RELATIONSHIP BETWEEN SELECTED REHABILITATION FACTORS AND RECOVERING ALCOHOLICS COMPETENCIES IN CENTRAL AND NAIROBI REGIONS, KENYA

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A thesis submitted to the Graduate School in partial fulfilment for the requirements of the Degree of Doctor of Philosophy in Counselling Psychology of Egerton University

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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 any University.

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Recommendation

This work has been submitted for examination with our approval as the University Supervisors.

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DEDICATION

To all parents: Mr. Robertson Muriithi, Mrs Margaret Muriithi, Mr Taboi Mwangi, Late Regina Wahu; My dear wife Mrs. Naomi Waithera Waweru for your prayers and invaluable encouragement. To my lovely children: Robertson and Patience for your understanding when I was not there for you while I carried out this work.

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ABSTRACT

Attainment of sobriety calls for appropriately planned and skillfully managed process that offers personal support and guidance, necessitating effective approaches during alcohol rehabilitation. An understanding of how various rehabilitation related factors influence recovering alcoholics' competencies is therefore key to their reintegration into society. Recovery from alcohol addiction should therefore result in a substantial improvement in the reduction of alcohol intake and an improvement in personal health and social functioning for the recovering alcoholic. The study sought to determine the relationship between selected rehabilitation factors on recovering alcoholics' social and personal competencies in Central and Nairobi regions, in Kenya. The study adopted behavioural, Adlerian and person centred theories for its theoretical framework. The study employed the *ex-post- facto* correlational research design with an accessible population of 202 recovering alcoholics and 81 addiction counsellors in 17 rehabilitation facilities in Central and Nairobi regions employing the 12 step facilitation approach. Census sampling method was used for the addiction counsellors while a sample size of 134 respondents calculated using Taro Yamane simplified formula was used for the recovering alcoholics. Data was collected using a structured questionnaire for the recovering alcoholics and addiction counsellors. The instrument was validated and adjustments made after the pilot study conducted in two rehabilitation centres in Nakuru County. Reliability was determined using the Cronbach's Alpha Coefficient for the study variables as 0.898, 0.860, 0.747, 0.742 and 0.887 respectively. The data was analysed using the IBM Statistical Package for Social Sciences (SPSS) version 22.0. Pearson correlations were used to test the relationship between the dependent variable (recovering alcoholics' competencies) and the independent variables (AA 12 steps facilitation, addiction counsellors' characteristics, recovering alcoholics' characteristics and level of family support). All independent variables were statistically significant at $p=0.000<0.05$ with the AA 12 steps facilitation model and recovering alcoholic characteristics reporting moderate positive association ($r=0.491$; 0.580), while addiction counsellor characteristics and level of family support reported strong positive association ($r=0.649$; 0.600) respectively on recovering alcoholics' competencies. The study recommends use of the 12-step approach in alcohol rehabilitation and strengthening of steps established to positively contribute towards social and personal competencies. Rehabilitation centres need to consider tailoring treatment based on gender to consciously address the low number of women seeking treatment for alcohol dependency.

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LIST OF ABBREVIATIONS AND ACRONYMS

A	Agree
AA	Alcoholic Anonymous
AJADA	Africa Journal of Alcohol and Drug Abuse
AUD	Alcohol Use Disorder
ASAM	American Society of Addiction Medicine
CSVR	Centre for the Study of Violence and Reconciliation
CVI	Content Validity Index
D	Disagree
e	Tolerable error (5%)
EE	Expressed Emotions
FBOs	Faith Based Organizations
I-CVI	Item-Level Content Validity Index
IISTE	International Institute of Science Technology and Education
IJCR	International Journal of Current Research
ISSUP	International Society of Substance Use Professionals
I-TS	Item-Total Statistics
HIV	Human Immunodeficiency Virus
n	Sample size
N	Population
NACADA	National Authority for Campaign against Alcohol and Drug Abuse
NACOSTI	National Commission for Science, Technology and Innovation
NGOs	Non-Government Organizations
NIDA	National Institute on Drug Abuse
RoK	Republic of Kenya
SA	Strongly Agree
SAMHSA	Substance Abuse and Mental Health Services Administration
SD	Strongly Disagree
SES	Socio Economic Status
SPSS	Statistical Packages for the Social Sciences
Std Dev	Standard Deviation
U	Uncertain
WHO	World Health Organization

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

The cost of alcoholism include the eventual price of death with around 3 million deaths or 5.1% of all the global deaths being attributed to the consumption of alcohol in the year 2016 (World Health Organization, 2018). Other consequences of alcohol dependency include deprivation of economic empowerment channels such as the loss of employment, family breakdown, social isolation and deterioration of health. While less than half of the global adult population used alcohol in 2017, the total burden of disease attributed to its harmful use is huge and surpasses those caused by many other risk influences and diseases high on the world's health agenda (WHO, 2018). The risk factors for the development of addiction are many and include gender, ethnicity, age, mental health disorders, environmental factors, stress and abuse (Clark, 2013). Estimates on the excessive use of alcohol give a mean of 30 years of potential life lost for each death caused by alcohol (National Council on Alcoholism and Drug Dependence, 2008). The global prevalence of alcohol use is approximately 42% of the youth and the adult population and is much higher than that caused by illicit drug use (Clark, 2013).

Alcoholics have been defined as persons suffering from alcoholism. Alcoholism also referred to as Alcohol Use Disorder (AUD) is a broad term referring to addiction to alcohol intake and the resultant challenges (Brower, Aldrich, Robinson, Zucker & Greden, 2013). Characteristics often associated with persons suffering from alcohol abuse are varied and include psychological and physical indicators that affect their capacity to think critically, perceptions, attitudes and skills (Milton, 2014). As progression of the alcohol use continues, negative psychological and physical attributes manifest themselves in a manner that the alcoholic cannot sustain a normal social and economic life in the community that he or she belongs. These negative psychological and physical attributes are evident in subjective self-destructive behavior patterns that results in the denial of existing and impending consequences, diminished levels of functioning and negatively impacting friends and families (Pabian, 2014). The regaining of the psychological competencies lost during the alcoholic's life are critical in helping the recovering alcoholic from lapsing back into alcoholism. The process of rehabilitation seeks to empower the alcoholic to possess normal functioning

human skills for the social, spiritual and economic life (McLeod, 2013). One of the most crucial abilities that human beings possess is the use of judgment and making of choices and decisions at personal and interpersonal levels, which in turn reflects on the quality of life (Pagano, Post & Johnson, 2010). The aspect of the alcoholic in recovery developing skills that may help in preventing lapsing back to alcoholism is considered critical in the recovery programme. Miller (2009), posits that successful treatment and recovery from addiction should concern itself with a broad range of intra and interpersonal factors that include coping skills, consequences of substance use, clients' practical needs, social support, spiritual beliefs and engagement in mutual self-help organisations.

People using alcohol as a coping strategy to the numerous pressures and stresses of life tend to build up tolerance through regular use eventually requiring more and more alcohol over time. At moderate doses, alcohol slows reaction time and impairs judgment, motor coordination of balance as well as eye-hand coordination (Witkiewitz & Masyn, 2008). At higher doses, alcohol impairs cognition, self-control and self-restraint, leading to the drinker becoming emotionally unstable and overly aggressive (Arnedt, Conroy & Brower, 2007). At very high doses, alcohol can diminish the sense of cold, pain and discomfort. It further causes dilation of the peripheral blood vessels which increases the amount of blood circulating through the skin making the drinker feel warmer and losing body heat faster (Mwathi, 2013). Alcohol and drug abuse have a huge impact on violence, crime and the criminal justice system with alcohol being a factor in 40% of violent crimes that comprise of rape, sexual assault, robbery, aggravated and simple assault (Clarke, 2013).

The process of enhancing social and personal competencies among recovering alcoholics is critical in supporting certain behavior patterns for both interim adaptations and long-term developmental advancements (Scarbrough, 2012). These competencies range from specific abilities and skills to general constructs such as self-esteem. Development of appropriate social and personal competencies among alcoholics in recovery reflects on their ability to appropriately handle issues at the home front, school, work and within the wider community and society (Aissen, 2013). Alcohol rehabilitation is geared to providing partial or full restructuring of the physical, psychological or social functioning that have been damaged by the long dependence on alcohol through counselling interventions (Kuria, 2015). Effective treatment of alcoholism can be realised if alcoholics can secure treatment and rehabilitation

services suited to their needs and of sufficient intensity, quality and duration (Hall, 2015). Prompt intervention and management for persons with alcohol use disorders is directed at achieving three goals namely; that of a humanitarian approach that seeks relief of human distress, as a mode of decreasing alcohol use and harm in society and as a technique of reducing alcohol-related health-care costs (Baljinder, 2014). Substance Abuse and Mental Health Services Administration (2012), notes that recovery from addiction can be sustained though evidence-based approaches that address the social determinants of health such as supported education, employment and housing. Recovery does not begin when an individual completes treatment but forms an integral part of the treatment process which begins when an individual resolves to address his or her substance use disorder. Achievement of abstinence from alcohol often rest on many factors but unfortunately, many programmes hardly make changes on the surroundings that alcoholics return to and therefore may continue to experience challenges related to lack of employment and educational opportunities, which may place them at the risk of relapse (Centre for the Study of Violence & Reconciliation, 2017).

Within the context of the alcohol rehabilitation, the most widely used model is the 12-step facilitation model popularised by the Alcoholic Anonymous (AA) group (Ingvarson & Page, 2013). The AA group was formed in 1935 in Akron, Ohio, in the United States of America by two friends, Bill Wilson and Dr. Robert Smith, who assisted each other to overcome alcohol addiction. The two friends adopted and modified five steps that were being used by a Christian group called the Oxford Group for the people who were committed to Christianity through personal salvation (Mjwara, 2013). The Oxford Group used a five-stage process for inducting new members. These stages comprised of the surrender to God, heeding to God's direction, seeking guidance, achieving restoration and sharing. The AA movement then expanded the initial five stages to 12 steps, modifying them for use in alcohol rehabilitation (Marsh, Dale & Willis, 2007). The twelve steps include acceptance by the alcoholic of their powerlessness over alcohol that had made their life unmanageable.

Family support is acknowledged as a critical factor in the rehabilitation process and the prevention of relapse occurrence for the recovering alcoholic. This has been attributed to the fact that alcoholism has sometimes been linked to family dysfunction and as such the family serves as a cornerstone in the recovery of the alcoholic and in the prevention of relapse

occurrence (Brown, Emrick, & Glaser, 2012). The presence of a caring family serves as a great source of identity and social support for recovering alcoholics and hence associated with better diagnosis and effective rehabilitation efforts (Githae, 2015). The level of family support in the recovery process is critical due to the fact that alcoholism often destroys critical family relationships due to violence, marital satisfaction inadequacies, economic challenges and general family happiness (Peter, 2015). The support given by family to the recovering alcoholic leads to improved communication levels as well as presenting a motivation for positive behaviour change for the alcoholic (Habibi, 2016). The level of family support is further determined by the family's emotional state as either high or low in terms of emotional expression. The high emotional expression often associated with higher levels of relapse is prevalent through the manner and content of family members' interaction (Scarbrough, 2012). In this context, attitudes such as hostility, criticism and emotional over-involvement may lead to the alcoholics' relapsing into alcoholism. Hostility amongst members of the family may lead to blaming the alcoholic for diverse aspects leading to relapse (Bauer, 2015).

The characteristics of the counsellors are critical within the context of rehabilitation of the recovering alcoholics. The focus of the rehabilitation efforts depends on the realisation by the alcoholics' that they are trapped by destructive habits and that they need to admit to the dependency situation in a confidential and non-judgmental surrounding that is free from shame and embarrassment (Brower et al., 2013). Counsellors play a critical role in the delivery of an enabling environment that facilitates the process of recovery. Training and competence of addiction counsellors is therefore key in the establishment of associations and carrying out the approaches that aid alcoholics in recovery change from addiction that threatens their survival and wellbeing to activities that enhance their recovery (Githae, 2015). The counsellors need to offer a simple perspective of addiction that take into account the information of current approaches and models, acknowledgement of the multiple settings in which alcohol abuse takes place and an awareness of the effects of alcohol use. The addiction counsellors need to exhibit knowledge regarding the range of care and the social circumstances affecting the management and healing process, as well as ability to recognise a range of helping strategies that can be personalised to meet the needs of the alcoholic (Koszycki, Raab, Aldosary & Bradwejn, 2014). The addiction counsellors must be prepared to adjust to a constantly varying set of encounters and limitations. White & Miller (2007),

assert that counsellors bring their human abilities and proficiencies that have influenced them in making their input one of the most influential inspirations in the rehabilitation process. The growth of effective modalities in the treatment of alcoholism depend on the existence of attitudes that reveal acceptance to different approaches, appreciation of diversity and the enthusiasm to change (ibid).

A nationwide survey on drug abuse in India placed the prevalence of alcohol consumption for men at 21% while that of women at 2% with half of alcohol users falling under a hazardous zone with a further one-fifth being considered as dependent drinkers (Easwaran, Bazroy, Jayaseelan & Singh, 2014). Sorel (2013), indicates that alcohol is the most abused substance in Africa. According to estimates by WHO (2004), the regions in Eastern and Southern Africa were placed as having the highest levels of alcohol consumption per drinker in the world. The occurrence of unsafe drinking patterns in the sub Saharan region, such as consumption of huge amounts of alcohol per session or frequent levels of intoxication ranked second to countries in Eastern Europe (Sorel, 2013). Though the highest levels of alcohol use are in Europe, the African continent carries the heaviest burden of disease and injury associated with alcohol (WHO, 2018). A review of the prevalence of alcohol use among young people in East Africa reveals that alcohol use and problem drinking are common among diverse groups of young people with prevalence being highest among university students at 70% and lowest among the general population and secondary school students (Francis, Grosskurth, Changalucha, Kapiga & Weiss, 2014). This puts into perspective a public health disaster in the developing world where the masses are subjected to the ills associated with alcohol and substance dependence (Sorel, 2013). Estimates by the United Nation's World Drug Report (2010), indicate that a small proportion of 5% of problematic substance users in Africa received treatment in 2009.

Kenya's first rehabilitation centre was started in 1986 at Asumbi, followed by Brightside DART center in 1998, Red Hill in 2001 and Mathare addiction center in 2003. By the year 2008, there were an estimated 61 registered rehabilitation centres in the country (Musyoka, 2013). Kuria (2015), indicate that in the Kenyan context, the registered rehabilitation centres mostly admit patients for a 90-day programme without undergoing detoxification. A report by the Ministry of Health in 2015 on non-communicable diseases risk factors revealed that approximately 19.3% of Kenyans consumed alcohol, with 13% of this proportion consuming

it on a daily basis. The age group between 30-44 years among men constituted the highest consumers of alcohol at 44%. A baseline survey by National Authority for Campaign against Alcohol and Drug Abuse in 2010 on alcohol use in Central Kenya revealed a worrying state of alcoholism in the region (Mutai, 2014). There was a strong consensus among communities in the region that alcohol poses a serious problem due to the high levels of usage, increasing trend and ease of availability, affordability and accessibility (NACADA, 2010a). The findings further revealed that two thirds of the members of the community reported that consumption of alcohol in their localities ranged from high to very high. The findings pointed to a high-level usage of alcoholic substances in Central region, justifying the great concern by public and policy makers on the high level of alcohol use in the region (Mwathi, 2013). The problem has therefore affected farming communities by wreaking havoc on individuals in terms of health, nutrition and productivity. This concern has further undermined food security in the region by lowering farm productivity, diverting economic resources and assets hence increasing levels of poverty and vulnerable members of the population (Kuria, 2015).

Studies conducted by NACADA (2012), point out to alcohol being the most commonly used substance in Kenya at 61%, with the prevalence of those who had used alcohol being placed at 35.6%. A rapid situation assessment of the status of drug and substance abuse in Kenya by NACADA (2012), reported that Nairobi region had the highest proportion of persons using alcohol at 22% when compared to other regions in Kenya. A study by Oteyo, Kariuki and Mwenje (2013), revealed to an increase in the numbers of secondary school students in Kiambu and Nairobi Counties abusing drug substances where current alcohol users were placed at 47.6% of the population. The magnitude of the alcoholism problem in Nairobi and Central regions is a strong revelation of a major underlying problem in the regions calling for strategies to ensure effective treatment and rehabilitation of person abusing alcohol. Persons with alcohol-related concerns often have multiple treatment needs across a range of personal, social and economic areas and subsequently the problems of alcohol abuse can be managed successfully if people can have access to services offering treatment and rehabilitation appropriate to their needs, be of sufficient quality, intensity and duration (NACADA, 2010b; United Nations Office on Drugs & Crime, 2003). The Global status report on alcohol and health by the World Health Organization (2018), notes with concern the well-documented negative effects on the well-being and health of persons and populations, underlining the importance of strengthening and sustaining concerted efforts to reduce the detrimental use of

alcohol in specific countries. Alcohol rehabilitation therefore forms an integral component in the efforts of stemming the tide brought about by the ills of alcohol abuse and serves as an avenue of bringing hope to many still held hostage by the yoke of alcoholism. Rehabilitation centers have over the years admitted substance users into their programmes to realise behaviour change, but scanty information is available regarding the effectiveness of drug rehabilitation programmes (Sereta, Amimo, Ouma & Ondimu, 2016). A policy brief by the National Council for Population and Development (2017), notes with concern that unless urgent steps are taken to address the concern of alcohol and drug abuse, achieving Kenya's Vision 2030 and harnessing the demographic benefits will remain an illusion as the productive young population wastes away. This study therefore sought to fill the gap by providing empirical data on relationship between selected rehabilitation factors and recovering alcoholics' social and personal competencies.

1.2 Statement of the Problem

The contribution of rehabilitation programmes is at the core of empowering alcoholics in recovery to have normal functioning human skills for their social, spiritual and economic wellbeing. Successful treatment and recovery from alcohol addiction should concern itself with a broad range of factors that include coping skills, consequences of substance use, social support, spiritual beliefs and engagement in self-help organisations. Statistics from NACADA indicate an increase in rehabilitation centres in the country and a demand for admission from around 13 in 1999 to over 70 centres in 2017. A rise in the demand for treatment and rehabilitation services has in turn involved many actors that include Faith Based Organizations (FBOs), Non-Governmental Organizations (NGOs), public and private institutions, civil society as well as individuals. Despite this growth which indicates an increase in accessibility to professional rehabilitation help for alcoholics, there lacked empirical evidence on the relationship between various factors related to alcohol rehabilitation and recovering alcoholics' social and personal competencies. Indicators outline that episodes of relapses following treatment are varied following treatment raising queries on the social and personal competencies gained by recovering alcoholics during rehabilitation. Such a study would give the concerned stakeholders a clear pointer on the relationship between AA 12 steps facilitation, addiction counsellors, recovering alcoholics characteristics, level of family support and recovering alcoholics social and personal competencies in rehabilitation centres. It is in this context that this study sought to fill this

gap by seeking to establish the relationship between the selected rehabilitation factors and recovering alcoholics' social and personal competencies in Central and Nairobi regions in Kenya.

1.3 Purpose of the Study

The purpose of the study was to determine the relationship between selected rehabilitation factors and recovering alcoholics' social and personal competencies in Central and Nairobi regions in Kenya.

1.4 Objectives of the Study

The study had the following objectives: -

(i) To describe recovering alcoholics social and personal competencies in relation to demographic characteristics (Gender, Age, Education level, Length of stay in rehabilitation and Region) in rehabilitation facilities in Central and Nairobi regions.

(ii) To determine the relationship between the Alcoholic Anonymous' 12 step facilitation and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

(iii) To establish the relationship between addiction counsellors' characteristics and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

(iv) To establish the relationship between recovering alcoholics' characteristics and recovering social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

(v) To establish the relationship between level of family support and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

1.5 Research Question

What are the recovering alcoholics' social and personal competencies (Gender, Age, Education level, Length of stay in rehabilitation and Region) in relation to demographic characteristics in Central and Nairobi regions?

1.6 Hypotheses of the Study

The study was guided by the following research hypotheses;

H_{o1}: There is no statistically significant relationship between the Alcoholic Anonymous' 12 step facilitation and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

H_{o2}: There is no statistically significant relationship between addiction counsellors' characteristics and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

H_{o3}: There is no statistically significant relationship between recovering alcoholics' characteristics and recovering social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

H_{o4}: There is no statistically significant relationship between level of family support and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

1.7 Significance of the Study

This study is expected to be of significance to a wide range of stakeholders in alcohol rehabilitation including NACADA, rehabilitation centres, families of alcoholics', the general population and researchers in the area of alcohol and substance abuse. This information may be important to NACADA for the purposes of policy formulation as well as capacity enhancement in the existing rehabilitation centers. It is anticipated that findings from the study may be helpful to policy makers such as NACADA and other relevant stakeholders in instituting changes in the rehabilitation of alcohol addiction especially concerns on salient factors addressed in the study and their influence in building competencies among recovering alcoholics. The information gained from this study is important to the rehabilitation centres in gaining insights on the diverse factors affecting the rehabilitation outcomes such as level of family support, alcoholics' characteristics, addiction counsellors' characteristics and the AA 12-step facilitative model. The study may also be significant to families of alcoholics in promoting change in their perceptions on alcohol addiction and treatment with the understanding that alcohol addiction is a treatable condition. The groups and organisations engaged in the rehabilitation of alcohol addiction may find the results of the study useful in evaluating rehabilitation programmes in place for persons with alcohol addiction and help in enhancing ways that assist individuals overcome addiction. Findings from the study are

expected to help in filling gaps in the area of alcohol addiction and recovery and may prompt other studies related to alcohol rehabilitation.

1.8 Scope of the Study

There may be many factors related to the successful treatment of alcohol addiction but in-order to facilitate an in-depth study, this research confined itself to the relationship between the selected rehabilitation factors and recovering alcoholics' social and personal competencies. The study's geographical scope was confined to Nairobi and Central regions cited as experiencing high prevalence rates of alcoholism. The study covered 17 rehabilitation facilities dealing with alcohol addiction employing the Alcoholic Anonymous 12 step facilitative model which is the most widely used approach in alcohol rehabilitation. The study scope included rehabilitation related factors namely 12 step facilitation, addiction counsellors' characteristics, recovering alcoholics' characteristics and level of family support.

1.9 Assumptions of the Study

The study made the following assumptions: -

(i) That management of the rehabilitation centres would offer co-operation to the researcher in collecting data from their respective rehabilitation facilities.

(ii) That targeted respondents would co-operate and provide honest responses to questionnaires administered.

(iii) That the independent and dependent variables under study would have some significant degree of association between them.

1.10 Limitations of the Study

The researcher anticipated respondents' apathy in responding to the questionnaire which was the data collection instrument. This apathy may have been as a result of their reluctance to divulge sensitive personal information and the purposes for which such information would be used. This apathy was mitigated by the researcher organising for group sessions with alcoholics in recovery and the addiction counsellors in the sampled rehabilitation centres. This was done so as to build rapport that aided in the administering of the questionnaire.

1.11 Definition of Terms

Addiction Counselling: The provision of professional services by a trained counsellor to a recovering alcoholic in a rehabilitation facility. The counselling includes a variety of services and activities such as evaluation and planning for treatment, making of referrals, education of the recovering alcoholic and family as well as documentation (Aissen, 2013).

Addiction Counsellor: A professionally trained helper that serves as an educator and advisor to a recovering alcoholic who assists the person move from a point of need to that of independence in dealing with their alcohol dependence (Githae, 2015).

Alcoholic: An individual with a disorder characterised by excessive use and dependence on alcoholic substances that eventually lead to physical and psychological harm as well as their social and vocational impairment (Rassool, 2008).

Alcoholism: A form of addiction that involves abusing an alcoholic substance that eventually ends up becoming a chronic and progressive disease. Alcoholism further means becoming dependent on alcoholic substances to feel normal (Roozen, Blaauw & Meyers, 2009).

Social and Personal Competencies: A concept where the alcoholic in recovery enhances his or her capacity to advance adaptive responses to various demands and make the most of the opportunities in one's surroundings. This ability involves the use of sound judgment to make decisions and choices both at personal and interpersonal levels that touches on the value of one's life. This ability is also manifested in the development of new behaviour patterns and social skills that promote formation of new and meaningful relationships with peers, family members and counsellors (Kuria, 2005).

Dependence: The compelling need for alcohol substances by alcoholics that embraces psychological and physical changes that make it problematic for the alcoholic to regulate the use of alcoholic substances. This reliance may either be psychological (where the alcoholic needs the alcohol to feel normal, good or function) or physical (when the body of the alcoholic adapts to the substance and needs larger quantities to attain the same result) (Bauer, 2015).

