	**60**	**100**

From Table 3 it can be observed that most of the sampled recovering alcoholics, 27 (40.3%) were aged between 25-34 years. This shows that most of the recovering alcoholics were struggling with alcoholism just after the adolescent stage which is characterized by peer pressure and rebellion. It is also noted that the lowest number of recovering alcoholics 5 (7.5%) were 56 years and above. In this advanced age the alcoholics would have recovered or died because of the fatal effects of alcoholism.

Table 4: Distribution of Recovering Alcoholics by Gender

Gender	Frequency	Percent
Female	7	10.4
Male	60	89.6
Total	**67**	**100**

Gender was used in the study to establish the distribution of recovering alcoholics' gender and which gender was affected the most. Table 4 indicates that most recovering alcoholics 60 (89.6%) were male. This concurs with the study by Emmite and Swierzewski, (2008) which indicates that men are more likely than women to use alcohol with some estimates indicating a ratio of 5:1.

Table 5: Distribution of Recovering Alcoholics by Level of Education

Level of education	Frequency	Percent
No formal education	1	1.5
Primary education	4	6.0
Secondary education	6	9.0
Middle level college	33	49.3
University	23	34.3
Total	**67**	**100**

Table 5 shows that the recovering alcoholic with no formal education was 1 (1.5%), primary education were 4 (6.0%), secondary educations were 6 (9.0%), middle level colleges were 33 (49.3%) and universities were 23 (34.3%). The reason for asking a question related to the level of education was to assess recovering alcoholics to their level of education. The computed mode (descriptive statistic) is 4 (table 3) which is equivalent to the highest frequency of 33 (table 5). Therefore most recovering alcoholics had middle level college education. Greenfield, Sugarman, Muenz, He and Weiss, (2003) assert that lower levels of education attainment before entry into treatment predicted shorter times to first drink and relapse in men and women.

Table 6: Distribution of Recovering Alcoholics by Marital Status

Age	Frequency	Percent
Single	27	40.3
Married	26	38.8
Separated	6	9.0
Divorced	6	9.0
Widowed	2	3.0
Total	**67**	**100**

Table 6 shows that most recovering alcoholics were single 27 (40.3%). Taking into consideration the ages of the recovering alcoholics, it is expected that all of them would be in marriage. Most recovering alcoholics were above the age of 25 years. This indicates that most recovering alcoholics did not get married because alcoholism severely interferes with personal development.

Table 7: Distribution of Recovering Alcoholics by the Number of Times Admitted in Alcohol Rehabilitation Centres

No. of Times	Frequency	Percent
One	43	64.2
Two	13	19.4
Three	7	10.4
Above three	4	6.0
Total	**67**	**100**

Table 7 shows that recovering alcoholics who had been to rehabilitation once were 43 (64.2%). In this study it is presumed that the clients were brought to the rehabilitation centres after they had tried to stop drinking severally but without success. This in itself is evidence of relapse. A total of 24 (35.8%) recovering alcoholics had been in rehabilitation centres more than once.

4.3 Counsellors Demographic Characteristics

The following demographic and background characteristics of counsellors were collected and analyzed as follows: age, gender, experience in rehabilitation counselling, level of training in counselling and percentage of relapse in the centre.

Table 8: Distribution of Counsellors by Age

Age	Frequency	Percent
15 to 24 years	1	7.7
25 to 34 years	9	69.2
35 to 44 years	3	23.1
46 to 55 years	0	0
56 and above	0	0
Total	**13**	**100**

Table 8 shows that most counsellors were in the age of 25-34 years. These counsellors were thus just graduated from college and had fresh skills and knowledge in counselling.

Table 9: Distribution of Counsellors by Gender

Gender	Frequency	Percent
Female	3	23.7
Male	10	76.9
Total	**13**	**100**

Gender was used in the study to establish the distribution of counsellors' gender. Table 9 shows that most of the counsellors were male.

Table 10: Distribution of Counsellors by Years of Experience in Counselling

Years of Experience	Frequency	Percent
0-1	4	30.8
1-2	1	7.7
2-5	4	30.8
5-10	2	15.4
Over 10 years	2	15.4
Total	**13**	**100**

Table 10 indicates that most counsellors with 2 years experience in counselling and above were 8 (61.5%); 2-5 years were 4 (30.8%), 5-10 were 2 (15.4%) and Over 10 years were 2 (15.4%). Only 4 (30.8%) had less than 1 year of experience. This shows

that most counsellors had adequate experience to deal with all issues in rehabilitation counselling.

Table 11: Distribution of Counsellors by Level of Education in Counselling

Level of Education	Frequency	Percent
Certificate	6	46.2
Diploma	4	30.8
Bachelors	3	23.0
Masters	0	0
PhD	0	0
Total	**13**	**100**

The question on counsellors' level of education in counselling was used in the study to establish the level of education of counsellors. Table 11 indicates that counsellors who had a certificate in counselling were 6 (46.2%). There were only 3 (23.0%) with bachelor's degrees. This indicates that most counsellors had basic education in counselling.

Table 12: Distribution of Counsellors Responses on Percentage of Relapse in the Rehabilitation Centre

Percentage	Frequency	Percent
0-20	3	23.1
20-40	8	61.5
40-60	1	7.7
60-80	1	7.7
Total	**13**	**100**

Table 12 indicates that most counsellors 8 (61.5%) viewed percentage relapse in the centres as 20-40 percent. The question on counsellors' view on percentage of relapse in the centres was to establish the rate of relapse in Asumbi and Jorgs Ark rehabilitation centres. This concurs with research in America by the National Survey on Drug Use and Health (NSDUH, 2006) that gives relapse rates at 50%-90%. In Kenya the National Campaign against Drug Abuse Authority (NACADA) has indicated that relapse rates are very high though their research was on areas with high drug use and drug of choice. NACADA (2011).

4.4 Psychological Factors Contributing to Relapse

In order to assess the contribution of selected psychological factors on relapse among recovering alcoholics in rehabilitation centers in Kenya, four psychological factors were considered; Dwelling on resentments that provoke anger due to unresolved conflict, loss of a loved one, belief that alcohol gives relief for stress and feeling overwhelmed, confused and useless. The views of both the recovering alcoholics and the rehabilitations counsellors were collected. This study examined the contribution of each of these psychological factors separately and cumulatively.

The research question aimed at establishing the contribution of selected psychological factors to relapse among recovering alcoholics in Asumbi and Jorgs Ark rehabilitation centres in Kenya.

Table 13: Means and Standard Deviations of Recovering Alcoholics and Counsellors Responses on Contribution of Psychological Factors to Relapse

Factors	Mean	Std. Deviation
Dwelling on resentments that provoke anger due to unresolved conflict	3.77	0.439
Loss of a loved one	3.08	0.760
Belief that alcohol gives relief for stress	2.69	1.494
Feeling overwhelmed, confused and useless	3.46	0.660

The means and standard deviations were used in analysis and discussions of all recovering alcoholics and counsellors responses on contribution of psychological factors to relapse.

Table 14: Recovering Alcoholics and Counsellors Responses on Dwelling on Resentments that Provoke Anger Due to Unresolved Conflicts Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Strongly Agree	23	34.3	10	76.9
Agree	30	44.8	3	23.1
Uncertain	5	7.5	0	0
Disagree	4	6.0	0	0
Strongly Disagree	5	7.5	0	0
Total	**67**	**100**	**13**	**100**

Table 14 shows that most recovering alcoholics and counsellors, 53 (79.1%) and 13 (100%) respectively, agreed that dwelling on resentment that cause anger due to unresolved conflict contributed to relapse. The computed mean (3.77) in table 13 therefore shows that most recovering alcoholics and counsellors agreed that dwelling on resentment that cause anger due to unresolved conflict contributed to relapse. This concurs with research by Snyder and Whisman, (2007) which found out that interpersonal problems were expected to have an indirect contribution to increased substance use because such problems could facilitate psychological distress.

Table 15: Recovering Alcoholics and Counsellors Responses on Loss of a Loved One Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Strongly Agree	14	20.9	4	30.8
Agree	18	26.9	6	46.2
Uncertain	10	14.9	3	23.1
Disagree	16	23.9	0	0
Strongly Disagree	9	13.4	0	0
Total	**67**	**100**	**13**	**100**

Table 15 indicates that 32 (47.8%) of recovering alcoholics and 10 (77%) of the counsellors agreed that loss of a loved one contributed to relapse. Three (23%) of the counsellors were uncertain because they may have not known about grief affecting their clients. The computed mean (3.08) in table 13 indicates that most recovering alcoholics and counsellors agreed that loss of a loved one contributed to relapse this concurs with a study by Conners and Franklin (2000) that the establishment of adaptive coping strategies for life events such as grief was important in maintaining sobriety. Another study by Wallace as cited in Connors, Donovan and DiClemente (2001) also found that painful emotional states were a precursor to relapse.