Recovering Alcoholic: An individual going through a process of change in a rehabilitation centre aimed at achieving abstinence from alcohol dependence, improved health, wellness and quality of life. The recovery process begins when the person decides to face his or her alcohol addiction and through various rehabilitation programmes develops coping skills that aid in maintenance of a drug-free lifestyle (SAMHSA, 2012).

Region: A recognised unit of administration by the Government employing the defunct boundaries of former provinces under regional coordinators comprising of several counties within the current constitutional dispensation. NACADA categorises rehabilitation facilities based on these regions within the country.

Rehabilitation: An all-inclusive integrated programme of vocational and psychological interventions that seek to support the recovering alcoholic to abstain from alcohol abuse and eventually attain a personally fulfilling and socially meaningful relation with the world. The set of programmes and activities within the 90 day residential setting are designed to enable the alcoholic gain independence from alcohol dependence (McCrady & Longabaugh, 2012).

Rehabilitation Centre: A designated facility for the recovering alcoholics to gain skills and competencies to become free from alcohol addiction**.** These facilities are licensed by NACADA and deal with treatment and evaluation of alcohol addiction and other disorders. A rehabilitation facility provides residential treatment (McLeod, 2013).

Relationship: The connection between the variables under study where the value of one variable is directly or not directly attributable to the other. Relationship was therefore determined between the independent and dependent variables that formed the focus of the study (Komen, 2012).

Selected Factors: Independent variables that the study hypothesised to have relationship with the dependent variable. The selected factors comprised the AA 12 steps facilitation approach, addiction counsellors' characteristics, recovering alcoholics characteristics and level of family support. The degree of association between the selected factors and dependent variables was sought to determine their influence on each other.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature related to the alcohol addiction, counselling and rehabilitation. Literature reviewed includes the concept of alcohol addiction, alcohol rehabilitation, the Alcoholic Anonymous 12 step facilitation model, addiction counsellors' characteristics, recovering alcoholics' characteristics, level of family support on recovering alcoholics and social and personal competencies in recovering alcoholics. This chapter also presents the theoretical and conceptual framework for this study.

2.2 Concept of Alcohol Addiction

Alcohol addiction results when an individual persists in the consumption of alcohol in spite of the adverse effects on his or her health often in spite of repeated attempts to stop (Aissen, 2013). Addiction as a concept is not all physical but has a psychological dimension where persons crave and hunger for alcoholic substances and its effects even when not physically dependent (Brower et al., 2013). This results from the rewarding effects that alcohol produces. Alcohol addiction manifests through the helplessness to steadily abstain; an impairment in one's behavioural control and craving, a weakened recognition of major difficulties with one's behaviour and interpersonal relationships as well as a dysfunctional emotional response (Gabhainn, 2003). The initial decision to take alcohol is essentially voluntary, but with sustained use, the individual's capability to exercise self-control can become seriously impaired which ultimately becomes the hallmark of addiction (NIDA, 2018).

Since alcohol is a depressant, more consumption leads to more depression resulting in adverse effects on the person's brain activity. Alcohol interferes with the cerebrum which is a part of the human brain responsible for high level functions that include vision, recognition, emotions as well as reasoning, resulting in a slowed function. At low doses, alcohol lowers inhibitions and affects judgment while at higher levels, it results in the impairment of vision, movement and speech. Alcohol further affects the brain aspect that helps in the coordination of movement, resulting in difficulties with reflex coordination and balance **(**Coombs & Howatt, 2005). Studies have shown that people become more friendly and outgoing under the influence of alcohol as a result of the reduced inhibitions and engage in some successful

social interactions while experiencing the effects of alcohol (Higgins, Bickel & Hughes, 1994).

The salient feature of addiction is the inability to fight an instinct, temptation or drive to undertake an activity that is detrimental to the person or others (Komen, 2012). A majority of the mechanisms that control problems associated with impulses share some strong psychological and behavioural aspects with alcohol addiction; that is a psychological state of craving before the occurrence of the behaviour, engaging in behaviour despite adverse consequences as a result of the loss of control (Aissen, 2013). An individual's biology, environment and development can explain why some individuals become addicted and others do not (Clark, 2013). Hereditary factors account for approximately 50 percent of the possibility that an individual will develop an addiction (NIDA, 2008). Predisposing genetic factors can make an individual more susceptible to both addiction and mental health disorders or increase the risk of the individual developing a second disorder after the first one occurs (ibid). Environmental factors also interact with an individual's biological factors and influence the degree to which hereditary factors exert their effect. Environmental factors include socioeconomic status, overall quality of life, pressure from peers, stress, sexual and physical abuse (ibid).

Physiological dependence means that the body becomes accustomed to the alcohol and needs the chemicals to function and the body of an addict craves for the substance (Arnedt et al., 2007). The physiological dependence is determined when a person experiences tolerance and withdrawal. This means that the body requires larger amounts of the alcoholic substance to create a similar effect and where the alcohol is not forthcoming, the person experiences physical symptoms (Cloete, 2014). Psychological dependence on the other hand means that the person comes to depend on the feeling received from the drug. This involves denial where the alcoholic fails to admit that he or she has problems with alcohol. A distinguishing feature of alcohol addiction is the quest for the drug at the expense of other usually satisfying activities despite the negative consequences (Githae, 2015). Persons who become addicted to psychoactive substances usually experience fairly less pleasure in response to the use of alcohol over time, but their yearning for and loss of control over the alcohol increases (Kuria, 2015). Despite the importance of understanding the physiological processes of tolerance and withdrawal in addiction, alcohol dependence is fundamentally a disorder characterised by

behavioural compulsion and a problem related to impulse control (McLeod, 2013). The reward value of the drug therefore suggest that alcohol abuse becomes magnified to the point that it dislodges other rewards and the person's ability to correctly assess the negative effects of alcohol use are seriously compromised (Barnard, 2014). Studies on brain imaging on persons with addiction show physical variations in areas of the brain that are instrumental in making judgement and decision, learning and memory as well as in the control of behaviour (Fowler, Volkow, Kassed & Chang, 2007).

Addiction to alcohol is similar to other prolonged diseases and involves series of relapse. Alcohol addiction without the involvement in activities promoting recovery or treatment becomes problematic and often results in ill health or premature death (American Society of Addiction Medicine, 2011; Babendreier, 2007). Strong links have been established with more that 200 health conditions that are related to harmful use of alcohol, ranging from road injuries, violence, liver diseases, cancers, suicides, tuberculosis, liver and cardiovascular diseases as well as HIV/AIDS (WHO, 2018). Addiction when left untreated can last a lifetime and may result in death (NIDA, 2018).

2.3 Concept of Alcohol Rehabilitation

Smith (2012), asserts that addiction from alcohol cannot be cured but can be successfully managed through a programme of treatment and abstinence as well as the involvement in supported recovery. The treatment enables recovering alcoholics to counter the addiction's powerful disruptive effects on the brain and behaviour allowing them to reclaim control of their lives (ibid). As is the case with other diseases and disorders, the possibility of developing an addiction varies from one person to another and no single aspect may dictate whether an individual becomes an alcohol addict (NIDA, 2018). The more risk aspects a person has, the higher the chances that alcohol use will result in addiction (ibid). Termination of all alcohol addiction occurs when alcoholics acknowledge that the substance altering their moods does not deliver support as initially thought, but is the basis of their mounting complications. Having been deceived by the addictive substances, alcoholics tend to mourn the loss of their lifestyle. Progressively, small but gradual steps are made where alcohol is substituted with healthier and rewarding activities and networks at home, work, school, places of worship and in settings that offer recreation (Coombs & Howatt, 2005).

Kalema and Vanderplasschen (2015), indicate that most treatment facilities employ the AA 12 step facilitation approach as a main instrument for recovery and relapse prevention with varying strengths of aftercare support. Many programmes that specialise in the treatment of alcohol addiction do so in a comprehensive manner with focus being on physical, psycho-social, spiritual and sometimes pharmacological interventions (Angres & Bettinardi, n.d). The hybrid nature of the Minnesota model employs a blend of professionals mainly counsellors, psychologists and psychiatrists whose work is complemented by medical experts, spiritual persons and social workers to meet the needs of the alcoholics (WHO, 2010). Rehabilitation may be carried out in the period during which the recovering alcoholic starts to address symptoms of accompanying mental disorders, learning to manage cravings and challenges of some of the issues that helped nourish the addiction. Rehabilitation may occur in a setting that is residential for some weeks or months and may also be carried out in programmes that are outpatient in nature offering group support and counselling to ensure self-restraint and help alcoholics resume a more normal lifestyle. Recovery from addiction has been argued to begin the moment that alcohol addicts directly confront their situation. This brings to fore the need for every treatment phase to be carefully planned to ensure that recovery does indeed take place. Several factors have been pegged to the successful treatment of alcohol addiction including the recovering alcoholics level of cooperation, nature and duration of the addiction, availability for treatment and counselling services and the level of family support to help prevent relapse and the drug or behaviour involved (Hollen, 2009). This brings to focus the gap on the need to examine certain factors related to recovering alcoholics competencies that may have a contribution to the process of attaining sobriety. The role played by addiction counsellors' characteristics, recovering alcoholics' characteristics, level of family support as well as the 12 steps facilitation model and recovering alcoholics social and personal competencies may therefore shed new insights on the process of attaining sobriety.

During the rehabilitation process, an evaluation of the alcoholic's commitment for their actions resulting in alcohol abuse is done so as to determine they suffers from some form of disorder that weakens their ability to control their own activities (Pagano et al., 2010; Hyman, 2007). Alcohol addiction does certainly deteriorate the addict's capacity to bring in line his activities with their position to evaluate decisions. The methods of prevention and recovery that highlight on the alcoholic grasping the will power to abstain from alcohol, or reprimanding them for lacking willpower, are unlikely to be adequate where interventions

intended at help the alcoholic avoid the indicators that initially activated cravings are absent (Cloete, 2014). In a scenario where alcohol abuse is a response to a distressing and stressful situation, action needs to be taken to reorganise that environment. Coombs and Howatt, (2005) notes that alcoholics in recovery with the help of addiction counsellors can become inspired to make improvements in their lives by sticking to a well-defined action plan with clearly spelt out goals leading to chosen outcomes. An alcoholic in recovery that adheres to a noble action plan starts to experience accomplishments, making changes along the way during their recovery period in rehabilitation and even after their discharge on successful completion of the programme (ibid).

A major concern of addiction treatment is the shortfall in coping skills that constitute a significant factor for substance use and the occurrence of relapse (Miller, 2009). A key tenet of the goal of treatment is helping the recovering alcoholic gain behavioral, affective and cognitive skills for coping with potential relapse situations. Previous studies have not clearly demonstrated that gaining of coping skills is linked to successful cognitive behavioral treatment outcomes, but recommendations have been provided on the need for assessment of coping skills in identifying targets for intervention and determining progress in treatment (Longabaugh, Donovan, Karno, McCrady, Morgenstern & Tonigan, 2005). The findings of a study on relapse process on substance use among Iranian women highlighted numerous blockades for addiction treatment that include aspects such as stigma, discrimination, the lack of access to treatment services as well as financial problems (Khazaee-Pool, Pashaei, Nouri, Taymoori & Ponnet, 2019). The study recommended incorporation of female staff as a means of making addicted women feel more at ease with the recovery programmes (ibid).

Gold and Adamed (2010), observe that a significant number of persons abusing alcohol decline seeking any form of treatment and fail to recognise the presence of a problem with alcohol and continue to abuse it until it ultimately takes its toll on their lives. Complications arising from alcohol abuse are liver disease, pancreatitis, cancer, brain damage among many other severe medical conditions (ibid). An individual's acceptance that he or she has a problem with addiction becomes the turning point to their path to sobriety (Gwinnell & Adamec, 2006). This awareness on its own is not adequate, but forms a necessary component of overcoming alcohol addiction. Gwinnell and Adamec (2006), further note that compelling a person who does not acknowledge the presence of an addiction for a treatment programme

often means that he or she will attend the sessions in order to avoid consequences for not attending. Such consequences may include losing a driver's license, losing custody of a child, dismissal from work or going to jail. However, without acknowledgment, the person is still likely to resume the addictive behaviour that led to his or her problems. Compulsory treatment programs have been noted to lead people to an awareness and acknowledgment of their addiction and therefore can be effective regardless of how an individual gets into a treatment programme (ibid). A key strategy in realising change among recovering alcoholics is the component of education regarding chemical addictions provided through lectures, readings as well as publications to enhance their understanding on the diagnosis and effects of alcohol on the human body (Kalema & Vanderplasschen, 2015). The introduction of the public service substance abuse workplace policy in Kenya (2017), spells out the need for rehabilitation services in realisation of effective substance abuse management. Counsellors in discussion with family and relevant service providers are expected to work together to offer professional help and employ the use of appropriate screening tools to identify civil servants in need of rehabilitation services (RoK, 2017). This is in realisation that substance abuse at the workplace has the potential of negatively affecting the health, safety and output of its workforce and hence the Government's concern and commitment in ensuring their wellbeing and productivity is upheld (ibid).

Shannon (2010), indicates that residential programmes provide an environment where various approaches of residential treatment such as the therapeutic community are offered. For the case of alcohol rehabilitation, a 90-day programme is offered in most facilities in Kenya that integrate a therapeutic community approach based on the fellowship of Alcoholics Anonymous 12-step programme (Clark, 2013). The initial phase of treatment places restriction of the recovering alcoholic with family, friends and work (ibid). For the case of adolescents, exceptions may be made where interactions with parents may be done. These controlled surroundings help the alcoholic in recovery establish some orientation and embrace the new community and make adjustments in the rehabilitation setting. This approach helps to break through the recovering alcoholics' denial and increases his or her openness and yearning for help. This treatment aids in the individual's ability to make significant strides out of their addiction and not continue to live in the pain of the past (Clark, 2013). The provision of life skills and spiritual programs are integral parts of the rehabilitation efforts where alcoholics in recovery are supported through self-awareness

programmes that empower them on various concerns (Kalema & Vanderplasschen, 2015). The involvement in relaxation techniques, management of stress and sessions involving decision making helps in building competencies that may sustain a sober life. Focused recreational activities involving sports and entertainment may help in promoting therapeutic and relaxation effects on the recovering alcoholics (ibid). Recovering alcoholics are expected to contribute in regular groupwork sessions with other alcoholics' resident in the rehabilitation centres performing various tasks such as clean up chores among other assigned duties (Wadd & Dutton, 2018).

Residential treatment may help recovering alcoholics with serious cases of alcohol abuse who have been unable to remain sober for long periods allowing for a significant period of treatment to follow. Continuing care or follow up is an important phase that allows an individual that has gone through a treatment programme successfully to manage the threats of abusing alcohol. The public service substance abuse work policy in Kenya recommends that an alcoholic serving in public service should seek rehabilitation for alcohol dependency in an accredited treatment facility (RoK, 2017). Once a recovering alcoholic is back to previous surroundings such as their community, school or workplace, the person experiences numerous temptations and cravings for alcohol. This brings to fore the need for follow-up services, where a family member meets periodically with a counsellor or a support group to determine how the recovering alcoholic is coping after discharge from rehabilitation in dealing with the challenges of recovery (Shanon, 2010). Irregular and short-term alcohol drinking incidents are appreciated as being part of the process of recovery and may be used as valuable lessons in the prevention of future relapse or slips on the road to sobriety (Kalema & Vanderplasschen, 2015). Most rehabilitation centres are yet to make a differentiation with regard to the treatment of alcoholics in recovery based on the aspect of age and gender among other orientations (Amanya, 2011; Kalema, 2008).

2.4 The Alcoholics Anonymous 12 Steps Facilitation Model

While there are diverse rehabilitation models for recovering alcoholics, the 12 steps facilitation model developed by the Alcoholic Anonymous organization is the most popular. However, different programmes that derive their steps from the original alcoholic anonymous 12 steps have emerged over the years with some attempting to address perceived weaknesses with the AA 12 step facilitative model (Hall, 2015). The Willmar state hospital in the United

States developed what came to be referred to as the Minnesota model (Githae, 2015). The Minnesota model embraces the goals of moving past the custodial management of alcoholics to expounding the difference between treatment and detoxification as well as recognising a range of components of care within one programme (McCrady et al., 2012). The range of care elements comprises of a primary residential rehabilitation programme, a diagnostic and referral center, a residential intermediate care such as the halfway houses, outpatient care, aftercare and a family programme as well as an extended care programme (Witkiewitz & Masyn, 2008).

The 12 alcohol recovery steps are attributed to the alcoholic anonymous groups which modified them from Oxford groups in 1935 (Morgenstern, Labouvie, Mccrady, Kahler, Frey & Prey, 2014). The original AA 12 steps facilitative model was meant to last for up to 60 days in a setting that was residential in nature with the hope that an environment that was caring and stress free removed from the regular daily routine for the recovering alcoholic would facilitate their recovery. This was however extended over the years to between 3 to 6 months (Roozen et al., 2009). The AA 12 step model remains the most popular of the 12-step facilitative model in alcohol rehabilitation process. An exploration of the 12 steps during rehabilitation and the sharing of similar experiences have been shown to build a sound support structure on which current and former members of the AA have been able to restore their existence without alcohol. The AA's 12 steps traditions have been modified by many treatment groups facing addiction resulting in the alteration of principles or words out of the necessity to define their values, beliefs and goals appropriately. These main principles ensure that the rehabilitation facilities following the 12 steps can provide safe, accessible and therapeutic environments in which recovering alcoholics find valuable support, acceptance and fellowship, saving them from the ravages of alcohol addiction (Hollen, 2009). Table 1 below presents an outline of the AA 12 steps facilitation model.

Table 1

Alcoholics Anonymous 12 Steps Model

1. We admitted we were powerless over alcohol and our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. We are entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs

Source: Rassool (2008).

Different scholars have documented the success of the 12 steps recovery programmes due to diverse strategies used. Aissen (2013), indicates that the rehabilitation programmes modelled along the 12-step principles such as the Alcoholic Anonymous programmes have registered high levels of rehabilitation success among alcoholics. Scarbrough (2012), indicates that the success of the AA 12 step process lay on four broad themes that were emergent in the twelve steps, that is the aspect of surrender, identification, hope and daily instructions for living. In this context, step one addresses surrender through admission of powerlessness over alcohol and as a result the alcoholic's life becoming unmanageable. The second step seeks to address the anxiety of insanity experienced by alcoholics. The third step further seeks to expand on

the surrender concept (Marsh et al., 2007). The fourth step seeks to address purification of the identity of the alcoholic through the analysis of past actions and activities so as to ascertain strengths and weaknesses of their characteristics (Kuria, 2015). The fifth step addresses the alcoholic's identity through shedding of emotional ties and insecurities. Step six and seven concentrate on the rebuilding of the individual character while step eight and nine assists in the rebuilding of relationships (Githae, 2015). According to Scarbrough (2012), the rebuilding of daily life of the alcoholic was then narrowed on centering of rituals, acts of personal responsibility and provision of service. The rituals focus on the re-establishment of routine daily activities of the alcoholic as well as the planning of daily activities with peers (Fidelis, 2014). The recovering alcoholic is then required through personal responsibility acts to develop new practices that deal with his day to day lifestyle, such as his diet, hygiene, sleep, exercises, clothes and recreational activities (Mjwara, 2013). The eventual restoration of daily life and the 12th and final step place emphasis on the performance of service, which involves taking an oath to ensure commitment to the aspect of sobriety and the leading of a spiritual life by the recovering alcoholic.

The 12 -step facilitation approach provides alcoholics seeking recovery with a new way of life that seeks to back their breaking the cycle of addiction and maintaining sobriety. The key strength and efficacy of the 12-step approach stems from several sources. The 12 step offers a developmental approach to recovery from addiction with the steps being organised from the simplest basic changes to the more radical ones that persons motivated to recover may seek to incorporate into their lives (Mercer & Woody, 1999). The success of the 12 step model rehabilitation process have been attributed to the programme's inspiration of the alcoholic's submission to the process of rehabilitation and recognising the need for treatment and growth of spirituality practices as a component for a healthy recovery (Pagano et al., 2010). The capacity of an alcoholic in recovery to admit their new identity as an alcoholic and acknowledging their loss of control over alcohol marks the beginning of the process of recovery (ibid). According to Aissen (2013), there are empirical results to suggest the centrality of the surrender benefits and the overall quality of the recovery of the alcoholics. The 12 step facilitation models have been shown to score higher on surrender scales compared to alternative rehabilitation models (Bauer, 2015).

The notion of surrender has been viewed as a major tenet of the success of the 12 step facilitation recovery process. Aissen (2013) noted that there is a difference between compliance and surrender in relation to an alcoholic's rehabilitation. In this context, the compliance has been described as the engagement in the treatment process but with inability to resist the unconscious forces limiting the recovery process (Peter, 2015). The phenomenon of surrender has been described as the complete involvement with reality (conscious and unconscious), recognition of one's limitations, surrendering to a higher power, shifting from hostile and destructive feelings to affirmative ones and seeking peace with the world (Musyoka, 2013). Coombs and Howatt (2005) observes that the spirituality model of the AA 12 steps assumes that addictive conditions emanate from an absence of spirituality, where alcoholics are disconnected from a "Higher Power," which according to its creed is the source of light, truth, love and wellness. Alcoholics Anonymous has been viewed as helping members make progress by developing a practical relationship with this higher power. Many alcoholics all over the world acknowledge the AA movement with saving them from the bondage of alcoholism and assert that its practices are the only passage to recovery. Critiques however disagree with the AA aspects of spirituality that call for surrender to a higher power but acknowledge the achievements of the society in aiding millions of addicts in distress to stay sober and lead fruitful and healthy lives (Hollen, 2009).

The engagement by recovering alcoholics in religious and spiritual aspects has been shown to provide support and supervision as well as in giving guidelines in the enhancement of a robust purpose in life (Pardini, Plante, Sherman & Stump, 2000). This aspect of spirituality has been linked with a decrease from substance use, less anxiety and development of more resilience (ibid). Alcoholics in recovering may benefit from aspects of spirituality and religion which offer a system that helps them in attributing meaning to stressors in life, to challenging and overcoming hopelessness and suffering and cultivating a more positive outlook towards life (Robinson, Cranford & Webb, 2007). The nature of services offered under spiritual care include daily meditation, prayers and retreats that seek to strengthen the faith and values of recovering alcoholics and aid in overcoming their shortfalls (Kalema & Vanderplasschen, 2015). Appreciating the nature and strength of a recovering alcoholic's spirituality may appraise treatment planning in various ways. The emphasis placed on spirituality forms a key component of the goal direction in 12-step facilitation that can be seen as a movement seeking spiritual recovery that strengthens obedience with its guidelines

by involving recovering alcoholics in a supportive caring and ordered social system that encourages a purposeful life that contributes to the process of recovery (Galanter, 2007).

The 12-step rehabilitation process has also been associated with other skills and competencies critical for a recovering alcoholic (White & Miller, 2007). The ability of the 12 step process in helping the members uphold sobriety through the sharing of experiences, strengths and expectations with others is a critical component for self-acceptance and improvement of self-esteem (Brower et al., 2013). This sharing of experiences and support structures ensures that the feeling of isolation and loneliness that recovering addicts feel is reduced hence aiding in the recovery process. Denzin (1987), observed a link between how alcoholics express their narrative in AA and recovery, which then helps recovering alcoholics streamline their earlier identification with the alcoholic self and restructure it in terms of a new person making a recovery. This new self is gradually shaped through the sharing of one's narrative during recovery. The 12-step process assists the recovering alcoholic to learn that alcoholism is a disease denying them the ability to predict and control the alcohol consumption. The recovering alcoholic also become cognisant of negative patterns of alcohol use and comes to recognise the damage brought by their drinking and begin to appreciate that the road to sobriety is a lifetime process (Cromin, 2013). The recovering addicts using the 12-step model learn to admit wrong doing and make amends to those they have hurt and become responsible for the messages of recovery to others. The recovering addicts also learn how to overcome grief in the recovery process. The grief is occasioned by a feeling of loss over diverse aspects of the alcoholic's life such as career, family, health and financial concerns (Kuria, 2015). Alcoholics with such problems may successfully struggle through their personal conflicts with the help of counsellors and other helping professionals and benefit from the 12-step programme (Gwinnell & Adamec, 2006).