Table 16: Recovering Alcoholics and Counsellors Responses on Belief that Alcohol gives Relief for Stress Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Strongly Agree	10	14.9	5	38.5
Agree	21	31.3	4	30.8
Uncertain	8	11.9`	1	7.7
Disagree	16	23.9	1	7.7
Strongly Disagree	12	17.9	2	15.4
Total	**67**	**100**	**13**	**100**

The question on belief that alcohol gives relief for stress was used in the study because it contributes to relapse. Table 16 shows that 9 (69.3%) counsellors agreed that recovering alcoholics believe that alcohol gives relief for stress. The computed mean (2.69) in table 13 indicates that most recovering alcoholics and counsellors agree that belief that alcohol gives relief for stress contributed to relapse. This is in agreement with studies by Kendler, Heath, Neale, Kessler and Eaves (1993) and Harrington, Fudge, Rutter, Pickles and Hill (1990) that stress leads to depression and that there is evidence of a persistent association between alcohol use disorders and major depression.

Table 17: Recovering Alcoholics and Counsellors Responses on Feeling Overwhelmed, Confused and Useless Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Strongly Agree	23	34.3	7	53.8
Agree	26	38.8	5	38.5
Uncertain	5	7.5	1	7.7
Disagree	6	9.0	0	0
Strongly Disagree	7	10.4	0	0
Total	**67**	**100**	**13**	**100**

It is evident in the data in Table 17 that 49 (73.1%) recovering alcoholics and 12 (92.3%) counsellors agreed that feeling overwhelmed, confused and useless contributed to relapse. The computed mean (3.46) in table 13 therefore indicates that most recovering alcoholics and counsellors agree that feeling overwhelmed, confused and useless contributed to relapse. This concurs with studies by Goldenberg and Goldenberg (2013) that autonomy helps individuals in pursuing their life goals that they believe in. It assists in reducing confusion and feeling useless and is a very important tool for any person to overcome behavioural problems.

4.5 Social Factors Contributing to Relapse

In order to assess the contribution of selected social factors on relapse among recovering alcoholics in rehabilitation centers in Kenya, four social factors were considered; unsupportive family environment, spouse or family member who uses alcohol, isolation and not attending AA meetings and hanging around alcoholic friends contributing to relapse. This study will examine the contribution of each of these social factors separately and cumulatively. The research question aimed to establish the contribution of selected social factors on relapse among recovering alcoholics in Asumbi and Jorgs Ark rehabilitation centres in Kenya.

Table 18: Means and Standard Deviations of Recovering Alcoholics and Counsellors Responses on Social Factors Contributing to Relapse

Factors	Mean	Std. Deviation
Unsupportive family environment	3.23	0.599
Having spouse or family member who still uses alcohol	2.69	1.251
Isolation/ not attending AA meetings	3.15	0.987
Hanging around alcoholic friends	3.62	0.506

The means and standard deviations were used in analysis and discussions of all recovering alcoholics and counsellors responses on social factors contributing to relapse.

Table 19: Recovering Alcoholics and Counsellors Responses on Unsupportive Family Environment Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	18	30.8	4	30.8
Agree	23	61.5	8	61.5
Uncertain	7	7.5	1	7.7
Disagree	14	20.9	0	0
Strongly Disagree	5	7.5	0	0
Total	**67**	**100**	**13**	**100**

Table 19 shows that 41 (92.3%) recovering alcoholics and 12 (92.3%) counsellors agree that unsupportive family environment contributed to relapse. The computed mean (3.23) in table 18 therefore indicates that most counsellors agreed that unsupportive family environment contributed to relapse. This is in agreement with a study by Templeton, Velleman and Russell (2010) that family members' involvement in therapy has a positive influence on the recovering alcoholic's motivation to change and maintain abstinence. Ibrahim and Kumar (2009), further explains that communities often view substance abusers as negative influences and distance

themselves leaving the recovering alcoholic feeling rejected and isolated which lead them to relapse.

Table 20: Recovering Alcoholics and Counsellors Responses on Spouse or Family member who still Uses Alcohol Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Strongly Agree	10	14.9	3	23.1
Agree	13	19.4	7	53.8
Uncertain	6	9.0	0	0
Disagree	25	37.3	2	15.4
Strongly Disagree	13	19.4	1	7.7
Total	**67**	**100**	**13**	**100**

Table 20 shows that 10 (76.9%) counsellors agree that spouse or a family member who still uses alcohol contributed to relapse. In the contrary, more than half the recovering alcoholics 38 (56.7%) disagreed. The reason is that among the recovering alcoholics 41 (61.2%) were not married thus the irrelevance of the question to them. However, Antoine, Christophe and Nandrino (2009), affirms that family treatment bring about marital satisfaction for alcoholics because it improves communication and positive couple functioning which in turn reflects positively on recovery.

Table 21: Recovering Alcoholics and Counsellors Responses on Isolation / Not Attending AA Meetings Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Strongly Agree	12	17.9	6	46.2
Agree	23	34.3	4	30.8
Uncertain	14	20.9	2	15.4
Disagree	13	19.4	1	7.7
Strongly Disagree	5	7.5	0	0
Total	**67**	**100**	**13**	**100**

Table 21shows that 10 (77%) counsellors agree and 35 (52.1%) recovering alcoholics agree that isolation and failure to attend AA meetings contributed to relapse. The computed mean (3.15) in table 18 shows that most recovering alcoholics and counsellors agreed that isolation and failure to attend support groups like AA contributed to relapse. In agreement with this study, Wilbourne and Miller (2003), confirm the importance of post treatment by asserting that there is a need for sustained pre-treatment, in-treatment, and post-treatment recovery support services.

Table 22: Recovering Alcoholics and Counsellors Responses on Hanging out with Alcoholic Friends Contributing to Relapse

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Strongly Agree	31	46.3	8	61.5
Agree	26	38.8	5	38.8
Uncertain	5	7.5	0	0
Disagree	4	6.0	0	0
Strongly Disagree	1	1.5	0	0
Total	**67**	**100**	**13**	**100**

Table 22 indicates that 57 (85.1%) recovering alcoholics and 13 (100%) counsellors agree that hanging out with alcoholic friends contributes to relapse. The computed mean (3.62) in table 18 shows that most recovering alcoholics and counsellors agree that hanging out with alcoholic friends contributed to relapse. Results of research by Marlatt and George (1984) explain that social pressure directly contributes to relapse. Hunter-Reel, McCrady and Hildebrandt (2009) further expound that codependent behaviours like pouring out drinks, persuasion, emotional pleading to change, threats to leave, drinking along with him/her, and nagging have been found to increase drinking.

4.6 Recovering Alcoholics Preparedness to Cope with Risks to Alcohol Relapse After Rehabilitation

The objective was aimed at determining the recovering alcoholics' preparedness to cope with risks to alcohol relapse after rehabilitation. This was done by evaluation of effectiveness of skills training in which the recovering alcoholics are equipped with so as to cope with risk to alcohol relapse after rehabilitation. The respondents were to rate the different types of skills on a five likert scale whether the services were effective or not.

Table 23: Means and Standard Deviations on Recovering Alcoholics and Counsellors Responses on Preparedness by Effectiveness of Skills Training

Skills	Mean	Std. Deviation
Relapse prevention	3.31	0.630
Greif management	2.62	0.961
Decision making	3.46	0.660
Problem solving	3.23	0.725
Time management	3.00	0.816
Stress management	3.31	0.630
Adherence to treatment plans	3.54	0.660
Anger and frustration management	3.46	0.660

The means and standard deviations were used in analysis and discussion of all recovering alcoholics and rehabilitations counsellors responses on preparedness by effectiveness of skills training.

Table 24: Recovering Alcoholics and Counsellors Responses on Relapse Prevention

Response	**Recovering Alcoholics**		**Counsellors**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	16	23.9	5	38.5
Good	21	31.3	7	53.8
Fair	21	31.3	1	7.7
Poor	6	9.0	0	0
Very poor	3	4.5	0	0
Total	**67**	**100**	**13**	**100**

Table 24 above shows that 37 (55.2%) recovering alcoholics and 12 (92.3%) counsellors rated effectiveness relapse prevention skill training as good and very good. The computed mean (3.31) in table 23 indicates that most recovering alcoholics and counsellors agree that relapse prevention was done well and will contribute to better treatment results. This study concurs with research by Moos and Finney (1983) which explains that relapse prevention seeks to give recovering alcoholics coping strategies so as to prevent a lapse from becoming a relapse. They expound that beliefs and expectations about a lapse may influence continued use and that a lapse is a normal part of acquiring abstinence and constitute opportunities for new learning.