The 12 step programme through the AA also helps members through the provision of sponsorship which gives them continuous and personal help from members who have advanced in the programme (Fidelis, 2014). This is critical especially during the initial stages of recovery where the recovering alcoholic encounters the greatest resistance. The AA 12 step also assists members from the dangers of relapse through the provision of social support, role models and social approaches for sustaining a sober way of life (Milton, 2014). A sponsor who is friendly with the recovering alcoholic can offer essential support and

guidance during the process of recovery, especially when the recovering alcoholic is experiencing episodes of emotional anguish and increased craving (Kraemer, 2012). Research studies indicate that a recovering alcoholic that indicates that most of the friends facilitate drinking, the alcoholic should be encouraged to join the Alcoholics Anonymous, which facilitates association with people seeking a life of sobriety (Miller, 2009). In a study that examined the features of 12-step facilitation, Montgomery, Miller and Tonigan (1993), established that groups involved in AA reported moderate to high emphasis on relationship dimensions that included cohesion and expressiveness, specific characteristics of goal direction (independence, self-discovery and spirituality) and organisation. Moos (2010), notes that in general, group members of AA with these active requirements tend to reveal higher satisfaction levels and well-being and experience better results during recovery.

Hollen (2009), posits that in spite of the positive bearing AA has had on millions of alcoholics and their families, censure of the movement has been extensive. Most of its critics are of the opinion that its persistence on total self-restraint against alcohol use is too rigid and disregards problem drinkers who can learn to moderate their use of alcohol and manage their lives in a better way. Some of its critics' further note that AA's persistence that alcoholism as a disease diminishes the role that discipline, willpower and personal responsibility have in the alcoholic's struggles to overcome his or her condition. A further group of critics assert that AA is cult-like and promotes dependent relationships in which older members take advantage of newer and vulnerable members (ibid). The major setback with the AA 12-step facilitation model has been the perceived high dropout rates with some studies reporting that about 50 % of patients stop participating before 3 months (Mckay, 2009). This is discouraging for many rehabilitation facilities as some alcoholics may fail to conform to the prescribed course of treatment and consequently carry on with the drinking after leaving the facility. Aspects such as low economic status and lack of family or social support for continuing abstinence are among the most important variables associated with lack of treatment adherence and eventual reversion to drinking after treatment. In spite of these criticisms, many centres offering rehabilitation and addiction counsellors strongly endorse AA attendance for new sober alcoholics, especially in the weeks and months following their release from treatment when they are struggling to re-establish steady lives (Hollen, 2009).

Corey (2013), observes that the AA 12-step programme has functioned relatively well for many alcoholics and point out that once recovering alcoholics understand the nature of their chemical addiction and are no longer using alcoholic substances, their likelihoods of making a recovery are greatly increased. This makes it possible to pay attention to other facets of their lives that seem challenging (ibid). It is therefore possible to manage alcoholism as well as carry out a programme of individual treatment geared to altering the recovering alcoholics' ways of thinking, feeling, and behaving. The AA 12 step facilitation model was selected as a result of its enduring standing as a feasible modality for the treatment of alcoholism and being the leading method of management employed in most rehabilitation centres (Evans, 2010; Mosher-Ashley & Rabon, 2001). The examination of an alcoholic's degree of AA participation and their present willingness for engagement with AA can be helpful in treatment planning as it may offer recovering alcoholics added support in managing sobriety (Miller, 2009). Studies on the mechanisms of the 12-step programme and it benefits in the development of competencies of persons with addiction with regards to resilience, self-efficacy and hardiness may provide useful data that could be transferable to other non-12-step treatment approaches (Stokes, Schultz & Assim, 2018). This brings to fore the gap on the need to examine the role that the 12-step facilitation model has on recovering alcoholics social and personal competencies and shed new light on the various steps on the road to recovery. The AA 12 step facilitation approach comprised of one of the independent variables that was part of the rehabilitation factors for this study.

2.5 Addiction Counsellors' Characteristics

The addiction counsellors' characteristics are critical in the development of the recovering alcoholics competencies (Erickson, 2009). The effectiveness of addiction counsellors requires sound procedures for appropriately making assessments on alcoholics in recovery and conceptualising the issues unique to each person. A solid theoretical basis is paramount for addiction counsellors to correctly define the needs of the recovering alcoholics and summarise possible treatment guidelines. An addiction counsellor must utilise the experience and education gained to inform on the most suitable treatment approach to use for each recovering alcoholic (Association for Addiction Professionals, 2009). Varied counsellor characteristics such as background knowledge, attitude, counselling skills and experience specific to dependencies all contribute to effective counselling on addictions and positive results of recovering alcoholics (Gabhainn, 2003). Other qualities for addiction counsellors

such as personality traits, interpersonal functioning and professional beliefs have been established as being critical in recovering alcoholic competencies (Pabian, 2014). An assessment of alcohol abuse and the resultant consequences is important as such information may help an addiction counsellor appreciate the magnitude of the problem associated with each alcoholic (Miller, 2009). The information further gives the therapist a picture of the alcoholics' frame of mind which may assist with the planning of treatment and in enhancing the client's motivation during rehabilitation. A clear insight by the counsellor of the perceived effects may assist in identifying and overcoming treatment barriers (ibid).

Mwathi (2013), indicates that counselling work is often emotionally draining calling for the need by counsellors to have coping mechanisms and traits. Mercer & Woody (1999), assert that addiction counselling gives the recovering alcoholic coping approaches and recovery tools and supports the AA 12-step philosophy and involvement. The main objective of addiction counselling is to empower the recovering alcoholic in realising and sustaining abstinence from alcoholic substances and behaviour. The concept of addiction counselling has a secondary objective of helping the recovering alcoholic move from the harm that alcohol addiction causes in one's life. The addiction counselling process works by aiding the alcoholic in identifying the presence of a concern regarding the mode of irrational thinking. The recovering alcoholic is then inspired to attain and uphold self-restraint and then move towards developing the required spiritual development and psychosocial skills and to remain in recovery as a lifetime commitment. Addiction counsellors must therefore have personal drive and motivating factors to enable them cope with this emotionally demanding role (Mcveigh, 2012). In this context, the self-efficacy beliefs among the addiction counsellors have been seen to mitigate work related strain and stress enabling the counsellors to cope better with the diverse demands of their roles (Morgenstern et al., 2014). The self-efficacy beliefs are defined as principles in one's proficiencies that shape and perform specific actions in such a way that sought after goals are accomplished (Melorose & Perroy, 2015). The connection between self-efficacy and addiction has been extensively studied and results demonstrate that a higher self-efficacy to refrain from alcohol is related to improved long-term treatment results in addiction (Marlatt & Gordon, 2005).

There are four major sources of self-efficacy among the counsellors dealing with addiction disorders that include enactive mastery, vicarious learning, social persuasion and

physiological arousal (Erickson, 2009). The occurrence of enactive mastery happens when a person undertakes a specific behaviour, interprets the effects of that specific behaviour in relation with the outcome and uses that interpretation to develop further opinions such as self-efficacy beliefs about his or her capabilities in a future condition or event (Bliss, 2008). This enactive mastery is acquired through experience and is considered to be the greatest source of self-efficacy beliefs and achievement of success that employs the use of a given pathway during counselling (Kivlahan, 2013). Vicarious learning as a source of self-efficacy beliefs is critical in relatively inexperienced counsellors and involves the addiction counsellors' observance, retention, recollection and replication of a model's performance on a given task (Rassool, 2008). The addiction counsellors with little enactive mastery are likely to use the vicarious learning through observance of diverse models such as AA 12 steps model in counselling sessions (Kuria, 2015). The social persuasion as a source of self-efficacy includes positive reinforcement that nurtures self-efficacy beliefs and a belief that success is indeed possible for alcoholics through counselling (Mwathi, 2013). Social persuasion may be achieved through the giving of positive words by family members of the alcoholic. The erroneous thought patterns model as postulated by Ladouceur, Gaboury, Dumont and Rochette (1988), assumes that illogical thinking underlies addiction and helping recovering alcoholics requires addiction counsellors to challenge faulty thinking patterns by teaching clients how to reason and perceive issues correctly.

The U.S. Department of Health and Human Services, (2011) identifies different skills and competencies that addiction counsellors should have irrespective of their specialty such as drug addiction or alcohol addiction. At the core of the skills and the competencies that the addiction counsellors should have are four trans-disciplinary fundamentals namely the need to understand addiction, knowledge on treatment, professional readiness and application to the area of practice as outlined in figure 1. The first competency is the need for addiction counsellors to appreciate a range of models and philosophies of addiction and other concerns related to substance abuse. This competence calls for the addiction counsellor to be knowledgeable on concepts of different addiction theories as well as their application in diverse scenarios. The second competency includes the addiction counsellor's capability to recognise the political, social, cultural and economic context under which alcohol and substance abuse take place. This includes resilience and risk elements that characterise the surroundings that people live in. Addiction counsellors must demonstrate sound professional

decisions, be able to promote rapport with most recovering alcoholics, be good listeners, be patient of the alcoholics and be in a position to use confrontation in a supportive manner (ibid). The third competency is the ability of the addiction counsellor to define the behavioural, physical, psychological and social effects of addictive substances on the individual using and significant persons around them. Finally, the addiction counsellor must be able to recognise the likelihood for disorders resulting from substance use mimicking a variation of mental and medical health concerns and the possibility for mental and medical health issues coexisting with substance abuse addiction (U.S. Department of Health & Human Services, 2011).

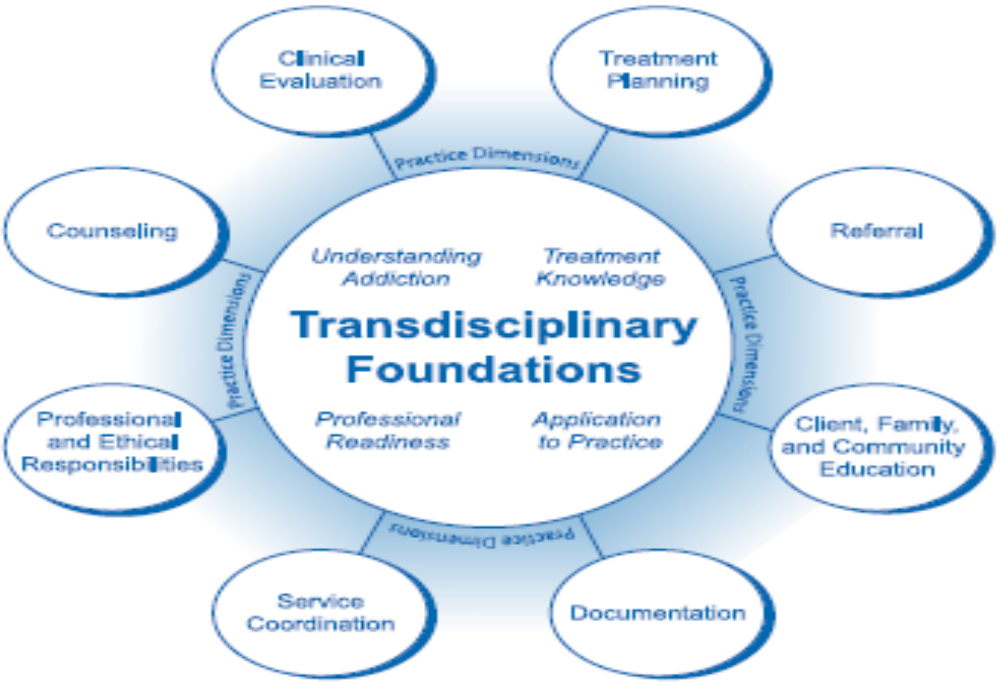

Figure 1. Components in the Competencies Model

Source: U.S Department of Health and Human Services (2011)

According to the U.S. Department of Health and Human Services (2011), the treatment trans-disciplinary foundation has four competencies that the addiction counsellors must have. These first competency is the ability of the addiction counsellor to describe the viewpoints, policies, practices and results of recognised and methodically supported approaches of treatment, relapse prevention, recovery and aftercare for addiction concerns. Mercer and Woody (1999), argue that it is essential for addiction counsellors to possess an in depth understanding of addiction and the tools that aid recovery as well as the ability to empathise

with the patient for them to be considered effective. The addiction counsellor must also recognise the significance of family, community and social networks in treatment and recovery processes; appreciate the importance of empirical studies and their use in clinical practice; and recognise the importance of an interdisciplinary method in dealing with alcohol dependency (ibid).

The United States Department of Health and Human Services (2011), describes nine competencies for the application to practice foundation stage that include the ability of addiction counsellors to establish diagnostic modality for disorders on substance use and define treatment and placement criteria within the range of care. Other competencies are the ability of the addiction counsellors to define a range of strategies for decreasing the undesirable effects of alcohol abuse and dependence; modifying the treatment approaches in dealing with alcohol dependence, recovery and provision of rehabilitation services suitable to the diverse needs of the alcoholic (ibid). The addiction counsellors must also be able to adjust their approaches to suit a wide variety of settings and strategies related to treatment; be acquainted with medical resources in the treatment of substance abuse conditions; appreciate the range of health and insurance care alternatives accessible and the significance of ensuring access of these benefits by their clients. Addiction counsellors must be in a position to recognise that crises may point out to an underlying condition of alcohol abuse giving way for an opportunity for modification of various techniques in the assessment of treatment results (ibid).

Expert preparedness as a trans-disciplinary foundation establishes six competencies that the addiction counsellor must have (U.S. Department of Health & Human Services, 2011). This includes the addiction counsellor's understanding of different backgrounds and the integration of the important needs of different cultural groups into clinical practice. Others include the understanding of the significance of self-awareness in an individual's professional and cultural life; the appreciation of the addiction counsellor's responsibilities to observe ethical and behavioural values of conduct in the counselling association; appreciating the significance of constant supervision and ongoing education in the provision of client services; understanding the responsibility of the addiction counsellor to take part in prevention and rehabilitation activities and embracing specific guidelines and procedures for managing crisis or unsafe situations, that include protection measures for recovering alcoholics (ibid). The

prognosis for a favourable outcome for the recovering alcoholic is highly dependent on the nature of association established with the addiction counsellor. In a scenario where the alcoholic in recovery fails to progressively open up and express himself openly, desirable outcomes during recovery may not be achieved eventually affecting the process of enhancing various competencies during rehabilitation. The relationship aspect between the addiction counsellors and the recovering alcoholic was therefore a critical point of focus in this study.

Some of the addiction counsellors are beneficiaries of recovery programmes such as former AA members and employ the use of behavioural models as a key tool in helping fellow recovering alcoholics to understand and deal with the nature of their concerns (Kalema & Vanderplasschen, 2015). Addiction counsellors engaged within rehabilitation facilities and are on the road to recovery from alcohol addiction, contribute significantly to the strength of the treatment interventions. Their observable presence tends to reassure recovering alcoholics that they are under persons that appreciate their needs and are in a position of providing genuine help. This further reassures the recovering alcoholic of the possibility of identifying with an addiction counsellor who is a recovering alcoholic and subsequently begin to re-align their own behaviours based on the accomplishments of what they observe (Reading, 2009). This aspect of providing an affirmative role model can give the recovering alcoholics a sense of optimism and bearing especially during the early phase of their attempted recovery. The recovering addiction counsellor tends to have a better appreciation of the downsides that alcoholics face as well as the power of thought processes that often results in relapses (ibid). Recovering addiction counsellors are often in a position of challenging poorly thought-out strategies for intervention and interrogate judgments and assumptions concerning change when dealing with alcoholics. Recovering addiction counsellors are in many instances personally committed to working with addictions and therefore have a habit of putting more into their work and practice in the field for longer periods than non-addicted counsellors (ibid).

Reading (2009), notes that recovering addiction counsellors also incorporate to the service the strong networks established with the recovering community during the course of establishing their own recovery. These contacts are significant not only in building the repute of the rehabilitation process but also in improving the relationship and referral of recovering alcoholics who require assistance from other service providers (Adams & Warren, 2010).

This brings to focus the need to establish the degree of association between the addiction counsellors' characteristics and the process of recovering alcoholics competencies under whose care recovering alcoholics are during their stay for the rehabilitation programme. This association would help shed light on the process of gaining social and personal competencies on the road towards sobriety.

2.6 Recovering Alcoholics Characteristics

Mjwara (2013), indicates that though a lot of attention has been given to the significance of choice and decision making in the rehabilitation counselling literature, there is a gap in the area of identification of recovering alcoholics decision-making style in the counselling relationship. This inquiry is important for boosting personal growth. The capacity of an individual to use judgment and make choices at both personal and interpersonal levels has been cited as an essential skill that strongly affects the value of life (Kuria, 2015). Howatt (2000), observes that behavioural change rests mainly with the inspiration of the recovering alcoholic and not the counsellor. Since alcoholics start the process of rehabilitation with different levels of motivation, the addiction counsellor should strive to match this drive with a treatment plan that is effective as this forms a critical component in achieving positive change for the alcoholic. Research shows that people with alcohol use disorders experience stigma from the public and from other health care professionals more harshly than persons with other mental disorders (Charlotte, Manthey, Martinez & Rehm, 2015). This perceived high stigma has been shown to reduce the prospect of using health care services contributing to a reduced likelihood of seeking rehabilitation services (Wallhed, Bakshi & Andreasson, 2014).

The rehabilitation literature encourages the evaluation of skills in problem solving as part of the vocational planning process for vocational training for persons observed to be undergoing difficulties in making choices. The onset of alcohol addiction has been established to be closely associated with the period of adolescence which is an age in where young people face many and tremendous dynamic and intense changes (Mjwara, 2013). Young people in groups often express their rebellion against the culture dominating their local populations by following different styles in culture, music and the spending of leisure time (Bauer, 2015). This often leads to acts of rebellion against parental authority that is the primary factor responsible for their socialisation. Coombs and Howatt (2005) observe that full addiction

may occur at any age where the focus moves away from other life activities to the act of obtaining and using alcohol and other drugs. The untangling of the social fabric of life begins when the use of drug substances becomes a daily routine and obsession. During the formative and escalation phases, substance users mainly take drugs for the psychological and social rewards they offer resulting in feelings of excitement and euphoria. These highs over time become more and more difficult to achieve resulting in difficulties for the alcoholic and life turns into a struggle for survival.

Shannon (2010) observes that the disorders related to substance use affect various aspects of an individual's life and the rehabilitation programme therefore needs to touch on every aspect of a recovering alcoholic's life. Treatment of alcohol is holistic in nature and involves more than helping the alcoholic stop drinking which serves as the beginning of the recovery process. The recovering alcoholic needs to re-learn a whole range of skills to help deal with anger, social situations and leisure activities without using alcohol (ibid). The identification of a variety of factors at a personal and the societal levels that impact on the scale and patterns of alcohol consumption that raise the risk of alcohol abuse disorders as important in the process of rehabilitation (Babor, Caetano, Casswell, Edwards, Giesbrecht & Graham, 2014).These factors consist of the aspects of gender, age and social economic factors (Githae, 2015). The age aspect is critical as studies point out to children, adolescents and ageing persons being more exposed to alcohol related harm from a given volume of alcohol than other age groups. This adolescent characteristic is consistent with the observation that development of alcohol addiction is greater amongst those individuals who engaged in substance abuse before the age 20 years (Clark, 2013).

Research studies point out that early introduction into alcohol use prior the age of 14 years is a determinant of a weakened health status and has been linked to rising cases of alcohol dependence and abuse at later stages of human development (Grundstrom, Bucholz, Rice & Bierut, 2012). Cases associated with alcohol use resulting in motor vehicle accidents and other unintended injuries have also been reported (ibid). Studies indicate that the use of substances at an early age affects brain development which is not complete until approximately the age of 20 to 23 for women and 23 to 25 in men (Hanson, Medina & Padula, 2011). One of the brain areas still experiencing maturity during the period of adolescence is the pre-frontal cortex, a part of the brain that allows people to make

assessment of situations, sound decisions and keep emotions and desires under control (NIDA, 2018). This therefore puts adolescents at an increased risk of making poor decisions such as experimenting with drug substances as well as their continued use. This therefore results in profound and long-lasting changes in the brain (ibid). As sex hormones and pleasure-related brain systems become more active during the period of adolescence, sexual interest stimulation and the prospect of consuming alcohol, smoking and abusing other drugs becomes more attractive (Reyna & Farley, 2006). The prospects of engaging in drug substances increases as young people spend more time with their peers and take more risks than younger children (Steinberg, 2008). Adolescents seem to be less conscious of risks and may participate in more irresponsible behaviour while intoxicated. Injuries related to alcohol abuse among older people results from diverse influences than alcohol-related harm among young people. While alcohol use usually declines with age, mature users normally drink alcohol more regularly than younger age groups (Mjwara, 2013). Alcohol use is provoked by the same influences that contribute to the commencement of imitation smoking and peer pressure with many young people viewing alcohol use as the in thing to engage in as it appears to signify independence, maturity, rebellion and is associated with having fun (Martin, Carlson & Buskist, 2010).

Gwinnell and Adamec (2006), observed that most addicted people are young adults in the 18–25 age range and are often male. Empirical studies by WHO (2018), indicate that the incidence of alcohol use among male respondents in urban settings was highest, with global projections suggesting that the consumption of alcohol will continue to rise by the year 2025. According to a report by UNODC (2014), there has been an overall surge in the prevalence of substance use by 18% in the world population aged 15-64 years. Young people below 18 years of age are more likely than adults to display risky behaviour with addictive substances that can result in their suffering from lifelong effects. When under the influence of alcohol or drugs, young people are more likely to commit crimes, assault others and engage in risky sexual behaviour. As people mature and advance in age, their body metabolisms are less capable of handling high levels of alcohol use as in previous years often resulting in a heavy burden from accident related injuries from falls. A report by the United Nations Office on Drug Control (2012), notes that individuals usually seek treatment for drug use when they are in the late 20s or early 30s and most drug-related deaths usually occur within the mid-30s. The burden of disease related to alcohol use among mature age groups is a growing public

health concern resulting from the fast aging population in the developed nations (Cloete, 2014). Corey (2012), observes that there is a need for early direction in the course of treatment for alcoholics and their children, as irrational behavior patterns have been observed in their control systems when required to make regular appraisals as a result of their lives being seriously compromised by alcohol abuse. Alcoholics are likely to have a distorted perspective with instances of appearing to be ignorant of what they want in their lives. As the alcoholics mature and grow in rehabilitation and forge positive associations with addiction counsellors, they gradually learn to make assessments with reduced assistance from the addiction therapists signifying an enhanced capacity in decision making (Wubbolding, 2011; Wubbolding & Brickell, 2005).

Alcohol abuse has been quoted as the single most cause for death in males aged between 15–59 years (Kuria, 2015). Studies have pointed out that women may be more susceptible to alcohol-related harm from a given level of alcohol use (ibid). The susceptibility of women to alcohol-related harm is a serious health concern as rising cases of alcohol use among females have been noted in line with economic empowerment and changing gender roles in society (Wilsnack, Wisnack, & Kantor, 2013). Differences in gender have been observed to be substantial in relation to the incidence of alcohol use disorders, with global estimates placing 237 million men and 46 million women as having alcohol related disorders (WHO, 2018). Trends across the world show a greater amount of substance abuse in men when compared to women, with 18.2% of males compared to 12.5% of females aged 12 and above reporting substance abuse in the United States (UNODC, 2012). Studies indicate that the progression through the stages of addiction for women is more rapid to that of men as a result of biological and social mechanisms that intensify their predisposition to substance addiction (Clarke, 2013). Gender variations in water content in the body results in higher blood alcohol concentration levels in women with a lower alcohol intake and long-term alcohol use resulting to serious health issues in women (Howatt, 2000).

Survey findings from developed nations associate the presence of more alcohol users with more drinking events with low-risk consumption trends in higher socio-economic groups, while those opting to abstain are mainly from the poorest social sections of society. Alcohol users of lower socioeconomic status seem to be more exposed to noticeable complications and consequences as a result of their prolonged use (Grittner, Kuntsche, Graham &

Bloomfield, 2012). The high predisposition among lower SES groups is explained by the fact that they are unable in most instances to avoid hostile situations of their activities due to limited resources at their disposal. It has been argued that persons with higher SES are able to identify safer surroundings to drink alcohol and have better access to high quality health care services. The relationship between alcohol-related harm and SES is an area of serious concern by the public owing to the liberalisation of markets and increased affluence that has availed cheap alcohol to lower SES groups in developing economies. These changes in alcohol affordability have often increased consumption especially among lower SES groups which is bound to intensify the attributable burden of diseases related to alcohol in developing countries like Kenya (McLeod, 2013).