Table 25: Recovering Alcoholics and Counsellors Responses on Grief Management

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	6	9.0	3	23.1
Good	18	26.9	3	23.1
Fair	18	26.9	6	46.2
Poor	18	26.9	1	7.7
Very poor	7	10.4	0	0
Total	**67**	**100**	**13**	**100**

Table 25 shows 24 (33.9%) recovering alcoholics and 6 (46.2%) counsellors rated grief management as good and very good. 25 (37.3%) recovering alcoholics rated grief management as poor and very poor. The computed mean (2.62) indicates that grief management was not effectively covered in the programme. This will affect treatment results negatively.

Table 26: Recovering Alcoholics and Counsellors Responses on Decision Making Skills

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	13	19.4	7	53.8
Good	22	32.8	5	38.5
Fair	21	31.3	1	7.7
Poor	6	9.0	0	0
Very poor	5	7.5	0	0
Total`	**67**	**100**	**13**	**100**

As evident in Table 26 that 35 (52.2%) recovering alcoholics and 12 (92.3%) counsellors rated preparedness by effectiveness of decision making skills as very good and good. The computed mean (3.46) in table 23 indicates that recovering alcoholics and counsellors agreed that decision making skills were effectively covered. This positively contributes to recovery.

Table 27: Recovering Alcoholics and Counsellors Responses on Problem Solving Skills

Response	**Recovering Alcoholics**		**Counsellors**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	9	13.4	5	38.5
Good	26	38.8	6	46.2
Fair	18	26.9	2	15.4
Poor	9	13.4	0	0
Very poor	5	7.5	0	0
Total	**67**	**100**	**13**	**100**

Table 27 shows that 11 (84.7%) counsellors and 34 (52.2%) recovering alcoholics responded with good and very good. The computed mean (3.23) in table 23 therefore shows that most counsellors confirm that the problem solving skills were effectively covered. This study concurs with studies by Botvin and Kantor (2007), they explain that alcoholics do not have sufficient skills, particularly life skills when encountering daily life problems. Effective training of life skills plays an important role in addiction treatment

Table 28: Recovering Alcoholics and Counsellors Responses on Time Management Skills

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	22	32.8	4	30.8
Good	21	31.1	5	38.5
Fair	17	25.4	4	30.8
Poor	5	7.5	0	0
Very poor	2	3.0	0	0
Total	**67**	**100**	**13**	**100**

Table 28 shows that 43 (63.9%) recovering alcoholics and 9 (69.3%) counsellors rated time menagement skills training as being good and very good. The computed mean (3.00) in table 23 indicates that time management skills were effectively covered and has a positive contribution towards treatment results.

Table 29: Recovering Alcoholics and Counsellors Responses on Stress Management

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	7	10.4	5	38.5
Good	18	26.9	7	53.8
Fair	22	32.8	1	7.7
Poor	14	20.9	0	0
Very poor	6	9.0	0	0
Total	**67**	**100**	**13**	**100**

It is clear from Table 29 that 12 (92.3%) counsellors rated stress management as good and very good and 6 (9%) recovering alcoholics rated it as very poor. The computed mean (3.31) in table 23 therefore indicates that stress management was effectively covered. This is in agreement with the study by Hooley and Gotlib, (2000) who

explain that psychosocial stress is a risk factor for relapse because recovering alcoholics can easily go back to drinking as a stress management strategy. It is for this reason that it is very important that relapse prevention programs should have a variety of effective strategies for stress management for recovering alcoholics.

Table 30: Recovering Alcoholics and Counsellors Responses on Adherence to Treatment Plans

Response	**Recovering Alcoholics**		**Counsellors**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	14	20.9	8	61.5
Good	19	28.4	4	30.8
Fair	24	35.8	1	7.7
Poor	5	7.5	0	0
Very poor	5	7.5	0	0
Total	**67**	**100**	**13**	**100**

It is evident from data in Table 30 that 12 (92.3%) counsellors rated adherence to treatment plans as good and very good. 57 (85%) recovering alcoholics also rated it from fair to very good. The computed mean (3.54) in table 23 shows that adherence to treatment plans was effectively covered. According to U.S. department of Health and Human Sciences (2007), it is vital for family members to maintain a drug free environment for the recovering alcoholic to maintain sobriety. This concurs with the study because one of the aspects of adherence is keeping a drug free environment.

Table 31: Recovering Alcoholics and Counsellors Responses on Anger and Frustration Management

Response	Recovering Alcoholics		Counsellors	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Very good	9	13.4	7	53.8
Good	18	26.9	5	38.5
Fair	19	28.4	1	7.7
Poor	13	19.4	0	0
Very poor	8	11.9	0	0
Total	**67**	**100**	**13**	**100**

Table 31 shows that 12 (92.3%) counsellors indicated that effectiveness of anger and frustration management skills were rated as good and very good. The computed mean (3.46) in table 23 indicates that most recovering alcoholics and counsellors agree that training on anger and frustration management was effective. According to Spurgeon, McCarthy-Tucker and Waters (2000) life-skills deficits are also commonly associated with relapse. These deficits include the inability to manage anger and frustrations and inappropriate reactions to stress. When these deficits are dealt with we expect success in treatment.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of this study was to establish the contribution of selected psychological and social factors on relapse among recovering alcoholics in Asumbi and Jorgs Ark rehabilitation centres, Kenya. In the study, section one of the questionnaire for both recovering alcoholics and counsellors was used to collect information concerning recovering alcoholics and counsellors personal details, section two gathered information on psychological factors, section three on social factors and four on recovering alcoholics preparedness to cope with risks to alcohol relapse after rehabilitation. This chapter therefore presents summary of the major findings, the conclusions reached as well as implications of the findings. In addition it highlights recommendations and suggestions for further research.

5.2 Summary of the Study

Based on the objectives, research questions and analysis of the study in chapter four, the following major findings were established:

i. Selected psychological factors contribute to relapse of recovering alcoholics. Specifically, dwelling on anger due to unresolved conflict contributed the most to relapse of recovering alcoholics. Both Feeling overwhelmed, confused and useless and belief that alcohol is a major stress reliever contributed substantially while there was least contribution of loss of a loved one on relapse of recovering alcoholics.

ii. Selected social factors contribute to relapse of relapsed alcoholics. Specifically, hanging out with alcoholic friends contributed the most while unsupportive environment, Isolation and not attending AA meetings and spouse or a family member using alcohol contributed substantially to relapse of recovering alcoholics.

iii. Relapsee's preparedness to cope with risks to alcohol relapse after rehabilitation contributed to relapse of recovering alcoholics. This was measured by levels in which certain skills were attained. The tested skills

were time management, relapse prevention, adherence to treatment plans, decision making skills, problem solving skills, anger and frustration management and finally grief management.

5.3 Conclusions

Based on the findings from chapter four, the following conclusions have been drawn:

i. There is a strong coherence between dweling on anger due to unresolved conflict and relapse among recovering alcoholics of Asumbi and Jorgs Ark rehabilitation centres.

ii. Among the selected social factors, hanging out with alcoholic friends emerged to be the major contributor to relapse among recovering alcoholics of Asumbi and Jorgs Ark rehabilitation centres.

iii. In view of recovering alcoholics' preparedness to cope with risks to alcohol relapse after rehabilitation, the respondents indicated that all the skills were taught effectively.

5.4 Recommendations

In view of the findings and conclusions made the following recommendations have been made:

i. Recovering alcoholics should be trained by rehabilitation counsellors on how to deal with anger due to unresolved conflict because it was a major reason for relapse. Rehabilitation centres are encouraged to strengthen individual counselling so as to solve this problem.

ii. Recovering alcoholics should be trained by rehabilitation counsellors on how to make and sustain meaningful relationships so as to counter hanging out with alcoholic friends that greatly contributed to relapse. Counsellors should stress the need for a change of friends and lifestyle.

iii. The role of support groups like Alcoholic Anonymous should be emphasised by rehabilitation centres and this should be communicated to the recovering alcoholics.

iv. There is need for government and relevant authorities to intervene by providing effective alcohol and drug abuse prevention and treatment programmes that are specially designed to target the youth who were the most affected in the study.