2.7 Level of Family Support on Recovering Alcoholics' Competencies

The family as a core socialising agent is largely responsible for the nurturing of its children and is expected to show uninterrupted care for its members' psycho-physical development. The family may be considered critical for the shaping of personality and may be viewed as a primary socialising agent that plays a central role in the upbringing and moulding of forthcoming generations (Janson, 2007). People who are unable to establish healthy connections with their parents or caregivers during their formative years tend to be inclined to alcohol abuse than those able to establish strong relations (Evans, 2010; Sachs, 2003). The strength that an individual gains through the quality of parenting and socialisation received can affect the level to which hereditary factors result in the behavioral signs of addiction (NIDA, 2008). Hereditary and environmental factors interact during the early years in an individual's life, which also affects an individual's predisposition to addiction (ibid). The social circles and work environment of alcoholics in recovery may strongly influence their use of alcohol and course of their rehabilitation (Miller, 2009). It is therefore important that an examination of the extent to which families assist the recovering alcoholic or hamper progress of their rehabilitation be established. If a recovering alcoholic has inadequate social support or the network comprises of active alcohol users, the rehabilitation programme should address these concerns with efforts being made to assist the recovering alcoholic develop relationships that promote sobriety (ibid).

Georgas (2006), observes that alcohol addiction poses on-going concerns for all persons involved especially family members of the alcoholic, who often have to acknowledge their

incapacity to manage the situation in an effective manner. The family cannot be viewed as an isolated unit, but rather as a central part of the wider community that strongly affects individual behavioural patterns as well as the wider society (ibid). The role played by family in the rehabilitation process is gradually finding recognition with the changing aspects of the family becoming core areas of knowledge that every addiction counsellor should posses (Council on Rehabilitation Education, 2004). The provision of love and support by family and networks of friends can help alcoholics recognise the need to focus on self-defeating behaviour and the use of interventions that are structured by an addiction counsellor to help realise this goal (Coombs & Howatt, 2005). There is solid proof supporting the success interventions by family in alcoholism rehabilitation, demonstrating that such interventions for alcoholics are effective in cultivating overall interactions and functioning of families (Saatcioglu, Erim & Cakmak, 2006). Shannon (2010), highlights the essence of family education in rehabilitation of alcoholics as this component can help members understand better the nature of alcoholism and causes, its effects and modalities of treatment. Rehabilitation programmes provide this instructional aspect through the giving of lectures, engaging in discussions and group meetings as well as the provision of counselling for families and married couples (ibid). Family counselling is especially critical in treatment of adolescents and parents need to be involved fully in treatment planning and follow up care decisions.

A critical factor in promoting recovery from alcohol addiction is the attitude of important people in the life of the recovering alcoholic that includes family and friends (Gwinnell & Adamec, 2006). Persons recovering from addiction with a social arrangement comprising of a network of support against the use of alcohol are more likely to understand and tolerate reduction in alcohol consumption (Wasserman, Stewart & Delucchi, 2001). Our culture has concerns deciding whether people with alcohol addiction should be punished or need to have their illness treated. Complicating the issue further is that people with addictive behaviour are often more likely to commit violent crimes and to end up in the criminal justice system regardless of which model of addiction is accepted. The social acceptance of addiction can also impede recovery. Family support is therefore crucial in the building of competencies among recovering alcoholics. According to Cloete (2014), there are various levels in which the family may be involved in the promotion of social and personal competencies among recovering alcoholics. Family participation is based on the willingness of family members,

the intended goals that need to be achieved and provisions for the involvement of family members in the rehabilitation programmes amongst other factors (Morgenstern et al., 2014). Family members need to acquire innovative ways of coping with a recovering alcoholic as well as taking time to understand their situation and begin to use the support of self-help groups available from networks identified through the help of addiction counsellors (Shannon, 2010).

Family members and parents of adolescents with alcohol dependency may be less resistant to involvement in treatment because the adolescent usually resides with them and may feel responsible for the adolescent's behaviour. When parents themselves are actively addicted to alcohol and other drug substances, the challenges of treatment are greater. Adolescents are less likely than adults to enter treatment to avoid incarceration but are more likely than adults to be pushed into treatment by their families or schools (Mack, Harrington & Frances, 2010). The first level of treatment involves the examination of the alcoholic by the counsellor where the focus is on individual recovery. Where the family is involved in the first level, the engagement is informal in nature and often occurs at the point where family members bring the alcoholic for admission. This initial step involves structuring of resources available within a family setup and seeing how they can be built upon. The preliminary interview process may involve a careful analysis of the resources available to the family to promote cooperation during rehabilitation by enhancing information sharing and communication from all family members (Ell, 1996). The second level of treatment involves the therapist having a brief discussion with the family members but the patient remains the main focus (Komen, 2012). Topics of discussion may include recommendations on how to deal with the patient in rehabilitation or to refer the family to a family therapist. The third level involves the counsellor educating the family on issues related to alcoholism and family dysfunctions that contribute to the problem (Barnard, 2014). The fourth level of intervention includes the family being involved in the recovery process with the aim of changing communication and behavioural patterns that contribute to the addiction at a family level. The final level of treatment involves intense sessions where the focus is on addressing more extensive topics which represents pure family therapy (Erickson, 2009).

The involvement of families in rehabilitation has a tremendous effect on the recovering alcoholic's drive to make changes and facilitate sobriety (Templeton, Velleman & Russel ,

2010). This involvement provides information about experiences and connections of the alcoholic that may have an influence on effective planning during treatment and in relapse prevention (Saatcioglu et al., 2006). A vigilant examination of the social dynamics of the family often points out to the changes that need to be made not only in the person showing the most maladaptive behaviours but in the other family members (Martin et. al, 2010).

The expressed emotions (EE) between the family members and the recovering alcoholic play an important role in the interpersonal relationship dynamics which is critical for the rehabilitation of the alcoholic (Maro, 2014). According to Githae (2015), expressed emotions denotes aspects such as hostility, emotional over-involvement (EOI) and criticism often displayed by family members towards an alcoholic. The hostility occurs where the family members attribute the negative consequences to factors within the alcoholic's control and hence hold the alcoholic responsible for their challenges. On the other hand, criticism is the expression of disapproval of the alcoholic and his behaviour that involve remarks disapproving of the person rather than the specific negative behaviours of the alcoholic (Brower et al., 2013). The EE often occur as the family coping mechanism to exercise control over what may be overwhelming behaviour by the alcoholic. Moos (2010), observes that emotional and instrumental care may enhance self-confidence and offer resources to help persons battling alcohol addiction and has been closely associated with better treatment outcomes.

The hostility aspect of the EE has three dynamics that consist of affective, cognitive and behavioural aspects in respect to the interpersonal relationships between family members and the alcoholic (Mjwara, 2013). Affective aspects have been associated with negative feelings such as contempt, distrust and anger, while cognitive characteristics of hostility include negative beliefs about others such as pessimistic attitudes and suspicion. Behavioural hostility includes the expression of anger, irritability, resentment, antagonism and assault (Bauer, 2015). The occurrence of hostility is as a result of family members blaming the alcoholic for his encounters. The recovering alcoholic is seen as being in control of the course of the alcoholism challenges and being perceived as displaying selfishness in the refusal to get better. The alcoholic may be blamed for negative family incidents (Hall, 2015). This is the perception that the alcoholic is engaging in the alcoholism misbehaviour affecting the wider family members; therefore affecting the interpersonal relationships (ibid). Although recovery

is in the long run the person's responsibility, encouragement is given to the recovering alcoholic through support from counsellors, peers under recovery and family members.

Hollen (2009), observes that comprehensive programmes that offer support and counselling to families could help them achieve normal functioning. It can be extremely helpful when families get counselling to help everyone deal with the foreseeable disruption and anger that alcohol addiction builds in a family. Beattie (2001), notes that the presence of strong family ties particularly a partner or a spouse, who provides direction, support and supervision are related with reduced substance use and higher prospects of abstinence. McCrady (2004), indicates that a steady reduction from alcohol conditions has been observed in recovering alcoholics with supportive partners as well as those from well-organised and cohesive families that keenly observe progress of the alcoholics in recovery. All these are important factors in determining why some alcoholics are able to permanently stop addictive use or behaviour, why others may recover fully with minimal interventions and why others relapse recurrently. In spite of previous studies recommending the importance of family involvement within the treatment course, inadequate progress has been made in actually including families in the rehabilitation process.

Strong assertions by family therapists point out that numerous families are at present overstrained by occupational, economic and social pressures that pose serious challenges for them to devote time and effort required in providing stable supervision for recovering alcoholics (Hollen, 2009). Moos (2010), observes that the backing of goals, social bonds and observation of the recovering alcoholic by family members and friends tend to offer abstinence related support and norms. They further aid in building the person' coping skills self-efficacy and in encouraging involvement in social and recreational activities that safeguard recovering alcoholics from exposure to substance use, increasing the prospect of a steady recovery. Evans (2006) indicates that alcoholics in recovery may be encouraged by the support from friends and family members without which they can easily be overwhelmed by fear, anxiety and a sense of hopelessness in their effort to disengage from the security previously received from alcohol (Wismer-Bowden, 1998). It was therefore important to determine the relationship between level of family support and recovering alcoholics social and personal competencies during the process of rehabilitation.

2.8 Social and Personal Competencies in Recovering Alcoholics

The social and personal competencies within the context of alcoholics include the interpersonal, intrapersonal, coping and judgement skills (Brower et al., 2013). Competence is regarded as a concept which refers generally to the capacity to enhance adaptive reactions to demands and make the most of opportunities in the surroundings. The individual enhancing their level of competency makes use of personal and environmental resources to realise a good progressive outcome. The concern for alcoholics by counsellors is on the aspects that can support or help improve the ability in alcoholics to develop certain behaviour for adaptations in the short term as well as developmental progress in the long term (Cromin, 2013). The range of possibilities include specific skills and abilities to general constructs such as self-esteem. The enhanced personal and social competencies reflect an adjustment by the recovering alcoholic to deal with issues within their operating environment that involves relations with family members, colleagues at school, work and society in general. The emphasis on competencies is on specific characteristics such as self-control, empathy, trust and the respect for others (Masinde, 2011). Previous studies on social competencies has received much attention from policy makers and researchers in social science due to concerns regarding erosion or the lack of social competencies in society (Odera, 2013).

Within the field of psychology, social competencies are defined as personality traits that are manifested in different capabilities such as empathy, tolerance, conscientiousness and the ability for cooperation (Ingvarson & Page, 2013). Social competences transform over the life course and rest on the development of capabilities such as social skills, social awareness and self-confidence. The social and personal competencies are not innate but must be enhanced overtime so as to advance and improve performance and continue as one progresses through life (Roozen et al., 2009). Competence is further realised through the supervision and interaction with resource persons such as addiction counsellors who watch, listen and talk to the recovering alcoholics during therapy as well as applying therapy techniques and strategies that involve practice and feedback (Kivlahan, 2013; Erickson, 2009; Corey, Corey & Callanan, 2001). Competence is realised when the recovering alcoholic engages in a process of learning and personal improvement that involves the search for personal therapy, embracing a healthy lifestyle and being truthful about ones fears, needs, failures and shortcomings (Brown et al., 2012).

Friedman and Rusche (1999), observe that the abuse of alcohol on a long term causes intense changes in the brain with the behaviour of alcoholic being greatly affected by the maladaptive socialisation that progresses with the addiction. Gwinnell and Adamec (2006), note that as addiction becomes the epicenter of an addict's world, the alcoholic becomes progressively disinterested in being considerate for and interacting with the people who care the most about them. Work may then become difficult for the alcoholic because of their overwhelming obsession with the addictive action (ibid). Some alcoholics may be able to maintain their jobs and may deceive family, friends and colleagues about the seriousness of their addiction. However, most are unable to maintain the illusion of normalcy for a lengthy period of time. Recovery from alcohol addiction does not imply the return to a previous state before the abuse of alcohol began, but rather, the recovering alcoholic must mature into distinct level of personal awareness with new patterns of behaviour (Friedman & Rusche, 1999).

Recovering alcoholics that develop the needed fundamental skills that aid their growth into new habits from alcohol dependence during rehabilitation are encouraged to progress to other life goals. Alcoholics in recovery that offer help to fellow peers maintain long-term abstinence after treatment are better placed in maintaining abstinence, possibly as a result of the social rewards that emanate from giving support to others (Pagano, Friend, Tonigan & Stout, 2004). Affiliation with the 12-step facilitation model reinforces reliance among recovering alcoholics on coping responses that are specific in helping moderate substance abuse. The involvement by individuals in AA increases their likelihood of relying on coping skills aimed at controlling alcohol abuse, such as seeking guidance on how to deal with their problematic drinking, time spent with sober friends and rewarding themselves for making efforts to end their drinking (Snow, Prochaska & Rossi, 1994). This brings to focus the role that learning and education contributes to the long-term development of any individual. Coombs and Howatt (2005), recommend the need by addiction counsellors to assist recovering alcoholics move past their addiction by promoting lifestyle changes through planning. Studies indicate that recovering alcoholics engaged more in group meetings and activities have better prospects of socialising with friends, attending cultural events, participating in sports activities and reporting higher likelihoods of attaining and sustaining sobriety (Moos, 2010; Moos & Moos, 2006; Bond, Kaskutas & Weisner, 2003). The involvement by recovering alcoholics in community activities has been strongly linked with higher prospects of alcohol reduction in the initial stages during treatment and recovery in the

long-term (Kurtz &, Fisher, 2003; Crape, Latkin, Laris & Knowlton, 2002). These community engagements include religious and educational activities, civic duties and health promotion campaigns (ibid). Zemore and Kaskutas (2008), indicate that recovering alcoholics actively engaged in giving assistance in rehabilitation through provision of encouragement, moral support and sharing their insights with regard to achieving sobriety are more likely to be engaged in the 12-step encounters and realising significant improvements during recovery in the short term. The engagement by recovering alcoholics in activities offering help tends to enhance their social status and level of self-esteem as well as strengthening their support network and personal resolve to abstinence after their stay in rehabilitation (Crape et al, 2002). The major concern in the measurement of competencies involves the diversity of methods employed, that range from self-ratings or reports of behaviour, direct behavioural observations, values and motivations, behaviour rating scales, the use of socio-metric methods as well as computer simulations (Schoon, 2009). A synthesis of various methods was sought for the measurement of social and personal competencies among the recovering alcoholics in rehabilitation.

2.9 Theoretical Framework

The theoretical framework of this study was based on three theories that is Behavioural, Adlerian and Person centred theories of counselling. Each theory reviewed has a distinct focus on the study variables. Behavioural and Person-centred theories explored the relationship between the addiction counsellors and recovering alcoholic in the rehabilitation process. Adlerian theory on the other hand looked at the recovering alcoholic and the role of the family in promoting recovery. This therefore justified the use of the three theories in this study.

2.9.1 Behavioural Theory

This study was built on John Watson's and B.F. Skinners behavioural approach and its therapeutic application (Aissen, 2013). From a behaviourist perspective, all behaviour is learned which includes even the most intricate human behaviour that can be explained, controlled and modified through learning processes (Bliss, 2008). Modern behaviour theory views the person as the creator and the creation of his or her surroundings (Cloete, 2014). This present trend is geared towards developing techniques that give recovering alcoholics skills which then intensifies their choices of self-determination. Both classical and operant

conditioning are viewed as contributing factors in the popularity of alcoholic substances that alter mood, arousal and perception. Several aspects of conditioning influence the effects of alcohol. An individual trying out an alcoholic drink may find it producing a desired emotional state, euphoria, excitement, relaxation and social rewards (Koszycki et al., 2014). These benefits serve as reinforcers. After alcohol has been taken for a while, stopping can cause painful withdrawal symptoms which may function as punishment and an attempted escape from these aversive consequences provides negative reinforcement (Kuria, 2015). Society creates pressure to drink which in turn plays a role in alcohol abuse. Billboards and glossy advertisements portray drinking as something sophisticated and glamorous that appeals to young people anxious to enter the adult world (Fidelis, 2014) .

Behaviour therapists argue that abnormal behaviour patterns are acquired in the same way that normal behaviour is acquired in a learning process. This implies that all pathological behaviour can best be understood and treated by focusing on the behaviour itself rather than by attempting to alter any underlying disease care (Habibi, 2016). The central task of all living organisms according to behaviour therapies is learning how to adapt to the demands of their current social and physical environment. Kraemer (2012), argues that when a being has not learned how to cope effectively, their adaptive responses can be overcome by interventions based on the values of learning or re-learning. The unique aspect of this treatment is that it is directed towards the modification of behaviour rather than curing something within the individual. Masinde (2011), indicates that although the focus is on changing behaviour, the relationship between the alcoholic and counsellor is important, mainly in offering support to the alcoholic through difficult times of change and discomfort. This no doubt may lead to building of social and personal competencies that were previously not well organised in the recovering alcoholic and may serve in assisting to deal with the pressures to continue abusing alcohol (Mwathi, 2013).

The focus of Behavioural therapy is on increasing individual's skills so as to give them more options for reacting (Corey, 2013). A key characteristic under behaviour therapy is dealing with the alcoholic's problems and aspects influencing them as opposed to historical causes (Marsh et al., 2007). In this study, focus was selected rehabilitation factors and recovering alcoholics competencies. Emphasis is placed on specific factors that can result in behaviour change. The nature of behaviour therapy is action oriented that underscores learning

processes as the centre during of therapy (Mcveigh, 2012). The recovering alcoholic therefore learns different and adaptive behaviours to substitute old and maladaptive ones. It was critical to determine the level to which social and personal competencies were developed during the rehabilitation process of the recovering alcoholic in this study. Musyoka (2013) views behaviour psychology as an approach that brings modifications in what people are thinking and doing. The core principle is that all behaviour is learned and sustained as a result of the individual's interaction with the surroundings. Behavioural therapies contrast in their emphasis where the alcoholic's motivation to change is addressed, building resilience to resist alcohol use as well as providing motivations for self-restraint and replacing alcohol using engagements with creative and satisfying activities. Focus may also involve the enhancement of skills for solving problems and enabling healthier interpersonal relations. The involvement by recovering alcoholics in programmes supporting peer and group therapy during and after rehabilitation has been advocated in helping to maintain abstinence (National Institute of Drug Abuse, 2009).

The Association for Addiction Professionals (2009), views key principles when working with behavioral therapy that involve the examination of measurable and observable behaviour of an alcoholic by an addiction therapist and identifying the processes that contribute to the undesirable behaviour. The concern by behavioural therapists is on adaptive and maladaptive behaviour that result in distress in the alcoholic's life but not on concepts such as thoughts, self-esteem, defense mechanisms, values or self-esteem issues. Behaviour therapy is remarkably effective for persons with a substance use condition such as alcohol, since there are repeatedly definite, learned individual behaviour or triggers related to the behaviour of using such substances. Behaviour therapy approach has wide applicability to a range of clients desiring specific behavioral changes that include substance abuse and rehabilitation (Corey, 2012).

2.9.2 Adlerian Theory

This theory was put forward by Alfred Adler who sought emphasis on the uniqueness and unity of the individual. This theory views human behaviour as not determined exclusively by inheritance and the environment, but rather the individual's ability to influence, interpret and create events (Fidelis, 2014). The individual has the ability to make choices on what to do with the abilities and limitations he or she possesses. According to Hall (2015), Adlerian

theory focuses on re-educating individuals and re-shaping society. This approach is also referred to as individual psychology where emphasis is placed on appreciating the person within the social context of family setup, school, culture and working environment (Kuria, 2015). A person's feelings, thoughts, beliefs, attitudes, convictions, actions and character are manifestations of his or her individuality. These manifestations reveal a strategy that permits for movement towards a goal in life that should be the focus of the rehabilitation process for a recovering alcoholic. Adlerians are concerned with the future without minimising the significance of influences from the past with assumptions that resolutions are grounded on the experiences of the person with regard to the existing situation and in the path the individual is moving towards (Mcveigh, 2012). Alfred Adler argues that the aim of success is driving people forward enabling them overcome obstacles. Individuals under recovery can also seek to modify a defect into a strong point like dealing with alcohol addiction in spite of the setbacks involved (Corey, 2013).

Adler further argues that interactions within the family setup and nature of the relationships established with relatives contribute to how individuals perceive, think, feel and behave. He further notes that the experiences themselves are not the critical factors but the individual's interpretations of these events which ultimately shape our character (Musyoka, 2013). Defective constructs often result in misguided ideas that significantly impact on our present behaviour. Once an individual becomes conscious of these patterns, they can decide to change the faulty conventions and make simple changes and construct a new style of living. The objective of Adlerian therapy is to help alcoholics appreciate their distinct lifestyles and support them in learning how to think about themselves, those around them and the world (Milliren, Evans & Newbauer, 2007). Effective use of Adlerian therapy by an addiction counsellor must endeavour to see issues from the viewpoint of the alcoholic through the process of phenomenology. This involves trying to understand the alcoholic from the point of view of his or her family setup, perceptions, cultural and social contexts and private logic. The addiction counsellor must identify the alcoholic's viewpoint and attempt to create change within as well as ascertain their level of social interest. This individual's awareness forms a component of the human community and contributes to how the alcoholic relates with the social environment. This concept is often practiced in the fellowship of 12 steps facilitation model employed by the Alcoholic Anonymous group (Association for Addiction Professionals, 2009). The relationship between the client and the therapist is based on the

aspect of mutual respect where the recovering alcoholic is not viewed as being a passive recipient but rather as an active party in an association between equals (Corey, 2012). Recovering alcoholics through a cooperative engagement recognise their responsibility for their behaviour. Attention is therefore placed on examining the lifestyle of the alcoholic in recovery which expresses much of what addiction counsellors do during the process of rehabilitation (ibid).

Adlerian theorists do not perceive alcoholics as ailing and in need of treatment, but favour the progression personality model rather than the sickness orientation (Basche, 2014). Counselling as a process places emphasis in the delivery of information, guiding, teaching and offering encouragement to discouraged alcoholics (ibid). Adlerian counsellors have the realisation that alcoholics often get discouraged and function below par as a result of faulty values, mistaken beliefs and goals that were never accomplished. Adlerians therefore operate on the notion that an alcoholic will behave and feel better as soon as they discern and correct their inaccuracies. The counsellors are therefore on a look out for major flaws in the alcoholic's thoughts and value system such as unrealistic ambitions, mistrust and the absence of confidence (ibid). The appropriate use of Adlerian therapy helps recognise and correct mistaken beliefs that directly impact on how a person becomes an alcoholic. As a therapeutic approach, Adlerian psychology is powerful in empowering recovering alcoholics cultivate a positive, sober lifestyle, a sense of feeling right and learning to adjust existing behaviour patterns to those that may be beneficial and fruitful (Association for Addiction Professionals, 2009). This is achieved when the counsellor assists alcoholics gain insight into the "basic mistakes" deeply held in their everyday life. Once this insight is achieved, alcoholics become naturally motivated to change in constructive ways (Corey, 2013). As a growth model, Adlerian theory helps people realise their full potential and its principles have a wide range of applications on human problems and in alleviating social conditions such as alcohol dependency that interfere with growth (Corey, 2012).

2.9.3 Person Centered Theory

This study was also based on the Carl Roger's person centred theory also referred to as humanistic therapeutic perspective (Arnedt et al., 2007). Cloete (2014) asserts that the aim of person-centred therapy, is helping the alcoholic discover his or her potentialities and place in the world and to accomplish self-actualisation. Person-centred theory indicates that each

person has within him or her ability for positive and dramatic growth. Under person-centred therapy, a recovering alcoholic can dialogue about his past, present or future. As it involves a nondirective therapy, the counsellor trusts the client's ability for growth with the client following his lead, discussing whatever the recovering alcoholic values as important (Kraemer, 2012). Person-centred therapy is effective when counsellors help clients bring back their natural tendency for growth by creating a therapeutic relationship characterised by genuineness or congruence and unconditional positive regard on the part of the counsellor (Mjwara, 2013).