5.5 Suggestions for Further Research

The researcher recommended that there is need for a comparative study on the contribution of selected psychological and social factors on relapse of recovering alcoholics in government sponsored, mission sponsored and privately owned rehabilitation centres.

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APPENDICES

APPENDIX A: QUESTIONNAIRE FOR RECOVERING ALCOHOLICS

Dear Respondent,

My name is Kositany Conrad, a student at Egerton University undertaking a Masters Degree in Psychology and Counselling. I am doing a research on *the contribution of psychological and social factors on relapse among recovering alcoholics of Asumbi and Jorgs Ark rehabilitation centers in Kenya.* You have been selected to participate in this study because you are in this facility. Participation in this study is voluntary and not linked to the services you receive in this facility. Do not write your name anywhere and your responses will not be linked to you. The success of this study depends on your truthfulness and honest responses to all the questions asked. For questions that apply, tick (✓) appropriately unless instructed otherwise. For those that do not apply use cross mark (×) unless instructed otherwise. There is no "right" or "wrong" answers. Please tick or write what you do or know. The responses you give will be treated with utmost confidentiality.

Thank you.

Section One: Recovering Alcoholics Personal Details

1. How old are you? Tick (✓) appropriately

Below 13 years ☐ 14 to 18 years ☐

19 to 25 years ☐ 26 to 35 years ☐

36 to 45 years ☐ Over 45 ☐

2. Gender Male ☐ Female ☐

3. What is your marital status? Tick (✓) appropriately

Single ☐ Separated ☐ Widowed ☐

Married ☐ Divorced ☐

4. What is your highest level of education?

No formal education ☐

Primary education ☐

Secondary education ☐

Middle level college ☐

University Bachelors ☐ Masters ☐ PhD ☐

5. How many times have you been in an alcohol rehabilitation centre?

Once ☐

Two ☐

Three ☐

Over 3 ☐

Section Two: Recovering Alcoholics Psychological Contribution Scale

Please read the following statements and tick (✓) to Agree or disagree to how these psychological factors influenced your relapse.

Psychological factors	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
6. Do you think anger and frustrations due to unresolved conflicts caused your relapse?					
7. Do you think the Loss of a loved one led you back to drinking alcohol?					
8. Do you believe that alcohol is a major stress reliever?					
9. Do you think feeling overwhelmed, confused and useless contributed greatly to your relapse?					

Section Three: Recovering Alcoholics Social Influence Scale

Please read the following statements and tick (✓) to Agree or disagree to how these social factors contributed to your relapse.

Social factors	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
10. Is unsupportive family environment one of the reasons why you relapsed?					
11. Did a spouse or family member who still uses					

alcohol make you relapse?					
12. Did isolating and not attending support groups lead you to relapse?					
13. Do you think that hanging around old drinking friends influenced your relapse?					

Section four: Rehabilitation Effectiveness Scale

Please read the following and rate how well you were taught the following skills in rehabilitation before you relapsed.

Skills	Very Good	Good	Fair	Poor	Very Poor
14. Relapse Prevention					
15. Grief management					
16. Decision making skills					
17. Problem solving skills					
18. Time management skills					
19. Stress management					
20. Adherence to treatment plans					
21. Anger and frustration management					

APPENDIX B: QUESTIONNAIRE FOR REHABILITATION COUNSELLORS

Dear Respondent,

My name is Kositany Conrad, a student at Egerton University undertaking a Masters Degree in Psychology and Counselling. I am doing a research on *The Contribution of* Selected *Psychological and Social Factor on Relapse among Recovering Alcoholics in Asumbi and Jorgs Ark rehabilitation centers, Kenya.* You have been selected to participate in this study because you are in this facility. The participation in this study is voluntary and not linked to the services you receive in this facility. Do not write your name anywhere and your responses will not be linked to you. The success of this study depends on your truthfulness and honest responses to all the questions asked. For questions that apply, tick (✓) appropriately unless instructed otherwise. For those that do not apply use cross mark (×) unless instructed otherwise. There is no "right" or "wrong" answers. Please tick or write what you do or know. The responses you give will be treated with utmost confidentiality.

Thank you.