Humanistic therapy rests on the hypothesis that the natural tendency of individuals is moving towards progress and that when the hurdles towards growth are removed, then the client lets go of the signs and moves forward with his or her life (Brower et al., 2013). Addiction counsellors play a critical role in removing obstacles that recovering alcoholics view as significant in the road to sobriety during the rehabilitation process (ibid). Person centred theory views the association between the addiction therapist and recovering alcoholic as empowering where alcoholic in recovery receives guidance on rebuilding his strengths and optimising them towards self-actualisation through the aid of a therapist during rehabilitation (Cloete, 2014). The therapeutic relationship generates positive therapy which is characterised by a connection between addiction counsellor and recovering alcoholic based on working together. The attributes of the addiction counsellor that control the association include accurate empathy, warmth, unconditional acceptance and respect for the client, caring, genuineness and the communication of those aspects to the alcoholic (Corey, 2013). These attributes are considered as vital for change to take place during therapy. Research reveals that for therapy to be effective it has to be based on the relationship between the client and counsellor together with the inner and external strengths of the recovering alcoholic who is able to apply the competencies in realising positive outcomes (ibid).

In person centred approach, the addiction counsellor is not viewed as an authority figure but as a facilitator who helps the recovering alcoholic deal with obstacles towards his growth. Rogers places emphasis on the attitudes and personal characteristics of the counsellor as well as the quality of relationship created between the counsellor and client being as the key elements of the outcomes of therapy (Corey, 2012). Human centred approach has been applied effectively in clients with a wide variety of concerns including anxiety disorders,

alcoholism, interpersonal difficulties, personality disorders, depression as well as the initial phases of crisis intervention work (Corey, 2012; Bozrath, Zimring & Tausch, 2002).

2.10 Conceptual Framework

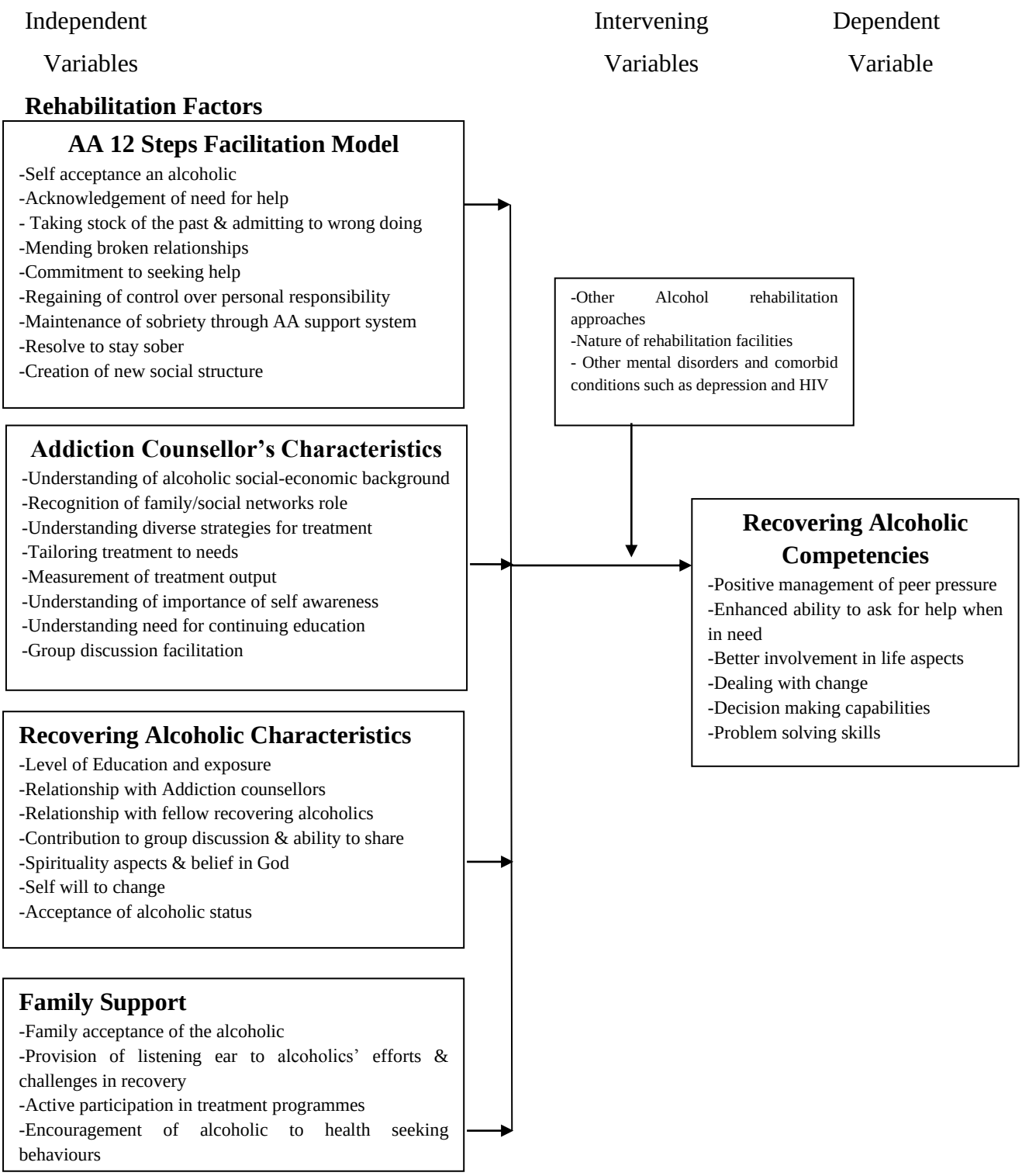

Figure 2. The Relationship between Selected Rehabilitation Factors and Recovering Alcoholic Social and Personal Competencies

According to Figure 2 above, the study hypothesised that there was a relationship between the independent variables (12 steps facilitation approach, addiction counsellors' characteristics, client characteristics, level of family support) and the dependent variable (recovering alcoholic competencies). The conceptual framework was based on the premise that relationship exists between the input variables depicted using directional arrows and the output variable for the study. The rehabilitation programme needs to enhance social and personal competencies among recovering alcoholics for their adaptations in the short- and long-term developmental progress. The failure to appropriately adapt may increase their likelihood of relapsing to alcohol. Intervening variables which may have affected the findings of this study include other approaches on alcohol rehabilitation, nature of facilities available in the rehabilitation centres and other mental disorders and conditions such as depression and HIV. These were controlled by obtaining a representative sample that ensured that the influence of these intervening variables on the findings of the study were minimised. It also ensured that all diverse characteristics of the population were represented. The relevance of Behavioural theory on this study was based on its unique approach to alcohol rehabilitation that is directed towards behaviour change rather than curing something within the person. It further seeks to enhance skills of the alcoholic in recovery by providing them with more options for responding. This allows the recovering alcoholic to acquire diverse and adaptive activities that aid in substituting old and maladaptive behaviour patterns. The importance of Person-centred theory was informed by its inclination that alcoholics in recovery can make positive strides towards their growth once hurdles in their path are removed. Its emphasis on the role played by addiction counsellors was viewed as significant in eliminating obstacles perceived as momentous in the road to sobriety by alcoholics. The role of the family in promoting recovery for alcoholics was viewed as significant by Adlerian theory hence its inclusion in the study. Adlerian theory puts premium on re-educating individuals and re-shaping society by helping alcoholics appreciate their distinct lifestyles and supporting them in learning how to think about the themselves, others and the world. Its approach of helping alcoholics in recovery recognise and correct erroneous views that directly affect their alcoholic nature was found to be essential in the study.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

Research methodology has been defined as the science of studying how research is done scientifically (Cooper & Schindler, 2011). This chapter examines the different aspects of research methodology including research design, location of the study, population, sample size and sampling procedures, instrumentation, validity and reliability, data collection procedures, ethical considerations and data analysis procedures.

3.2 Research Design

The study employed the *ex-post-facto* correlational research design. The *ex-post-facto* correlational research design is appropriate where the independent variable cannot be directly controlled by the researcher because their manifestation has already occurred and therefore not possible to manipulate (Sekaran & Bougie, 2011). The researcher then studies the independent variable or variables in retrospect for their possible relationship to and effects on the dependent variable or variables (Cohen, Manion & Morrison, 2007). This research design seeks to describe and measure the degree of association between an independent and dependent variable where the researcher does not control or manipulate any of the variables but rather examines on whether there exists a co-variation between two or more variables (Creswell, 2014). This design assists in finding out on whether two or more variables influence each other. This research design was suitable for this study because recovery from alcohol addiction is an on-going phenomenon among recovering alcoholics in rehabilitation facilities and the researcher would not manipulate the factors in the rehabilitation facilities under study.

3.3 Location of the Study

The study was carried out in 17 rehabilitation facilities in Nairobi and Central regions that employed the AA 12-step facilitation approach in alcohol addiction recovery. The choice of Central and Nairobi region was based on the high-level usage of alcohol compared to other regions in Kenya. An analysis of current usage of alcohol among respondents aged 15 – 65 years showed Nairobi region leading in the prevalence of current usage of alcohol at 17.5% (WHO, 2018). A rapid situation assessment of the status of drug and substance abuse in Kenya by NACADA in 2012 reported that Nairobi had the highest proportion of persons

using alcohol at 22% when compared to other regions in Kenya (NACADA, 2012). A baseline survey by NACADA in 2010 on magnitude, causes and effects in Central Kenya revealed a worrying state of alcoholism in the region pointing to a rather high level of usage of alcohol in Central Kenya (Mutai, 2014). A report by NACADA in 2010 indicated that two thirds of community members in Central Kenya indicated that alcohol consumption ranged from high to very high. These regions had also the highest number of established rehabilitation facilities further justifying their selection for the study (NACADA, 2012). The justification of regions as units of administration was based on NACADA's categorisation of rehabilitation facilities based on regions within the country.

3.4 Target Population of the Study

Target population refers to a group of elements in which the researcher seeks to make an inference or conclusion about (Fricker, 2019). The target population comprised recovering alcoholics and addiction counsellors within rehabilitation facilities in Nairobi and Central regions that embraced AA 12 step facilitation model approach in alcohol addiction recovery. The inclusion criteria for recovering alcoholics respondents consisted those that had been in the rehabilitation centers for at least 30 days. The target population of the recovering alcoholics were 202 while addiction counsellors were 81. The 30 days period inclusion criteria was deemed suitable in ensuring that the recovering alcoholics had been exposed to the rehabilitation efforts and programmes for an appropriate time frame to have had a noticeable effect. This period was deemed adequate for recovering alcoholics to have developed various social and personal competencies within the rehabilitation facilities reflecting their enhanced ability to deal with issues in the family, work or school and society. The social and personal competencies would therefore be enhanced through interactions with addiction counsellors, fellow recovering alcoholics, family members and the 12-step facilitation approach. The researcher established that there were 81 addiction counsellors and 202 recovering alcoholics as at October 2017 as shown on Table 2.

Table 2

Respondents Accessible Population in the Selected Regions

Region	Rehabilitation	Recovering Alcoholics	Addiction Counsellors
Nairobi	NR1	11	5
	NR2	21	7
	NR3	9	6
	NR4	14	4
	NR5	8	4
	NR6	7	4
Total	6	70	30
Central	CR1	23	10
	CR2	10	5
	CR3	16	5
	CR4	12	4
	CR5	7	5
	CR6	19	6
	CR7	12	3
	CR8	6	3
	CR9	7	3
	CR10	9	3
	CR11	11	4
Total	11	132	51
Grand total	**17**	**202**	**81**

Source: Rehabilitation Centres in Central and Nairobi regions, 2017

3.5 Sample Size and Sampling Procedure

In this study, purposive sampling technique was used to select 17 rehabilitation facilities in Nairobi and Central that employed the 12 AA facilitation approach in alcohol addiction recovery. Etikan, Musa and Alkassim (2016), note that purposive sampling is the deliberate choice of the specific members of the population to form sample membership due to the qualities that they possess. The researcher utilises their own judgment in selection of sample members. The sample size was determined through two different methods for the addiction counsellors and the recovering alcoholics. The sample size for the addiction counsellors was

81 members which constituted the whole population of the addiction counsellors hereby employing a census method. The census sampling technique was employed for the addiction counsellors due to their small numbers. The census sampling involved the picking of all the addiction counsellors in the 17 rehabilitation facilities to form part of the sample size. This is often used where the population is a small number and as such all the population members can form the sample size (Gall, Gall & Borg, 2007).

The sample size for recovering alcoholics was determined through the use of the Taro Yamane simplified formula as provided by (Scott, 2008) that is :-

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

where n= sample size

N=Population size = 202

e= tolerable error (5%)

$$n=\frac{202}{1+202(0.05^2)} = 134$$

A sample size of 134 was used for the recovering alcoholics. The names of the selected rehabilitation centres were withheld because of the need to maintain anonymity of the respondents and to protect their privacy as well as that of the rehabilitation facilities selected. Codes were therefore used for the regions, namely NR and CR for rehabilitation centres in Nairobi and Central regions respectively. A summary of the sample size is given in Table 3.

Table 3

Sample Size of Recovering Alcoholics and Addiction Counsellors in Selected Regions

Region	**Rehabilitation**	**Recovering Alcoholics**	**Addiction Counsellors**
Nairobi	NR1	4	3
	NR2	15	7
	NR3	5	5
	NR4	9	4
	NR5	2	3
	NR6	3	3
Total	6	37	25
Central	CR1	17	8
	CR2	5	4
	CR3	12	5
	CR4	6	4
	CR5	3	5
	CR6	15	6
	CR7	2	2
	CR8	3	2
	CR9	2	2
	CR10	2	3
	CR11	2	2
Total	11	70	43
Grand total	**17**	**107**	**68**

Source: Rehabilitation Centres in Central and Nairobi regions, 2017

3.6 Instrumentation

The study used a structured questionnaire for both the addiction counsellors and the recovering alcoholics. Kothari (2004) defines a structured questionnaire as a questionnaire in which there are definite, concrete and pre-determined set of response options presented with exactly the same wording and in the same order to all respondents. The questionnaire was preferred because it allowed greater uniformity of questions. The structured questionnaire consisted of five parts that comprised of background information, AA 12 step facilitation model, addiction counsellors' characteristics, recovering alcoholics' characteristics, level of

family support and recovering alcoholics' competencies respectively (Appendix II). There were provisions for the non-applicable option within the background information questions in part A in order to accommodate both groups. Part B which discussed the role of the alcoholic anonymous 12 step facilitation model on the recovering alcoholic competencies had questions adapted and modified from the AA 12 steps facilitation model (Rassool, 2008). This was with a view of finding the role of different steps on the recovery of alcoholic competencies. The questions for Part C examined addiction counsellors' characteristics and was adapted and modified from the United States Department of Health and Human Services competencies model for addiction counsellors (2011). This department has developed one of the most extensive and exhaustive competence models that have been adapted across the world. The questions in relations to Parts D, E and F were developed from the reviewed literature. The questionnaire utilised a five-point likert scale for parts B to F using metrics of strongly agree, agree, uncertain, disagree and strongly disagree so as to capture the views of respondents on different rehabilitation factors and their impact on recovering alcoholics' competencies.

3.6.1 Pilot Study

The pilot study was carried out in two rehabilitation centers in Nakuru County. According to Saunders, Lewis & Thornhill (2007), 30% of the sample size should be used for pilot study. A total of 24 addiction counsellors and 40 recovering alcoholics were used during the piloting phase. The pilot study was undertaken for testing reliability and validity of the questionnaire.

3.6.2 Validity of Research Instrument

Validity of a test refers to the accuracy with which it measures what it is designed to measure (Heale & Twycross, 2015). Mohajan and Mohajan (2017), further note that validity refers to the degree to which the results are truthful. A total of five experts comprising psychologists and counsellors from Egerton University and rehabilitation centres examined the test instrument and ranked the individual questions based on a four-point ordinal scale; Not relevant, somewhat relevant, quite relevant, and highly relevant. Both the Item to item level content validity index (I-CVI) and scale-level content validity index (S-CVI) were used for the study. An I-CVI threshold of 0.5 was used for the study. The S-CVI was calculated through the addition of individual I-CVIs and dividing by the number of items (Gadsboell & Tibaek, 2017). This ensured that the face and content validity of the instruments were

checked, and the test items scrutinised to identify and remove items that were unclear or ambiguous to the respondents.

I-CVI = $\frac{Number\ of\ Responses\ as\ "3\ or\ 4"}{Total\ number\ of\ responses}$ **(I-CVI calculation formula)**

3.6.3 Reliability of Research Instrument

Reliability of an instrument for data collection refers to the consistency of the instrument in measuring the concepts being studied with accuracy and without random errors (Dikko, 2016). This instrument was measured to ascertain the level of internal consistency using the Cronbach's alpha coefficient. Cronbach's alpha coefficient (α), is a method for testing internal consistency reliability of a summated or composite measurement scale. Table 4 gives the results of reliability of the research instrument.

Table 4

Reliability of the Research Instrument

Variable	No. of Items	Cronbach's Alpha Coefficient
Alcoholic Anonymous' 12 step facilitation	9	0.898
Addiction counsellors' characteristics	8	0.860
Recovering alcoholics' characteristics	8	0.747
Level of family support	6	0.742
Recovering alcoholics' competencies	6	0.887

Table 4 gives Cronbach's Alpha Coefficient for the five variables of the study namely; AA 12 step facilitation, addiction counsellors' characteristics, recovering alcoholics' characteristics, level of family support and development of recovering alcoholics' competencies as 0.898, 0.860, 0.747, 0.742 and 0.887 respectively. According to Mugenda and Mugenda (2013), a Cronbach alpha coefficient of 0.7 and above confirms the reliability of the test instrument. This means that the research instrument used for this study had internal consistency of items and therefore reliable. The research instrument would therefore give consistent results each time it is used to measure the variables.

3.7 Data Collection Procedures

The researcher sought authorisation from the Board of Post Graduate studies, Egerton University, to obtain a Research clearance and authorisation permit from the National Commission for Science, Technology and Innovation (NACOSTI) (Appendix III). The data collection instrument was submitted to the Egerton University ethics review committee for a review of the research protocols in the study (Appendix VI). In order to collect data from the alcohol rehabilitation facilities, the researcher sought an introductory letter from the National Authority for the Campaign against Alcohol and Drug Abuse, NACADA (Appendix V). This aided in undertaking the research in the targeted rehabilitation facilities. The researcher got in touch with the administrators of the rehabilitation facilities through initial visits with the introductory letter and an explanation of the intended research. Appointments were then made with the administrators on the ideal timelines to administer the questionnaires. The researcher then made travel arrangements to the targeted rehabilitation facilities where the questionnaires were administered by the researcher personally to the recovering alcoholics and addiction counsellors respectively from November 2017 to May 2018.

3.8 Ethical Considerations

Prior to data collection, the research instrument was submitted to the Egerton University ethics review committee for a review of the research protocols in the study. Upon review, it was determined that the study was non –invasive and had minimal risks on the intended subjects. To facilitate data collection, the researcher organised for a group session to build a rapport with recovering alcoholics and addiction counsellors. The researcher sought the consent from the respondents and their participation was made voluntary. The respondents were duly informed that the information collected was intended for academic purposes only and their responses would be kept anonymous at all times. Respondents were assured of utmost confidentiality. Some of the respondents had a challenge of responding to some of the test items that were written in English. To mitigate this challenge, the researcher explained the same in Kiswahili as well as helping interpret some test items in the questionnaires to the respondents. The names of the respondents and sites of the study were kept anonymous in order to protect their privacy as well as using codes instead of the names of the rehabilitation centres. The researcher protected the research participants from psychological harm by ensuring that the questions asked were appropriate and could not trigger disturbing emotions on the part of respondents.

3.9 Data Analysis Procedures

The data processing before data analysis involved data editing and data coding. Data editing involved examination of the collected raw data with a view to detecting errors and omissions. The IBM Statistical Package for the Social Sciences (SPSS) version 22 was used for data entry. This study employed both descriptive and inferential statistical analysis methods. The descriptive statistics enabled the researcher to meaningfully describe the distribution of scores using statistics such as mean, mode and standard deviations. The study objectives were used to derive the study research question and hypotheses that were analysed using both descriptive and inferential statistics. Pearson's correlation coefficient was used to determine the level of association between dependent and the independent variables. All tests of significance were computed at coefficient alpha (α) equal to 0.05.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction

This Chapter presents the interpretation and discussions of research findings on the relationship between selected rehabilitation factors and recovering alcoholics social and personal competencies in Central and Nairobi regions in Kenya. The data was analysed using both descriptive and inferential statistics. Descriptive statistics included frequencies, means, standard deviations while inferential statistics included pearson correlation. The results are presented in tables and figures and their implications discussed. The chapter is guided by the following research question and hypotheses:-

Research Question

What are the recovering alcoholics social and personal competencies (Gender, Age, Education level, Length of stay in rehabilitation and Region) in relation to demographic characteristics in Central and Nairobi regions?

Research Hypotheses

H_{01}: There is no statistically significant relationship between the Alcoholic Anonymous' 12 step facilitation and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

H_{02}: There is no statistically significant relationship between addiction counsellors' characteristics and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

H_{03}: There is no statistically significant relationship between alcoholics' characteristics and recovering alcoholics social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

H_{04}: There is no statistically significant relationship between levels of family support and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

4.2 Response Rate

The questionnaires were distributed to all the sampled respondents for this study. The sample size was 81 and 134 respondents for addiction counsellors and recovering alcoholics respectively. This made a cumulative number of 215 respondents. Forty questionnaires were not analysed due to failure to return the questionnaires (12 questionnaires) and failure to correctly complete the responses (28 questionnaires) as shown by Table 5. Consent was sought from respondents at the onset of the survey with participants being informed of their rights before continuing with the survey.

Table 5

Questionnaire Return Rate

	Total Questionnaires	**Used Questionnaires**	**Questionnaire Return Rate**
Recovering alcoholic	134	107	79.85%
Addiction counsellor	81	68	83.95%
Total	**215**	**175**	**81.40%**

The response rate for recovering alcoholics was approximately 80% while that of addiction counsellors was 83.95%. Creswell (2014), indicates that a response rate of at least 80% is desirable for survey studies.

4.3 Demographic Characteristics

The demographic data sought from the respondents included gender, age, level of education, marital status, period battled with alcoholism, length of stay in rehabilitation centre and number of times committed to rehabilitation facilities before.

4.3.1. Distribution of Respondents by Regions

The numbers of respondents from the study regions were examined and results presented in Figure 3.

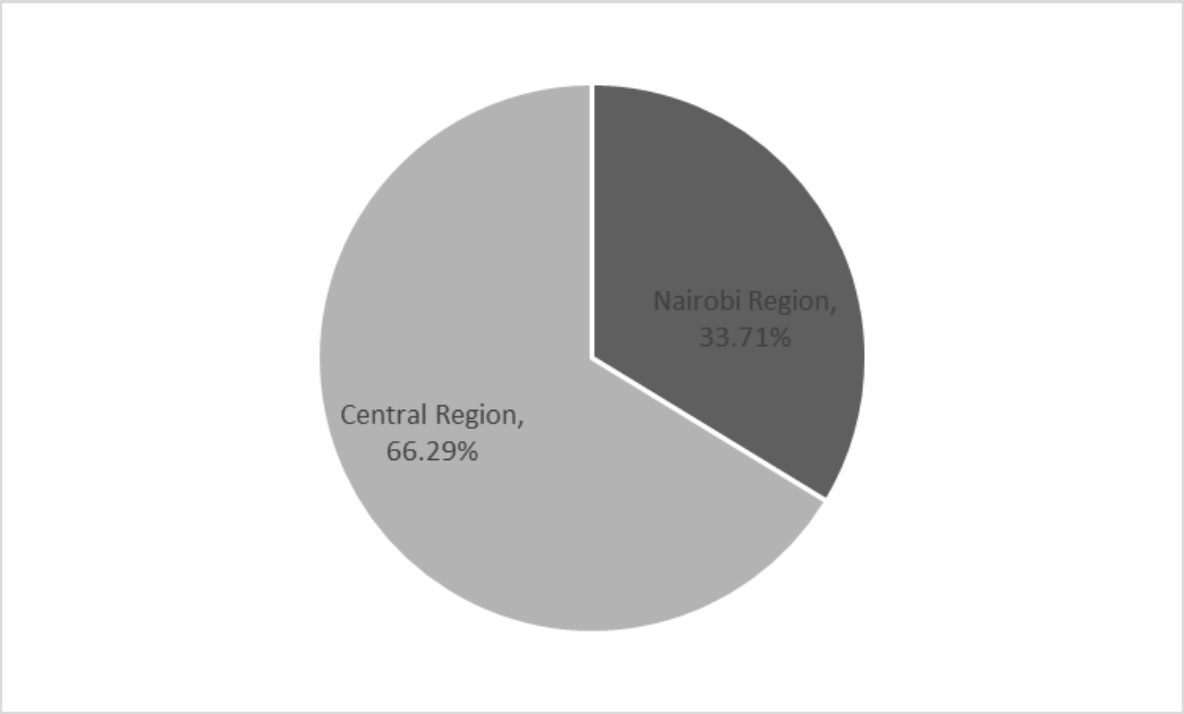

Figure 3. Distribution of Respondents based on Regions

Results on the distribution of respondents indicated that 116 of respondents (66.29%) were drawn from Central region while 59 (33.71%) of the respondents were from Nairobi region. The study results indicate a majority of the respondents were from the Central region compared to the Nairobi region. This can be attributed to the efforts that have been made by the County governments and National government within the central region to get rid of the alcoholism menace by encouraging the alcoholics in the region to visit rehabilitation centres. Central region had specifically been targeted by the National government in collaboration with diverse stakeholders such as the political leadership in the region and the country governments due to rising concerns of alcoholism. The County Government of Murang'a initiated a rehabilitation programme for alcoholics following the acknowledgment of a development need for prevention and reduction of drug and alcohol abuse (Murang'a County, 2018). Strategies have since been put in place for the treatment and rehabilitation of youth in the region that were actively engaging in drug abuse and consumption of illicit brews under the "Kaa Sober" rehabilitation programme in Kiambu County (Irungu, 2019; Kihuria, 2019).