Section One: Counsellors Personal Details

1. Age (complete in years) ☐

2. Gender Tick (✓) appropriately Male ☐ Female ☐

3. What is the highest level of education that you completed

No formal education ☐

Primary education ☐

Secondary education ☐

Middle level college ☐

University Bachelors ☐ Masters ☐ PhD ☐

4. How many years of experience do you have in Rehabilitation counselling?

0-1 year ☐ 1-2 years ☐ 2-5 years ☐ 5-10 years ☐ over10years ☐

5. Are you a recovering alcoholic? Yes ☐ No ☐

6. Do you have any training in counseling? Yes ☐ No ☐

7. If yes what is your level of training in counseling?

Certificate ☐ Diploma ☐

Bachelor's Degree ☐ Master's Degree ☐

PhD ☐

8. After the rehabilitation programme where does the centre discharge the clients to?

Family ☐ Community ☐ Self-help groups (AA/NA) ☐

Any other (specify) _____

9. From experience, what is the percentage of relapse in this centre?

0-20% ☐ 20-40% ☐ 40-60% ☐ 60-80% ☐ 80-100% ☐

Section Two: Counsellors Psychological Contribution Scale

Please read the following statements and tick (✓) to Agree or disagree to how these psychological factors contributed to relapse.

Questions Psychological factors	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
10. Dwelling on resentments that provoke anger and frustrations due to unresolved conflicts					
11. Loss of a loved one					
12. Belief that alcohol gives relief for stress					

13. Feeling overwhelmed, confused and useless.					
Questions Social factors	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
14. Having a spouse or family member who still uses alcohol					
15. Isolating- not attending support groups					
16. Hanging around old drinking friends					

Section four: Rehabilitation Effectiveness Scale

Please read the following and rate how well you prepare clients to prevent relapse

Skills	Very Good	Good	Fair	Poor	Very Poor
17. Relapse Prevention					
18. Grief management					
19. Decision making skills					
20. Problem solving skills					
21. Time management skills					
22. Stress management					
23. Adherence to treatment plans					
24. Anger and frustration management					

APPENDIX C: LETTER OF PERMISSION TO JORGS ARK REHABILITATION CENTRE

4th May, 2015.

Kositany Conrad,

Email: kositanyconrad@yahoo.com

Tel. 0715251740

Treatment Manager,

Jorgs Ark Rehabilitation Centre,

Limuru, Kiambu County.

Dear Sir / Madam,

RE: REQUEST TO DO RESEARCH IN YOUR INSTITUTION

I would like to request for permission to do research in Jorgs Ark Rehabilitation Centre. I am a student at Egerton University pursuing a Masters degree in Psychology and Counselling.

My research topic is *The Contribution of Selected Psychological and Social Factors to Relapse among Recovering alcoholics of Asumbi and Jorgs Ark Rehabilitation Centres, Kenya.*

I plan to administer Questionnaires to your clients (recovering alcoholics) and Rehabilitation counsellors.

Thanks in advance and hope to work with you for the success of this research.

Yours faithfully,

Kositany Conrad

APPENDIX D: LETTER OF PERMISSION TO ASUMBI TREATMENT CENTRE

4th May, 2015.

Kositany Conrad,

Email: kositanyconrad@yahoo.com

Tel. 0715251740

Treatment Manager,

Jorgs Ark Rehabilitation Centre,

Limuru, Kiambu County.

Dear Sir / Madam,

RE: REQUEST TO DO RESEARCH IN YOUR INSTITUTION

I would like to request for permission to do research in Jorgs Ark Rehabilitation Centre. I am a student at Egerton University pursuing a Masters degree in Psychology and Counselling.

My research topic is *The Contribution of selected Psychological and Social Factors to Relapse among Recovering Alcoholics of Asumbi and Jorgs Ark rehabilitation centres, Kenya.*

I plan to administer Questionnaires to your clients (recovering alcoholics) and Rehabilitation counsellors.

Thanks in advance and hope to work with you for the success of this research.

Yours faithfully,

Kositany Conrad.

APPENDIX E: NACOSTI AUTHORISATION LETTER

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
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when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/16/99900/12113**

Date: **1st August, 2016**

Conrad Chirchir Kositany
Egerton University
P.O. Box 536-20115
EGERTON.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"The extent to which selected psychological and social factors influence relapse among relapsed alcoholics of Asumbi and Jorgs Ark Rehabilitation Centres in Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Homa Bay and Kiambu Counties** for the period ending **30th July, 2017.**

You are advised to report to **the County Commissioners and the County Directors of Education, Homa Bay and Kiambu Counties** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Homa Bay County.

The County Director of Education
Homa Bay County.