4.3.2 Distribution of Respondents by Gender

The respondents were requested to indicate their respective gender on the questionnaire and findings are presented in figure 4.

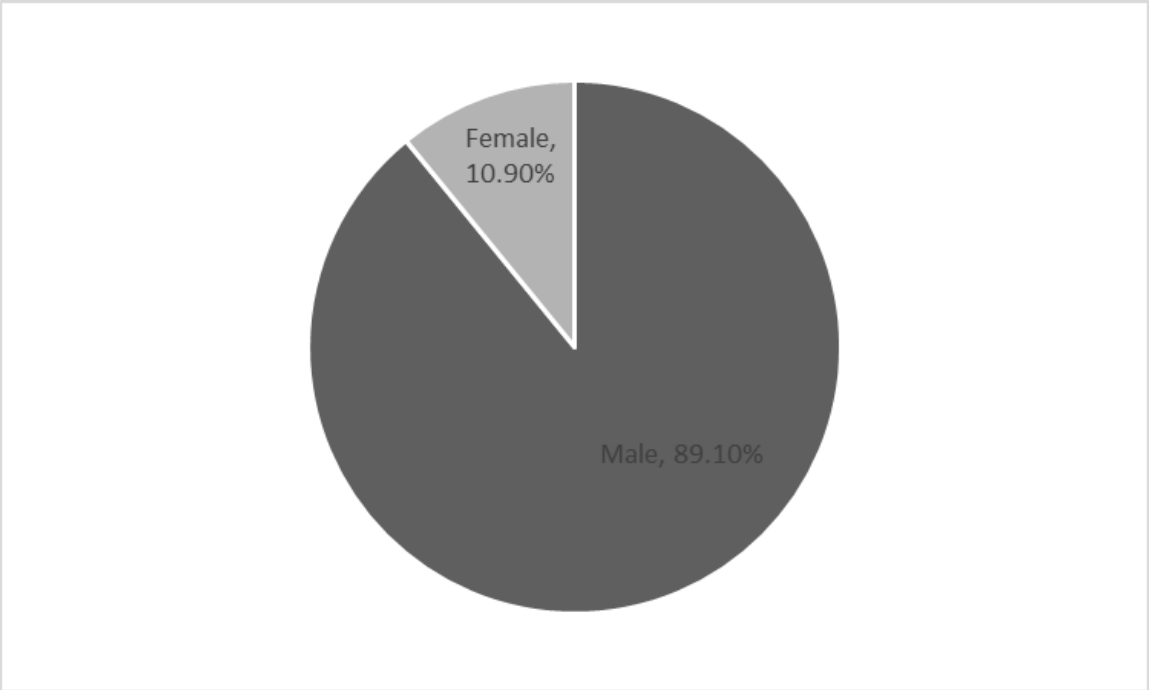

Figure 4. Gender of Respondents

The results indicated that 89.1% (156) of the respondents were male while 10.9% (19) were female. The high number of male respondents in the rehabilitation centres compared to the female members can be attributed to more male members of the society indulging in alcohol consumption and therefore more predisposed to alcoholism. The large number of male respondents may be attributed to the societal predisposition where it is against the norm for women to indulge in alcohol use. Clarke (2013), posits that gender can affect an individual's susceptibility, rate of recovery and risk of relapse. The findings are consistent with the WHO (2018) Global Status Report on Alcohol and Health that points out on the skewed gender differences observed in 2017 being substantial in relation to the incidence of alcohol use disorders, with global estimates placing 237 million men and 46 million women as having alcohol related disorders. The findings agree with the WHO (2007), Expert committee on alcohol related consumption problems that indicated in different societies, compared to women, men are less often abstainers, drinking more often and in higher quantities per occasion. This means that there are more heavy drinkers and more heavy drinking occasions among men and consequently, men dominate among harmful drinkers. The view held in many cultures that excessive alcohol consumption is less appropriate for women than for men

is a socio-cultural factor that helps explain higher rates of alcohol abuse among men in those cultures (Timko, Finney & Moos, 2005). However, the presence of female respondents indicates that there are significant proportions of women that indulge in alcohol drinking. This is consistent with findings by Birech, Kabiru, Misaro and Kariuki (2013), who noted that the few numbers of female respondents in rehabilitation centres is a possible indicator of fewer women consuming alcohol and therefore less likely than men to develop tolerance to and subsequent dependence on alcohol following their prolonged use. Traditionally in Kenya, young and middle-aged women did not consume alcohol to the point of intoxication with restrictions being placed as the young mothers still played a key role in running homes (ibid). Clark (2013) observes that the social stigma attached to treatment facilities in general, as well as treatment facilities geared more towards men serve as barriers for women seeking freedom from alcoholism. Githae (2015), notes that local cultures are more prejudiced to women suffering from alcoholism women and the stigma experienced from society prevents their seeking for help from alcohol addiction. Clark (2013), further observes that women abusing alcohol are less likely to seek treatment than men, especially among women who have children under their and are of low socioeconomic status as they are at risk of losing their children if their substance abuse is viewed as a threat to the children's livelihood by the justice system (ibid). This may in turn explain the low levels of women respondents to men in the study sample.

Mack et al. (2010), observe that women are underrepresented in treatment programmes and their special needs are often not addressed during treatment with the stigma associated with substance use disorders gravely affecting women. Women in the traditional treatment programmes often experience discomfort when talking about their concerns and may feel intimidated and outnumbered by men in alcohol rehabilitation programmes. Although treatment for alcoholism and drug abuse in women is similar in many ways to that in men, tailoring of their treatment is needed to address gender differences (ibid). Howatt (2010), observes addiction treatment for women need to pay attention to specific concerns unique to women. These comprise of the aspects of sexual abuse, low self-esteem, battering and child abuse, which are issues that may not be addressed adequately in rehabilitation centres targeting booth genders (ibid). The attitudes, beliefs and values in society have been changing resulting to higher alcohol consumption levels by women. In a study on alcohol abuse in Nandi County, Birech et al. (2013), established that the guidelines that guarded against

misuse of alcohol such as sex, age, time, occasion, frequency and amount were no longer valid. This implies that with women empowerment and the challenge by women on traditional cultural norms, statistics that currently appear skewed in favour of men to women on alcohol use are bound to change over time. Wilsnack et al. (2013), cites the vulnerability of women to alcohol-related harm being a key public health concern as alcohol use among women has progressively been on the rise in line with economic development and a change in gender roles. Room and Selin (2005), observe that with the rising influences of globalization, women have began challenging the status quo that previously lowered them to the background where limited amounts of alcohol were consumed.

4.3.3 Nature of Respondents

Respondents were requested to indicate the phrase that best describes them between that of a recovering alcoholic and an addiction counsellor. The results are presented in figure 5 below;

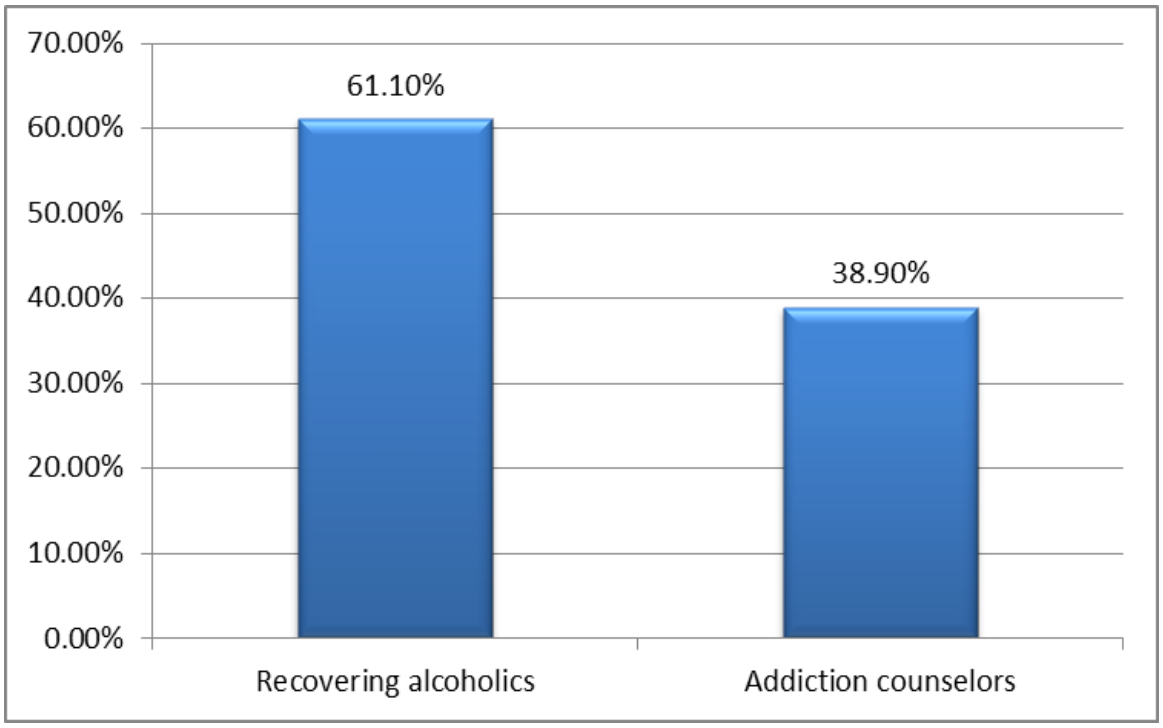

Figure 5. Nature of Respondents

The results indicated that the recovering alcoholics were 61.1% (107) compared to addiction counsellors at 38.9% (68) as shown in figure 5. The high number of the recovering alcoholics is attributable to there being a proportionate small number of counsellors supervising a huge number of recovering alcoholics in the sampled rehabilitation centres. It is worth noting that

some of the addiction counsellors were also recovering alcoholics accounting for 27.9% (18) of the addiction counsellors serving in rehabilitation facilities. Addiction counsellors employed within addiction services and are on the road to recovery from their own addiction concerns contribute significantly to the strength of service interventions. The observable presence of recovering addiction counsellors tends to reassure recovering alcoholics that they are under persons that appreciate their needs and are in a position of providing genuine support (Reading, 2009).

4.3.4 Age of Respondents

Respondents were asked to indicate the age bracket that best suited their age. The distribution of the age groups comprised those below 25 years, 25 to 35 years, 36 to 45 years, 46 to 55 years and over 55 years. The results are displayed in Table 6.

Table 6

Age Bracket of Respondents

Age Bracket	**Frequency**	**Percentage**
Below 25 years	33	18.9
25 to 35 years	72	41.1
36 to 45 years	54	30.9
46 to 55 years	13	7.4
Over 55 years	3	1.7
Total	**175**	**100.0**

Most of the respondents comprised those aged between 25 to 35 years (41.1%) while those aged between 36 to 45 years comprised 30.9% of the sampled respondents. Respondents aged below 25 years accounted for 18.9% of the proportion while those aged 46 to 55 years accounted for 7.4%. Respondents aged over 55 years formed the least proportion of the respondents (1.7%). These results point out that the majority of respondents were aged 45 years and below. These findings agree with reports by NACADA (2012), indicating that young people in Kenya comprise of the largest proportion of the population severely affected by alcohol abuse. Kuria (2015), notes that alcohol abuse has been quoted as the single most cause for death in males aged between 15–59 years. The finding are consistent with the WHO (2007), Expert Committee on problems related to Alcohol consumption which observes that

abstinence or irregular alcohol consumption is more predominant in mature and old segments of the population and heavy alcohol consumption are more frequent among young adults and adolescents.

4.3.5 Highest Education Level of Respondents

The highest education level of respondents was examined with options given as post graduate, graduate, diploma level, and secondary level and results shown in Table 7.

Table 7

Highest Education Level of Respondents

Education level	**Frequency**	**Percentage**
Post graduate	12	6.9
Graduate	72	41.1
Diploma level	40	22.9
Secondary level	51	29.1
Total	**175**	**100.0**

The results indicated that in respect to highest education status, there were 6.9%, 41.1%, 22.9%, and 29.1% respondents with postgraduate, graduate, diploma level and secondary school level education status respectively. The significant proportion of respondents with a graduate level education can be attributed to two factors. Persons with high education level are likely to be more knowledgeable on the concept of alcoholism and the role that rehabilitation centres play in assisting persons dependent on alcohol. They are also likely to be more receptive to committing to the rehabilitation process. The addiction counsellors are also likely to have an advanced education level in order to be effective in counselling work. According to the U.S Department of Health and Human Services (2011), addiction therapists need to have the capacity to describe the perspectives, guidelines, practices and results of the most widely accepted and scientifically supported treatment and recovery approaches which requires training and education and training on addiction and other substance-related concerns.

4.3.6 Period Respondents had Battled with Alcoholism

The study examined the period respondents had battled with alcoholism by grouping the periods in five categories, that is, below 1 year, 1-5 years, 6 - 10 years, over 10 years and non-applicable as shown in Table 8.

Table 8

Period Respondents had Battled with Alcoholism

Period	**Frequency**	**Percentage**
Below 1 year	12	6.9
1-5 years	50	28.6
6 - 10 years	22	12.6
Over 10 years	43	24.5
Non applicable	48	27.4
Total	**175**	**100.0**

The results indicated that 6.9%, 28.6%, 12.6%, and 24.5%, of the respondents had battled alcoholism for below a year, 1-5 years, 6-10 years and over 10 years respectively. A further 27.4% indicated the question was not applicable to them as they fell under addiction counsellors who had no previous encounters with alcohol addiction. The results indicated that the respondents had battled alcoholism for fairly lengthy periods of time before committing to the rehabilitation process. The findings indicated to a small number of the respondents who had only battled alcoholism for less than one-year accounting for 6.9%.

4.3.7 Length of Stay in Rehabilitation Centre

Respondents were requested to indicate the number of days they had stayed in the respective rehabilitation centres. The findings are presented in Table 9.

Table 9

Length of Stay of Respondents in Rehabilitation Centre

Period of Stay	**Frequency**	**Percentage**
31 to 49 days	50	28.5
50 to 69 days	28	16.0
70 to 90 days	49	28.0
Non-Applicable	48	27.5
Total	**175**	**100.0**

Most of the respondents had stayed in the respective rehabilitation centres for 31 to 49 days (28.5%), followed by those who had stayed for 70 to 90 days (28.0%), as shown in Table 8. Respondents who had stayed in the rehabilitation centre for 50 to 69 days accounted for 16.0% of the respondents. Respondents who had not stayed in a rehabilitation centre (non-applicable) were 27.5% of the respondents who comprised the addiction counsellors in the rehabilitation centres. The length of period in the rehabilitation centre is critical as it documents the period the person has been exposed to the recovery interventions. The length of stay is also essential to the recovering alcoholic developing competencies. According to Roozen et al. (2009), the original AA 12 step facilitation model was meant to last for a period of 60 days with the expectation that a low stress and supportive surrounding detached from the routine daily activities for the recovering alcoholic would facilitate their recovery. This was however extended over the years to between 3 to 6 months (ibid). In underlying the importance of the length of stay in rehabilitation, Mckay (2009), notes that a major setback with the AA 12 step facilitation model has been the perceived high dropout rates with some studies reporting that about 50% of patients stopped participating before the period of 3 months. This may lead to some of the recovering alcoholics failing to conform with the suggested treatment modality and consequently resume drinking after leaving the rehabilitation centre. It is thus notable that a huge number of respondents in this study (28%) had stayed for a period of between 70 to 90 days indicating that they were nearing their completion of the specified period in rehabilitation programme.

4.3.8 Times Committed to Rehabilitation Facility Before

The study examined the number of number of times respondents had been committed to a rehabilitation facility before and results displayed in Table 10.

Table 10

Times Respondents Previously Committed to a Rehabilitation Centre

	Frequency	**Percentage**
Never before	55	31.4
Once	39	22.2
Twice	17	9.7
More than twice	16	9.3
Non applicable	48	27.4
Total	**175**	**100.0**

Most of the respondents (31.4%) indicated that they had never been committed to a rehabilitation facility before. Respondents who had been committed to a rehabilitation facility once accounted for 22.2% while those who had been committed to a rehabilitation facility twice before were 9.7%. The respondents who had been committed to a rehabilitation facility previously for more than two times accounted for 9.3% of the respondents. In a study of risk factors for relapse in treatment for drug abuse in Gauteng Province, South Africa, 20% of admissions in the treatment centres were noted as being re-admissions, with high incidences being reported among young adults of African descent (Ilze, Geyer & Crafford, 2015). Respondents who indicated that the question was not applicable to them were 27.4%. This proportion accounted for some of the addiction counsellors working in the facilities since some of them were also recovering alcoholics. Globally, the relapse-rates following treatment have been noted as high, reaching proportions of 75% in the 3- to 6-month period following treatment (Adinoff, Talmadge, Williams, Schreffer, Jackley & Krebaum, 2010). Hollen (2009), observes that several factors have been linked to the successful treatment of alcohol addiction which include the recovering alcoholics level of cooperation, nature and duration of the addiction, level of family support, availability of treatment and counselling services to help prevent relapse.

4.3.9 Marital Status of Respondents

The study further examined the marital status of respondents as part of the background characteristics. The respondents were asked to indicate whether they were single, married or divorced and results shown in Table 11.

Table 11

Distribution by Marital Status of Respondents

Marital status	**Frequency**	**Percentage**
Single	85	48.6
Married	78	44.6
Divorced	12	6.9
Total	**175**	**100.0**

Most of the respondents were single (48.6%) closely followed by respondents who were married (44.6%). Respondents who were divorced accounted for 6.9% of the sample. The number of the respondents who were divorced (6.9%) can be explained by the aspect of marriage breakdown due to alcohol related challenges such as lack of support from their spouses and families. This may be witnessed through expressions of hostility that involve aspects such as irritability, resentment, outbursts of anger, incidences of assault and cases of antagonism where family members place blame on the alcoholic for his or her challenges (Bauer, 2015). The presence of family support is critical in the recovering alcoholic gaining competencies. According to Mckay (2009), the absence of family or social support for on-going abstinence are among the most essential attributes associated with lack of treatment compliance and that eventually result in relapse after treatment.

4.4 Recovering Alcoholics' Competencies

The aspect of recovering competencies comprised of the dependent variable for the study and was measured on a five-point likert scale using six indicators namely strongly agree, agree, uncertain, disagree and strongly disagree. These latent indicators measuring competencies for the recovering alcoholics comprised positive management of peer pressure, enhancement of the ability to ask for help when in need, better involvement in life aspects such as work, dealing with change, decision making capabilities and problem-solving skills. The descriptive statistics for the recovering competencies are presented in Table 12.

Table 12

Distribution of Responses on Recovering Competencies

	Percentages and Frequencies						
	SA	**A**	**U**	**D**	**SD**	**Mean**	**Std Dev**
Positive Management of peer pressure	62.9% 110	30.9% 54	0.6% 1	2.3% 4	3.4% 6	4.47	.902
Enhancing ability to ask for help when in need	50.3% 88	38.3% 67	4.6% 8	5.1% 9	1.7% 3	4.30	.906
Better involvement in life aspects e.g. work	54.9% 96	34.3% 60	5.1% 9	4.0% 7	1.7% 3	4.37	.886
Dealing with change	50.9% 89	39.4% 69	5.7% 10	1.7% 3	2.3% 4	4.35	.850
Decision making capabilities	46.9% 82	41.7% 73	7.4% 13	1.7% 3	2.3% 4	4.29	.858
Problem solving skills	48.6% 85	38.9% 68	6.3% 11	1.7% 3	4.6% 8	4.25	.985

The results presented in Table 12 indicate that in respect to the respondents having positive management of peer pressure, the achieved scores were 4.47 and 0.902 for means and standard deviations respectively. This is further evidenced by the frequency distribution scores. It was established by this study that majority of respondents agreed (30.9%) and strongly agreed (62.9%) that they could positively manage peer pressure due to services provided at the rehabilitation facilities. Almost a negligible number of respondents (0.6%) was not sure whether they could positively manage peer pressure a result of their residential period in rehabilitation centers. It was noted that 3.4% and 2.3% of the respondents disagreed and strongly disagreed respectively on positively managing peer pressure due to services provided at the rehabilitation facilities. The results are consistent with findings by Pagano et al. (2004), that indicate that alcoholics in recovery that offer help to fellow recovering peers maintain long-term abstinence after treatment are better placed in maintaining abstinence possibly as a result of the social rewards that emanate from giving support to others. The National Institute of Drug Abuse (2009), advocates the involvement by recovering alcoholics

in programmes supporting peer and group therapy during and after rehabilitation in an attempt to help maintain abstinence.

In respect to the recovering alcoholics ability to ask for help when in need during their stay in rehabilitation facilities, the respondents on average tended to agree that such ability is there. This was due to a mean of 4.30 and a standard deviation of 0.906. This can further be seen through the distribution of the scores across the five-point likert scale. In this context, this study established that the competence of enhancing their ability to ask for help when in need was enhanced as a result of their stay in rehabilitation centers as cited by majority of the respondents (Strongly Agree=50.3%; Agree=38.3%). It was however worth noting that 4.6% of the respondents were undecided concerning whether their ability to ask for help when in need was enhanced while at the rehabilitation facilities. A small percentage of the respondents disagreed (Disagree=5.1%; Strongly disagree=1.7%) that their ability to ask for help when in need was enhanced while at the rehabilitation facilities. The results are congruent with findings by Coombs and Howatt (2005), who note that recovering alcoholics with the help of addiction counsellors can become inspired to make improvements in their lives by sticking to a well-defined action plan with clearly spelt out goals leading to chosen outcomes. The study findings agree with Zemore and Kaskutas (2008), who observe that recovering alcoholics actively engaged in giving assistance in rehabilitation through provision of encouragement, moral support and sharing their insights with regard to achieving sobriety are more likely to be engaged in the 12-step encounter and realise significant improvements during recovery in the short term. Crape et al. (2002), indicates that engagement by recovering alcoholics offering help tends to enhance their social status and level of self-esteem as well as strengthening their support network and personal resolve to abstinence after their stay in rehabilitation.

The results displayed in Table 12 indicates that in respect to the respondents being involved in life aspects such as work, a mean and standard deviation of 4.37 and 0.886 respectively was posted by the respondents. This indicates that the respondents on average were inclined to agree in respect to the indicated measure. The aspect of respondents being better involved in life aspects for example work posted favorable responses (Strongly Agree=54.9%; Agree=34.3%) with a relatively low number of respondents disagreeing that their involvement in life aspects improved as a result of their stay in the rehabilitation facilities

(Disagree=4.0%; strongly disagree=1.7%). Cromin (2013), observes that a key concern for recovering alcoholics by the addiction counsellors is on the aspects that can support or help improve the ability in alcoholics to develop certain behavior patterns for both adaptations in the short and long term for their developmental progress. These include social and personal competencies that reflect adjustment of the alcoholic to deal career concerns, family, health and financial issues. Kuria, (2015) indicates that these aspects reflect a decisive plan that allows for progression towards a self-directed life goal which should be the focus of the rehabilitation process for a recovering alcoholic.

The capacity to deal with change due to services provided at the rehabilitation facilities is one of the key components of recovering alcoholic competencies. This indicator achieved a mean score of 4.35 and a standard deviation of 0.850. This can further be elaborated by the frequency distribution that indicated that 50.9% and 39.4% of the respondents strongly agreeing and agreeing respectively. The standard deviation of 0.850 indicates a moderate spread of the data thus indicating moderate consensus in respect to the specific indicator. The 12 steps offer a developmental approach to recovery from addiction, with the steps being organised from the simplest basic changes forward to more radical ones that persons motivated to pull through may seek to incorporate into their lives (Mercer & Woody, 1999). This serves as an important milestone for a recovering alcoholic with the acceptance of their new identity as that of an alcoholic and the acknowledgement of their loss of control over their life, which then serves as the starting point of their recovery from addiction (Pagano et al., 2010). Social and personal competencies constantly change over the persons course of life depending on the development of capabilities such as social skills, social awareness and self-confidence (Roozen et al., 2009). Musyoka (2013), notes that once an individual becomes cognisant of these patterns, they can then alter defective traditions and create simple changes and fashion a new style of living. The Association for Addiction Professionals, (2009) observes that Adlerian psychology is powerful in empowering recovering alcoholics cultivate a positive, sober lifestyle, a sense of feeling right and learning how to adjust current behavior patterns to those that are more beneficial and productive.

In respect to decision making capabilities, the achieved mean and standard deviation scores stood at 4.29 and 0.858 respectively. The achieved mean score thus indicated that the respondents on average agreed that decision making was one of the key components of

recovering alcoholic competences. This was further elaborated by the frequency distribution results. Most of the recovering alcoholics strongly affirmed that decision making capabilities (46.9%) were improved in the rehabilitation centers. It was only a small percentage of 1.7% and 2.3% of the respondents who disagreed and strongly disagreed respectively that the decision-making aspects were enhanced. The findings are consistent with Mjwara (2013), who indicates on the existence of a gap in the area of identification of clients' decision-making style in the counselling relationship. This analysis is important in encouraging personal growth of recovering alcoholics. The findings further agree with Pagano et al. (2010), who observe that one of the most crucial abilities that human beings possess is the use of judgment and making of choices at personal and interpersonal levels that reflect on the quality of life. A person's feelings, thoughts, beliefs, attitudes, convictions, character and actions are manifestations of his or her individuality, which therefore reveal a strategy that allows for movement towards a self-directed goal in life which should be the focus of the rehabilitation process for a recovering alcoholic (ibid). The findings are consistent with Mcveigh (2012), who notes that the concern of Adlerian therapy is on the future without minimising the significance of influences from the past with assumptions that resolutions are grounded on the experiences of the person with regard to the existing situation and in the path the individual is moving towards.

The development of problem-solving skills as a competence in rehabilitation process had a mean of 4.25 and standard deviation of 0.985. This implied that the respondents on average agreed that problem solving skills were a key component enhanced during the rehabilitation process. This can be seen from a majority of 46.9% of the respondents who agreed that the problem-solving skills had been improved. The rehabilitation literature encourages the evaluation of skills in problem solving as part of the vocational planning process for the vocational training for persons felt to be undergoing difficulties in making choices. The onset of alcohol addiction has been well established to be closely connected to the period of adolescence which is an age where young people experience many dynamic and intense changes (Mjwara, 2013). The core principle is that all behaviour is learned and sustained as a result of the individual's interaction with the surroundings, which stresses the assertion by behaviour therapies on the need to address the recovering alcoholic's motivation, building resilience to resist alcohol use as well as providing motivations for self-restraint and replacing alcohol using engagements with creative and satisfying activities (NIDA, 2009).

The results are consistent with McLeod (2013), who highlights on the importance alcohol rehabilitation that strives to enhance the capacity of the recovering alcoholic to possess normal functional skills geared for the spiritual, social and economic life.

4.5 Recovering Alcoholics' Competencies in Relation to Demographic Characteristics

The first objective of the study sought to describe recovering alcoholics' social and personal competencies in relation to demographic characteristics in rehabilitation facilities in Central and Nairobi regions This objective was determined through the crosstabulation of recovering alcoholic respondents' demographic attributes against social and personal competencies. The demographic characteristics comprised of the aspects of gender, age, education level, length of stay in rehabilitation and region of the rehabilitation centre.

Table 13

Respondents Gender and Levels of Recovering Alcoholics' Competencies

	Levels of Recovering Alcoholics Competencies			
Gender	**Low**	**Moderate**	**High**	**Total**
Male	4.3%	12.1%	76.6%	96.3%
	8	13	82	103
Female	0.0%	0.9%	2.8%	3.7%
	0	1	3	4
Total	4.3%	13.1%	79.4%	100.0%
	8	14	85	107

As seen from Table 13, 76.6% (82) of male respondents had a high-level recovering competency with 2.8% (3) of female respondents registering the same respectively. Respondents that had moderate levels of recovering competencies accounted for 12.1% (13) for males with 0.9% (1) for females. Respondents that registered low levels of recovering competencies formed the least proportion based on gender accounting for 4.3% (8) and none (0.0%) for male and females respectively. A closer look reveals that 13.1% and 79.4%, of the total sample of recovering alcoholics reported to having experienced moderate to high levels of recovering social and personal competencies. This was an indicator that efforts put in place in the rehabilitation centres were realising better outcomes among the alcoholics in recovery in spite of the skewed numbers in favour of males to that of women. Women frequently face

numerous hurdles in seeking alcohol and substance use rehabilitation that are of a personal, social, cultural, and structural nature (Khazaee-Pool et al, 2019). These include stigma, discrimination, shame, poverty, and low social support (ibid). Wright (2002) asserts that a male orientated rehabilitation programme may overlook some of the needs of female alcoholics. These findings are consistent with Amanya (2011), who observed that most rehabilitation centres are yet to put in place aspects of differentiation with regard to the age and gender in the treatment of recovering alcoholics. Studies indicate that progression of women through addiction stages occurs more rapidly than in men, owing to the prospect that women's biological and social components increase their susceptibility for the development of addiction (Clarke, 2013). These concerns need to be addressed so as to consciously address the low number of women currently receiving treatment in alcohol rehabilitation centres. Empirical studies by WHO (2018), indicate that the incidence of current use of alcohol is highest among males with global projections suggesting that the consumption of alcohol will continue on an upward trend by the year 2025.

Table 14

Age of Recovering Alcoholics and Levels of Recovering Alcoholics' Competencies

	Levels of Recovering Alcoholics Competencies			
Age	**Low**	**Moderate**	**High**	**Total**
below 25 years	0.0%	4.7%	12.1%	16.8%
	0	5	13	18
25 to 35 years	3.7%	5.6%	29.9%	39.3%
	4	6	32	42
36 to 45 years	1.9%	2.8%	29.0%	33.6%
	2	3	31	36
46 to 55 years	1.9%	0.0%	6.5%	8.4%
	2	0	7	9
over 55 years	0.0%	0.0%	1.9%	1.9%
	0	0	2	2
Total	7.5%	13.1%	79.4%	100.0%
	8	14	85	107

As is evidenced on Table 14 out of the 107 recovering alcoholics, 85 (79.4%) reported high levels of recovering competencies. The age groups with the highest levels of recovering competencies were those aged between 25 to 35years and 36 to 45 years with 29% affirming to having realised significant change during their stay in rehabilitation. Low and moderate levels of recovering competencies received few respondents with 3.7% for the age groups between 25 to35 years, while the age groups between 36 to 45 years and between 46 to 55 years reported a response of 1.9% respectively. The findings are consistent with a report by the UNODC (2012), that indicates individuals usually seek treatment for drug use when in their late 20s or early 30s with drug-related deaths usually occurring within the mid-30s. This points to a need for early direction in the course of treatment for alcoholics in these vulnerable age groups to deal with the number of rising cases of alcohol abuse as they form a significant segment of the active and working population in society. Coombs and Howatt (2005) observe that full addiction may occur at any age where all other important activities in life become subordinate to procuring and using alcohol and other drugs. Alcoholism is partly responsible for the untangling of social fabric of life where it has become a daily devotion and obsession.

Table 15

Length of Stay in Rehabilitation Centre and Levels of Recovering Alcoholics' Competencies

	Levels of Recovering Alcoholics Competencies			
Length of stay in days	**Low**	**Moderate**	**High**	**Total**
31 to 49 days	2.8%	5.6%	33.6%	42.1%
	3	6	36	45
50 to 69 days	1.9%	0.9%	20.6%	23.4%
	2	1	22	25
70 to 90 days	2.8%	6.5%	25.2%	34.6%
	3	7	27	37
Total	7.5%	13.1%	79.4%	100.0%
	8	14	85	107

As presented on Table 15, the lengths of stay in the rehabilitation facilities registered high levels of recovering competencies among the alcoholics with 85 (79.4%) respondents. The period between 31 to 49 days registered the highest levels of recovering competencies with 36 (33.6%) respondents. The periods between 50 to 69 days and 70 to 90 days reported 22 (20.6%) and 27 (25.2%) responses with high levels of recovering competencies respectively. This is a clear indicator of that the different periods of stay in the rehabilitation had strong input in promoting recovering competencies among alcoholics. The high levels of competency realised in the period between 31 to 49 days may be as a result of the immediate restriction placed on recovering alcoholics away from family, friends and work following long periods of alcohol abuse. This seclusion helps the alcoholic in recovery make significant strides out of their addiction and not continue to live in the pain of the past (Clark, 2013). The level of cooperation among recovering alcoholics, availability of treatment and counselling services have been identified as important factors for the successful treatment of alcohol addiction (Hollen, 2009).

Table 16

Region of Rehabilitation and Respondents Levels of Recovering Alcoholics' Competencies

	Levels of Recovering Alcoholics Competencies			
Regions	**Low**	**Moderate**	**High**	**Total**
Central	5.6%	5.6%	53.7%	64.5%
	6	6	57	69
Nairobi	1.9%	7.5%	26.2%	35.5%
	2	8	28	38
Total	7.5%	13.1%	79.4%	100.0%
	8	14	85	107

As presented in Table 16, Central region posted a larger proportion of 57 (53.7%) of recovering alcoholic respondents with high-level recovering competencies while Nairobi had 28 (26.2%) respectively. Respondents that reported moderate levels of recovering competencies from Nairobi region fared slightly higher than those from Central accounting for 8 (7.5%) and 6 (5.6%) respectively. The findings confirm the significance of treatment for alcohol dependency with 79.4% of the recovering alcoholics affirming to having high levels of competencies following their stay within the rehabilitation facilities. These progressive

outcomes are indicators that the substitution of alcohol with healthier and rewarding activities and networks in rehabilitation are indeed helpful in building competencies that may sustain a sober life for the recovering alcoholic (Coombs & Howatt, 2005). Since each recovering alcoholic is aligned to specific short and long-term goals, the aspect of abstinence is the overriding theme with positive long-term results being attributed to it (McKay & Hiller-Sturmhöfel, 2011).

Table 17

Recovering Alcoholics' Educational Qualifications and Levels of Recovering Competencies

	Levels of Recovering Alcoholics Competencies			
Qualifications	**Low**	**Moderate**	**High**	**Total**
Post Graduate	0.9%	0.0%	5.6%	6.5%
	1	0	6	7
Graduate	1.9%	2.8%	33.6%	38.3%
	2	3	36	41
Diploma	0.9%	4.7%	16.8%	22.4%
	1	5	18	24
Secondary level	3.7%	5.6%	23.4%	32.7%
	4	6	25	35
Total	7.5%	13.1%	79.4%	100.0%
	8	14	85	107

As presented in Table 17, recovering alcoholics with a graduate level of education formed the largest proportion of 36 (33.6%) with high-level recovering competencies, followed by those with secondary level qualification with 25 (23.4%) respectively. Recovering alcoholics with diploma level and post graduate qualifications formed the proportions with the least number of respondents reporting 18 (16.8%) and 6 (5.6%) respectively. A closer examination of the findings revealed high levels of competencies among the sampled recovering alcoholics accounting for 79.4% of the sample compared to those that reported moderate and low levels at 13.1% and 7.5% respectively. Cutler and Lleras-Muney (2010), outline the role that education plays in conveying accurate knowledge on health-related concerns and raising cognitive skills that affect decisions that promote health. The level of education may help to raise a recovering alcoholics' understanding of the undesirable effects of alcohol abuse and

may serve to improve a person's capacity in managing problematic drinking (Huerta &, Borgonovi, 2010).

Table 18

Times Committed in Rehabilitation and Levels of Recovering Competencies

	Levels of Recovering Alcoholics Competencies			
No of times	**Low**	**Moderate**	**High**	**Total**
Never before	3.7%	5.6%	34.6%	44.0%
	4	6	37	47
Once	0.9%	3.7%	24.3%	29.0%
	1	4	26	31
Twice	1.9%	1.9%	10.3%	14.0%
	2	2	11	15
More than twice	0.9%	1.9%	10.3%	13.1%
	1	2	11	14
Total	7.5%	13.1%	79.4%	100.0%
	8	14	85	107

As presented in Table 18, recovering alcoholics who had never sought help for alcoholism reported the highest levels of recovering competencies at 34.6% (37) while those who had been to a rehabilitation facility once before reported 24.3% (26) respectively. The findings revealed lower responses for those who had sought help twice or more times accounting for 10.3% respectively for high competency levels. Kalema and Vanderplasschen (2015), observes that the occurrence of episodes of occasional and temporal alcohol drinking setbacks should be acknowledged as being part of the recovery process and used to strategise on ways to prevent relapses in future. Achievement of abstinence from alcohol dependency is dependent on other factors and the failure by many programmes to change the environments that recovering alcoholics return to forces them to continue experiencing difficulties in seeking employment and educational opportunities, which may in turn increase the risk of relapse (CSVR, 2017).

4.6 Relationship between Alcoholics Anonymous 12-Step Facilitation and Recovering Alcoholics' Competencies

The inventory seeking responses on the role of the alcoholic anonymous 12 steps facilitation model on the recovering alcoholic competencies had indicators adapted and modified from the AA 12 step facilitation model. This was done with a view of determining the role of the 12 different steps on the recovering alcoholics' competencies. The inventory utilised a five-point likert scale using the metrics of strongly agree, agree, uncertain, disagree and strongly disagree. This was done in order to capture the responses on the alcoholics anonymous 12 steps.

The indicators used for this examination included aspects of self-acceptance as an alcoholic, acknowledgement of the need for help, mending broken relationships, commitment to seeking help, coping with alcoholism challenges, regaining of control over personal responsibility, maintenance of sobriety through AA support system, the resolve to stay sober and creation of new social structures. For the descriptive statistics, this study employed the use of the mean and standard deviation to analyse the obtained data for the five study variables. The study used the mean to describe the sample with a single value to represent the centre of the data. The results are as displayed in Table 19. Normality test was employed to determine whether the sets of data for Alcoholics Anonymous 12 step facilitation was modelled for normal distribution. This involved the use of a graphical method for evaluating normality which included a histogram and normality plot (Pallant, 2007). Therefore, the data for this independent variable was normally distributed as verified by the histogram in Figure 6.

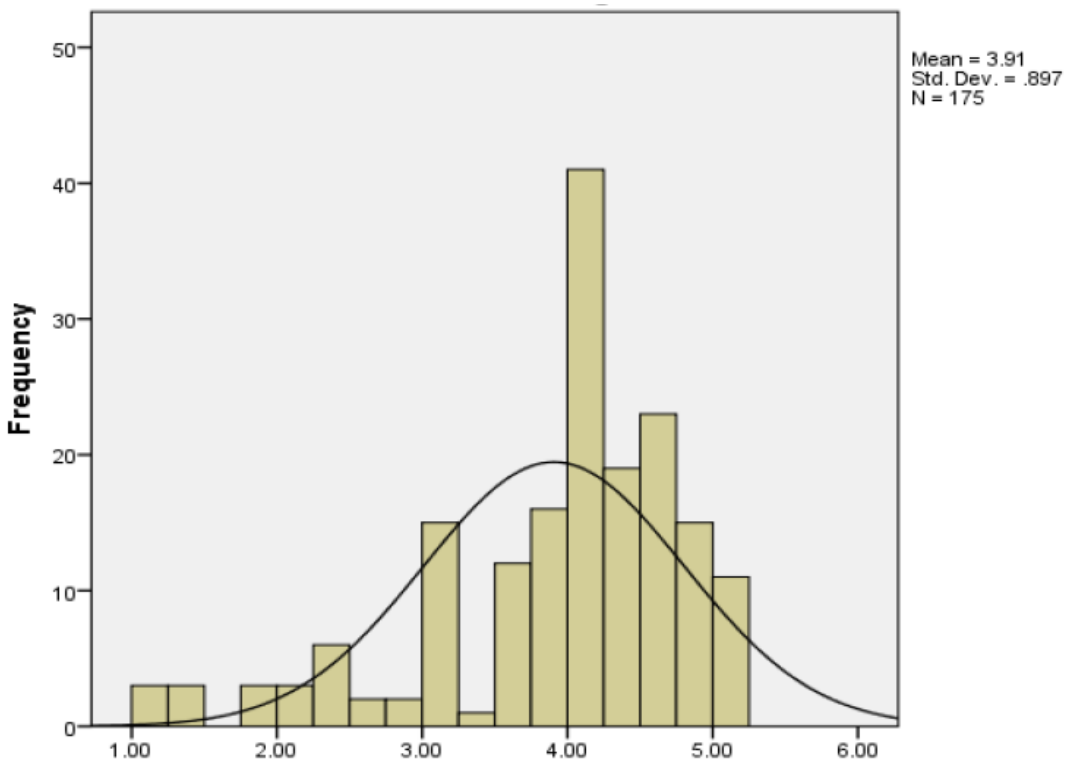

Figure 6. Distribution of Responses for AA 12-Step Facilitation Model

Figure 6 shows the use of a histogram as used to test normality of the data for Alcoholics Anonymous 12-step facilitation model. The data is skewed to the left meaning that the data had a longer tail to the left as compared to the right. This can be seen from the visual representation in the histogram.

Table 19

Distribution of Responses on AA 12-Step Facilitation Model

	Percentages and Frequencies						
AA 12 Steps Indicators	**SA**	**A**	**U**	**D**	**SD**	**Mean**	**Std Dev**
Self-acceptance as an alcoholic	46.9% 82	30.3% 53	6.3% 11	6.3% 11	10.3% 18	3.97	1.111
Acknowledgement of the need for help to get better	44.0% 77	36.0% 63	9.1% 16	3.4% 6	7.4% 13	4.06	0.958
Taking stock of past and admit wrong doing	35.4% 62	43.4% 76	9.1% 16	0.6% 1	11.4% 20	3.91	1.024
Mend broken relationships	29.7% 52	36.0% 63	18.3% 32	7.4% 13	8.6% 15	3.71	1.013
Commit to continuing to seek help to get better	42.9% 75	36.0% 63	8.6% 15	5.1% 9	7.4% 13	4.02	0.982
Regain control over personal responsibility over daily living dynamics e.g. diet, hygiene, sleep	35.4% 62	38.9% 68	11.4% 20	5.1% 9	9.1% 16	3.86	1.019
Maintain sobriety through support system in the AA community	37.7% 66	39.4% 69	8.6% 15	8.0% 14	6.3% 11	3.94	0.963
Strengthen resolve to stay sober through helping others stay sober	30.9% 54	44.6% 78	10.3% 18	4.0% 7	10.3% 18	3.82	1.013
Create new social structure and friends that help recovery	34.9% 61	39.4% 69	12.0% 21	5.7% 10	8.0% 14	3.87	0.987

The findings in Table 19 point out to the means of all the indicators used to measure the latent variable on 12-step facilitation were between 3.5 and 4.5. The interpretation is that on average the respondents tended to agree that the indicators had influenced on recovering alcoholics' competencies. The results displayed in Table 19 indicate that the aspect of self-acceptance as an alcoholic achieved a mean of 3.97 and a standard deviation of 1.111. The

mean of 3.97 implies that the respondents on average tended to agree that the concept of self-acceptance as an alcoholic was achieved during their stay in rehabilitation. This was due to means lying between 3.5 and 4.5 in a five point likert scale as indicated by (Moffatt, 2015). Further support is provided by the cumulative percentage of 77.2% of the respondents who selected the strongly agree and agree metrics respectively. The high standard deviation of 1.111 indicated a huge spread of data from the mean of 3.97. This can be attributed to significant scores of respondents who disagreed and strongly disagreed with the metric at 6.3% and 10.3% respectively. The results realised with respect to this indicator were consistent with those of Brower et al. (2013), that point out on the ability of the 12-step process in helping members sustain abstinence through sharing of experiences, strengths and hope with each other as well as promoting self-acceptance and improvement of a person's self-esteem. This component of the 12-step process assists the recovering alcoholic to learn that alcoholism is a disease that denies one of the abilities to predict and control alcohol consumption (Cromin, 2013). The recovering addict also becomes cognisant of negative patterns of alcohol use and comes to recognise the damage brought by their drinking and begin to appreciate that the road to sobriety is a lifetime process (ibid).

The indicator that the AA 12-steps facilitation led to the acknowledgement for the need to get help in getting better reported means and standard deviation scores of 4.06 and 0.958 respectively. This mean of 4.06 implied that on average the respondents tended to affirm that AA 12 steps led to respondents acknowledging their need for help to move towards sobriety. This can further be supported by a relatively high score of 80% in respect to the respondents who agreed and strongly agreed as opposed to 9.1%, 3.4%, and 7.4% of the respondents who were uncertain, disagreed and strongly disagreed respectively. A standard deviation of 0.958 indicated a moderate score spread from the mean, hence implying moderate agreement amongst the respondents in respect to the achieved average mean. Proponents of the person-centered theory indicate that that each person has within him or her the ability for positive and dramatic growth (Cloete, 2014). The study results agree with findings by Coombs and Howatt (2005), that indicate that termination of all alcohol addiction occurs when persons facing addiction recognise that mood-altering substances do not offer support as they had initially thought, but form the basis of increasing their problems. The findings are consistent with Gwinnell and Adamec (2006), who observe that a recovering alcoholic's acceptance of the presence of an addiction problem becomes the turning point on their path to sobriety. This

awareness is however inadequate on its own, but forms a necessary component of overcoming alcohol addiction (ibid).

The ability of the respondents to take stock of the past and admit wrong doing was noted as a key component influencing the recovery of alcoholic social and personal competencies in rehabilitation centres. In this context, the indicator scored a mean of 3.91 and a standard deviation of 1.024. The mean score of 3.91 in a five-point likert scale indicated that the respondents on average agreed that this AA step enabled them take stock of the past and admitting to wrong doing. However, there were a notable number of respondents who were uncertain, disagreed and strongly disagreed. The prevalence of these thoughts stood at 9.1%, 0.6%, and 11.4% scores for uncertain, disagree and strongly disagree responses respectively. These findings are consistent with those by Denzin (1987), that established an association between how alcoholics in recovery narrate their encounters, which helps streamline their earlier identification with the alcoholic self and restructure it in terms of a new person attempting a recovery. The recovering alcoholic therefore learns to use this indicator of taking stock of the past and admitting wrong doing to make amends to those they have hurt and becoming responsible for the messages of recovery given to others (Kuria, 2015). The study findings resonate with the views of Adlerian theorists that places keen interest in the future of recovering alcoholics without minimising the importance of previous influences.

This study also established that the respondents agreed that rehabilitation helped them to mend broken relationships as indicated by achieved scores of 3.71 and 1.013 for the means and standard deviations respectively. The high mean score of 3.71 in a five-point likert scale indicates that the respondents on average tended to agree that this aspect of the AA step helped in mending of broken relationships. These findings are further supported by respondents who indicated strongly agree and agree at 29.7% and 36.0% respectively in respect to the metric. However, proportions accounting for 7.4% and 8.6% of the respondents who disagreed and strongly disagreed with the metric led to a large standard deviation of 1.013 that implied a lack of consensus in respect to the achieved mean score amongst the respondents. Alcoholics Anonymous has been viewed as a strong avenue in its approach to helping participants recover from alcohol dependency (Hollen, 2009). Rehabilitation from alcohol is critical due to the fact that alcoholism often destroys critical family relationships due to violence, marital satisfaction inadequacies, economic challenges and general family

happiness (Peter, 2015). The findings are in agreement with those of Saatcioglu et al. (2006), that provide solid evidence in support of effective interventions within the family in the management of alcoholism that demonstrate that therapy for families of recovering alcoholics is indeed instrumental in enhancing general relations and functioning within the family setup. Studies have shown a decline is outcomes for overall substance use where retention and engagement in therapy is carried out for recovering alcoholics (ibid). Critics of the 12 steps however lay claim that the AA is cult-like and tends to foster relationships that are dependent, where there is a tendency of exploiting newer and vulnerable members seeking help by those who have been in the organisation for longer periods (Hollen 2009).

A mean score of 4.02 and a standard deviation score of 0.982 was achieved in respect to the AA 12-step indicator that sought to assist the rehabilitation respondents to continue seeking help to get better. A mean score of 4.02 in a five-point likert scale indicated that the respondents on average tended to agree that this AA 12-step helped respondents to continuously seek for help to get better during the rehabilitation period. The standard deviation of 0.982 implied a moderate consensus in respect to the achieved mean score. The findings are consistent with Moos (2010), who observes that recovering alcoholics who engaged more in group meetings and activities have better prospects of socialising with friends, attending cultural events, participating in sports activities and reporting higher likelihoods of attaining and sustaining sobriety.

The results of Table 19 revealed that the AA 12-step led to regaining of control over personal responsibility over daily living dynamics like diet, hygiene and sleep among others and achieved a mean of 3.86 and standard deviation of 1.019. A significant proportion of the respondents (38.9%), were inclined to agreeing that the AA step indeed helps recovering alcoholics regain control over personal responsibility in daily living dynamics such as diet, hygiene and sleep, closely followed by those who were inclined to strongly agree (35.4%) on the same. These findings agree with Fidelis (2012), who argues that the restoration of daily life for the recovering alcoholic is centred on traditions that focus on the re-establishment of the regular day to day activities. The results resonate with findings by Mjwara (2013), who points out that actions of personal responsibility require the recovering alcoholic to form new behaviour patterns to deal with his day to day lifestyle, such as his diet, hygiene, sleep, exercises clothes and recreational activities.

The maintenance of sobriety through support systems in the AA community posted a mean of 3.94 and a standard deviation of 0.963. The relatively high mean implied a tendency for the respondents to agree on average in respect to the metric and a moderate standard deviation implied a moderate consensus on the mean. This is further illustrated by the frequencies. The AA step helps recovering alcoholics maintain sobriety through a support system in the AA community (Strongly Agree=37.7%; Agree=39.4%). However, there were 8.0% and 6.3% of respondents who disagreed and strongly disagreed that this AA Model helps recovering alcoholics to maintain sobriety through support system in the AA community, respectively. The findings reported in respect to this indicator are consistent with those of Hollen (2009), that indicate exploration of the 12 steps during rehabilitation and sharing of common experiences among recovering alcoholics have been shown to develop a firm support organisation on which current and former members of the AA have been able to reconstruct their lives. The rehabilitation facilities embracing the main traditions of the 12-steps were noted to provide safe, accessible and therapeutic environments where recovering alcoholics find support, acceptance and fellowship, saving them from the ravages of alcohol addiction (ibid). The 12 -step facilitation approach offers persons seeking recovery from addiction a new way of life that seeks to aid their breaking the vicious addiction cycle and maintaining sobriety. The findings further agree with Brower et al. (2013), which observe that the sharing of experiences and support structures ensure that the feeling of isolation and loneliness that the recovering addicts feel are significantly reduced aiding in the recovery process.

Results presented in Table 19 revealed that strengthening of the resolve to stay sober through the helping of others stay sober had achieved means and standard deviation scores of 3.82 and 1.013 respectively. This can further be illustrated by the frequency distribution of 30.9% and 44.6% of the respondents who indicated responses of strongly agree and agree respectively. This implied that the respondents on average agreed that the AA step helped in strengthening their resolve to stay sober. The findings in respect to this indicator are in agreement with Zemore and Kaskutas (2008), which point to the fact that individuals actively engaged in giving assistance in rehabilitation through provision of encouragement, moral support and sharing their insights with regard to achieving sobriety are more likely to be engaged in 12-step encounters and realising significant improvements during recovery in the short term. The findings concur with studies by Pagano et al. (2004), that indicated recovering individuals keen on helping their fellow alcoholics maintain long-term abstinence

following their treatment were themselves better able at maintaining sobriety, probably as a result of the social benefits that came from the provision of support to others. The study findings are consistent with Crape et al. (2002) that point out on the essence of engagement in helping activities by recovering alcoholics which improves their social standing and self-esteem. The resolve to seek sobriety strengthens their social support and provides a framework for successful commitment to leading a sober lifestyle following their discharge from the rehabilitation facility (ibid). This acceptance that the recovering alcoholic has a problem with addiction becomes the turning point to their path to sobriety (Gwinnell & Adamec, 2006).

In respect to the 12-step rehabilitation process helping in creation of new social structure and friendship that can help in recovery, mean and standard deviation scores of 3.87 and 0.987 respectively were achieved. This can further be illustrated through scores of 34.9% and 39.4% of the respondents who strongly agreed and agreed respectively. The respondents on average tended to agree that the rehabilitation process helped in creation of new social structures and friendship. These results resonate with findings by Musyoka (2013), that observe that once a recovering alcoholic becomes aware of the maladaptive patterns present in their life, they get in a situation of modifying faulty assumptions and institute basic changes and create a new style of life. These results agree with the Association for Addiction Professionals (2009), that point out the need for suitable use of Adlerian psychology in identifying and correcting erroneous beliefs that directly impact on how a person becomes an alcoholic. As a therapeutic approach, Adlerian psychology is powerful in empowering recovering alcoholics cultivate a constructive, sober lifestyle, a sense of belonging and learning how to change current behaviours to those that are more useful and productive (ibid).

The relationship between Alcoholic Anonymous' 12-step facilitation and recovering alcoholics competencies was determined using Pearsons correlation coefficient. All tests were done at coefficient alpha (α) equal to 0.05. Wilson and MacLean (2011) confirm that Pearson's correlation coefficient is suitable when both variables that the researcher wishes to study are measured in either interval or ratio scales and are continuous. Table 20 summarises the results.

Table 20

Relationship Between AA 12 Step-Facilitation and Recovering Alcoholics' Competencies

		Recovering Alcoholics Competencies
AA 12 Steps	Pearson Correlation	0.491
	Sig. (1 tailed)	0.000

r = .491, Significance at .05

As indicated in Table 20, the Pearsons correlation coefficient yielded an r value of .491 and a P value of .000 . On the basis of $p < .05$, the null hypothesis that stated that there was no statistically significant relationship between the Alcoholic Anonymous' 12-steps facilitation and recovering alcoholics' social and personal competencies in rehabilitation facilities was rejected. This implied that a statistically significant relationship exists between Alcoholic Anonymous' 12-step facilitation and recovering alcoholic competencies. Table 20 confirms that competencies among recovering alcoholics is positively and moderately associated with the AA 12-step facilitation at a confidence level of 95% ($p=0.000<.05$). The moderate positive association between development of competencies and AA 12-step facilitation indicated that when the AA 12-step facilitation increases, social and personal competencies among recovering alcoholics is likely to increase.

These findings are consistent with Mercer and Woody (1999), that indicate that the 12-step facilitation approach offers alcoholics seeking abstinence a new way of life that seeks to back their breaking the addiction cycle and sustaining sobriety. The 12 steps are organised from the simplest changes to more advanced ones that recovering alcoholics motivated to recover may seek to incorporate into their lives. The study findings also agree with White and Miller (2007), who content that the 12-step rehabilitation process has been associated with development of skills and competencies viewed as critical for a recovering alcoholic. The findings are consistent with studies by Brower et al. (2013), that observe that the capacity of the 12-step process in contributing to alcoholics in maintaining sobriety through sharing of experiences, strengths and hope with each other is critical for self-acceptance and improvement of their self-esteem.

Previous studies done indicate that competence is realised by the recovering alcoholic engaging in a process of learning and personal improvement that involves the search for personal therapy, embracing a healthy lifestyle and being honest about ones needs, fears, failures and shortcomings (Brown et al., 2012). This hypothesis receives support by findings that show rehabilitation programmes modelled along the 12-step principles such as the AA programmes have registered high levels of rehabilitation success among alcoholics (Aissen, 2013). This view is supported by findings by Brower et al. (2013), that indicate the sharing of experiences and support structures ensures that feelings of isolation and loneliness experienced by the recovering alcoholic are reduced hence aiding in the recovery process. This view is further supported by Corey (2013), who observes that the AA 12-step programme has yielded good results for many alcoholics who on understanding the nature of their chemical dependence are able to abstain from alcohol, increasing their chances of making a recovery. This focus of behavioural therapy is on increasing the skills of recovering alcoholics and providing them with more options for responding to situations (Corey, 2009). The recovering alcoholic gets an opportunity to learn new and adaptive behavior patterns by being engaged in the AA 12 steps that eventually lead to replacement of old and maladaptive behavior patterns. The AA 12-step approach further gets support from the person-centered therapy, through the mechanisms that provide recovering alcoholics with forums to talk about their past, present or future (Kraemer, 2012). The findings are consistent with Brooks, Kay-Lambkin, Bowman and Childs (2012), that view the AA as a model that aids recovering alcoholics appreciate their plight as persons suffering from a condition and warrant the help and love from family and friends to overcome. The presence of a strong support system provides the alcoholic in recovery with a community that appreciates their pain and struggles with alcohol. Newcombe (2015), observes that a support system helps recovering alcoholics view themselves as being part of the wider global experience and not isolated persons with a unique condition.

4.7 Relationship between Addiction Counsellor Characteristics and Recovering Alcoholics' Competencies

The inventory seeking responses on the relationship of the addiction counsellor characteristics on the recovering alcoholic competences was examined. The items measuring addiction counsellors' characteristics were adapted and modified from the United States Department of Health and Human Services (2011) competencies model for addiction counsellors. This was because the department has developed one of the most extensive and exhaustive competence models in the world. The inventory utilised five-point likert scale using the metrics of strongly agree, agree, uncertain, disagree and strongly disagree in order to capture the responses on the addiction counsellor characteristics. Normality test was used to determine whether the data set for Addiction Counsellors' characteristics was modelled for normal distribution. A graphical method for evaluating normality which included a histogram and normality plot was used which indicated to the the data for this independent variable was normally distributed as verified by Figure 7.

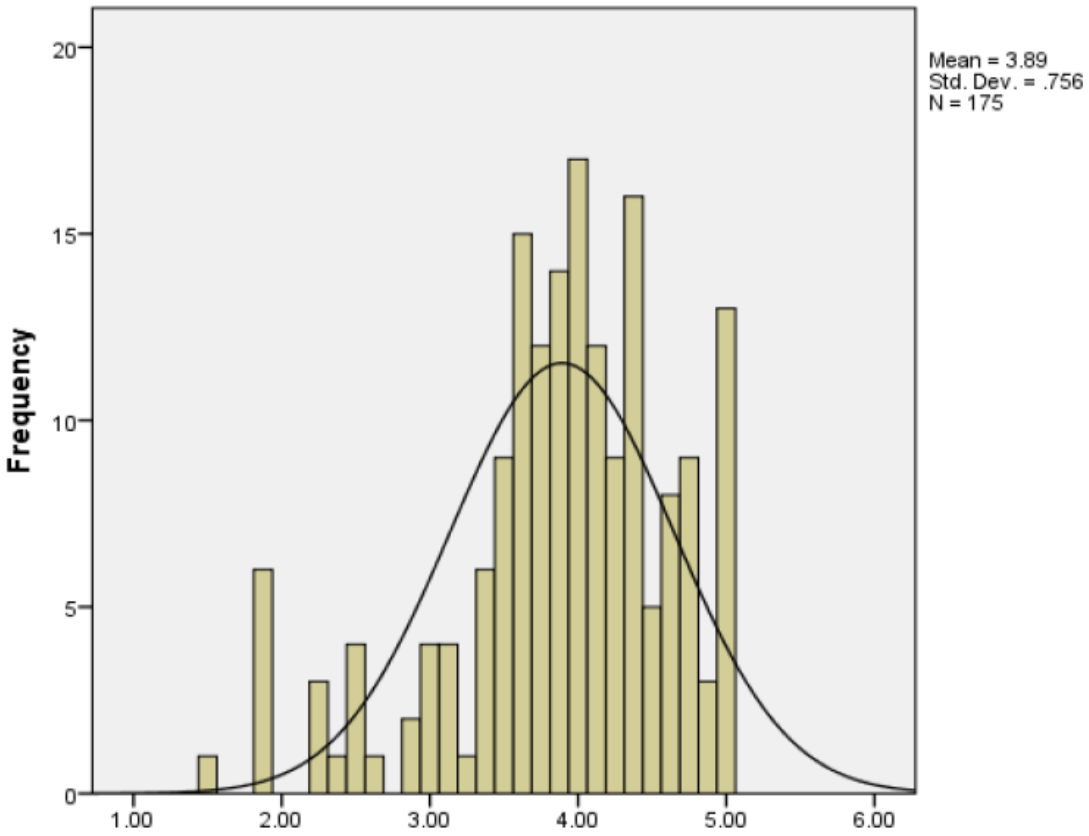

Figure 7. Distribution of Responses for Addiction Counsellors' Characteristics

Figure 7 shows the histogram as used in testing normality of the data for addiction counsellors' characteristics. The data is skewed to the left meaning that the data had a longer tail to the left as compared to the right. This can be seen from the visual representation in the histogram.

The study sought to establish the relationship between addiction counsellors' characteristics and recovering alcoholics' competencies in rehabilitation facilities. Various indicators including understanding of alcoholic social-economic background, diverse effects of alcoholism, recognition of family/social networks role and understanding diverse strategies for treatment were used. Additionally, tailoring treatment to needs, measurement of treatment output, understanding of importance of self-awareness, understanding the need for continuing education, counsellor's attitude and group discussion facilitation were other indicators used. Table 21 contains the results of this examination.

Table 21

Distribution of Responses on Addiction Counsellors' Characteristics

	Percentages and Frequencies						
	SA	**A**	**U**	**D**	**SD**	**Mean**	**Std. Dev.**
Understanding of the alcoholic's social economic background and its contribution to alcoholism	24.0% 42	46.9% 82	15.4% 27	8.6% 15	5.1% 9	3.76	0.872
Recognition of the importance of family, social networks, and community systems in the treatment and recovery process.	39.4% 69	40.6% 71	10.3% 18	4.6% 8	5.1% 9	4.05	0.871
An understanding of a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence.	39.4% 69	36.6% 64	14.3% 25	5.7% 10	4.0% 7	4.02	0.864
Tailoring helping strategies and treatment modalities to the alcoholics' stage of dependence, change, or recovery.	29.1% 51	42.9% 75	16.6% 29	8.0% 14	3.4% 6	3.86	0.836
Understand the need for and the use of methods for measuring treatment outcome.	26.3% 46	44.6% 78	16.6% 29	4.6% 8	8.0% 14	3.77	0.933
Understand the importance of self-awareness in one's personal, professional, and cultural life.	36.0% 63	43.4% 76	12.6% 22	4.6% 8	3.4% 6	4.04	0.791
Understand the importance of on-going supervision and continuing education in the delivery of client services	26.3% 46	46.3% 81	16.0% 28	8.0% 14	3.4% 6	3.84	0.816
The counsellor's facilitation model among the group discussions	29.1% 51	41.7% 73	15.4% 27	7.4% 13	6.3% 11	3.80	0.930

The results presented in Table 21 indicate that the aspect of understanding the alcoholic's social economic background and its contribution to alcoholism achieved a mean of 3.76 and a standard deviation of 0.872. The mean of 3.76 implies that the respondents on average tended to agree that the understanding by addiction counsellors of the alcoholic's social economic background and its contribution to alcoholism was achieved during their stay in rehabilitation. This is further supported by a cumulative percentage of 70.9% by the respondents who chose the strongly agree and agree metrics respectively. A standard deviation of 0.872 indicated a moderate score spread from the mean implying a moderate consensus amongst the respondents in respect to the achieved average mean. This can be attributed to significant scores of respondents who were undecided, those that disagreed and strongly disagreed with the metric at 15.5%, 8.6% and 5.1% respectively. The results achieved in respect to this indicator was consistent with those of Koszycki et al. (2014), that outline the need for counsellors in providing a simple understanding of the concept of addiction that comprises of knowledge of existing models and theories, cognition of the multiple contexts within which alcohol abuse takes place and an awareness of the effects of alcohol use. These findings are further supported by Cromin (2013), that indicate the need for recovering alcoholics becoming aware of destructive forms of alcohol use and recognise the loss of control over their drinking as they eventually learn to appreciate that the road to sobriety is a lifelong process.

The U.S Department of Health and Human Services (2011), identifies a key competency that addiction counsellors must have, which is the ability to recognise the political, social, economic and cultural contexts within which substance abuse and alcohol addiction occur. This includes resilience and risk factors that characterise persons and groups and their living backgrounds. The findings are consistent with the Adlerian theory, which places focus on understanding the person within the social context of family setup, school, culture and working environment (Kuria, 2015). This individual's awareness on the part of the addiction counsellor helps shape their understanding of the human community and how the alcoholic interacts with the social world (Association for Addiction Professionals, 2009).

The indicator on acknowledgment of the prominence of the family, community systems and social networks in the management and recovery process by addiction counsellors reported a mean of 4.05 and a standard deviation of 0.871. The mean of 4.05 implied that the

respondents on average tended to agree on appreciation of the importance of family, community systems and social networks in the treatment by addiction counsellors having been achieved during rehabilitation. This is further supported by a relatively high score of 80.0% with respect to the respondents who were in agreement as opposed 10.3%, 4.6% and 5.1% of the respondents who were uncertain, disagreed and strongly disagreed respectively. These findings are consistent Gwinnell and Adamec (2006), which highlight the importance of the stakeholder's attitudes in the life of recovering alcoholics who include family and friends. The findings agree with Wasserman et al. (2001), which observe that persons recovering from addiction with a social arrangement comprising of a network of support against the use of alcohol are more likely to realise and tolerate reduction in alcohol consumption. Githae (2015), argues that a family that readily offers support is the strongest source of social support and identity for persons recovering from addiction and is associated with better prognosis and successful rehabilitation efforts. The level of family support in the recovery process is important, since alcoholism often destroys critical family relationships due to violence, marital satisfaction inadequacies, economic challenges and general family happiness (Peter, 2015).

The understanding by addiction counsellors of a variety of helping strategies for reducing negative effects of substance abuse and dependence was noted as a significant characteristic by respondents in the rehabilitation centres. This indicator posted a mean of 4.02 and a standard deviation of 0.864. The mean score of 4.02 in a five-point likert scale indicated that the respondents on average agreed on the need for addiction counsellors possessing a broad perspective on helping approaches for decreasing the negative effects of substance use and abuse. A notable proportion of respondents however reported sentiments of being uncertain, disagreeing and strongly disagreeing that stood at 14.3%, 5.7% and 4.0% respectively. These findings are consistent with Koszycki et al. (2014), which outline the importance of addiction counsellors being able to demonstrate knowledge about the range of care and the social circumstances affecting the management and healing process, as well as the ability to identify a variety of helping strategies that can be tailored to meet the needs of the alcoholic. The U.S Department of Health and Human Services (2011), identifies a key competence for addiction counsellors to develop an appreciation of a range of theories and treatment models of dealing with concerns of alcohol addiction. This competence requires the addiction counsellors be

knowledgeable on concepts of different addiction theories as well as their applicability in diverse scenarios (ibid).

The study established that the respondents agreed that adapting helping strategies and treatment approaches to the alcoholics' phase of dependence, recovery or change was an important trait of the addiction counsellors during rehabilitation. In this context, the indicator posted a mean of 3.86 and a standard deviation of 0.864. Most of the respondents (42.9%) were inclined to agreeing closely followed by those who were inclined to strongly agree (29.1%) on the same. The standard deviation of 0.864 implied a moderate consensus in respect to the achieved mean. The findings agree with the U.S Department of Health and Human Services (2011), on the importance of addiction counsellors being able to adapt their practice to suit a varied range of treatment settings and approaches when dealing with recovering alcoholics. Gabhainn (2003), observes that varied counsellor characteristics such as background knowledge, attitude, counselling skills and experience specific to dependencies all contribute to effective counselling of addictions and positive results of recovering alcoholics. These findings are consistent with observations by Erickson (2009), who indicates that competence of recovering alcoholics is aided through the supervision and interaction with resource persons such as addiction counsellors who watch, listen and talk to the recovering alcoholics during therapy as well as applying therapy techniques and strategies that involve practice and feedback. These findings are congruent with Charles, Suranski, Barber-Stephens, Allen, Ticheli & Tonore (2003), who note that the capacity of being able to dialogue with the alcoholic promotes deeper communication and understanding as a means of facilitating a rapport that is therapeutic. These findings further concur with the goal of Adlerian therapy that seeks to help recovering alcoholics develop a more adaptive lifestyle. This is accomplished when the therapist helps clients develop insight into the "basic mistakes" deeply held in their everyday life. Once this insight is achieved, alcoholics become naturally motivated to change in constructive ways (Corey, 2013).

The understanding by addiction counsellors on the need to use methods for measuring treatment outcomes scored a mean of 3.77 and a standard deviation of 0.933. The relatively high mean implied a tendency for the respondents to agree on average in respect to the metric and a moderate standard deviation implied a moderate consensus on the mean. This is further illustrated by the frequency distribution of 23.6% and 44.6% of the respondents who

indicated strongly agree and agree respectively. There were however a notable number of respondents, who were uncertain, disagreed and strongly disagreed that stood at 16.6%, 4.6% and 8.0% respectively. The results achieved in respect to this indicator was consistent with those of Reading (2009), which places addiction counsellors in a better position of better appreciating the downsides that alcoholics face as well as the power of thought processes that often results in relapses. Recovering addiction counsellors are often in a position of challenging poorly thought-out strategies for intervention and interrogate judgments and assumptions concerning change when dealing with alcoholics (ibid).

Results presented in Table 21 revealed that understanding the importance of self-awareness in one's personal, professional and cultural life was an integral characteristic for addiction counsellors, achieving a mean of 4.04 and a standard deviation of 0.791 respectively. This can further be illustrated by the frequency distribution scores of 36.0% and 43.4% of the respondents who indicated strongly agree and agree respectively. This implied that the respondents on average agreed that an appreciation by counsellors on the role of self-awareness in a recovering alcoholics' life helped improve on their competencies during the rehabilitation programme. The findings in respect to this indicator are consistent with Cromin (2013), that contend that the concern for alcoholics by counsellors is on the aspects that can support or help improve the ability in alcoholics to develop certain behavior patterns for both adaptations in the short term as well as developmental progress in the long run. The findings agree with Cloete (2014), who points out that the essence of person-centered therapy on counsellor characteristics in promoting competencies and the role of helping clients recapture their natural propensity for growth. Person-centered theory views the association between addiction therapist and recovering alcoholic as empowering where alcoholic in recovery receives guidance on rebuilding his strengths and optimising them towards self-actualisation through the aid of a therapist during rehabilitation (ibid). The focus is therefore on social and personal competencies, particularly on the aspects of trust, self-control, empathy and the respect for others (Masinde, 2011). These social and personal competencies are not innate but must be enhanced overtime so as to advance and improve performance and continue as one progresses through life (Roozen et al., 2009).

In respect to the understanding by addiction counsellors on the importance of ongoing supervision and continuing education in the delivery of services, a mean and standard

deviation of 3.84 and 0.816 respectively was achieved. This can further be illustrated through scores of 23.6% and 46.3% of the respondents who strongly agreed and agreed respectively. The respondents on average tended to agree with the understanding by addiction counsellors that ongoing supervision and education helped improve on their service delivery and build on the competence of recovering alcoholics in rehabilitation. These results resonate with findings by Kivlahan (2013), who observes that competency among recovering alcoholics' is realised through the supervision and interaction with addiction counsellors who employ various therapy techniques and strategies to promote awareness and change. This is made possible by the recovering alcoholic engaging in a journey of knowing and improving on oneself. The findings are consistent with Coombs and Howatt (2005), who highlight on the role that learning and education play in the overall growth of any individual and go on to assert that addiction counsellors assist recovering alcoholics move forward by promoting healthy activities to replace their former addiction through planning. The findings resonate with Mcveigh (2012), who observes that the nature of behaviour therapy is action oriented and underscores the role of learning processes being at as the centre during of therapy. The recovering alcoholic may therefore acquire new adaptive behaviour in place of earlier maladaptive ones.

The addiction counsellor's facilitation role during group discussions scored a mean of 3.80 and a standard deviation of 0.930 respectively. The relatively high mean implied a tendency for the respondents to agree on average to the metric and a moderate standard deviation implied a moderate consensus to the mean. This is further illustrated by the frequency distribution of 29.1% and 41.7% of the respondents who indicated strongly agree and agree respectively. The findings of this indicator are consistent with those of Crape et al. (2002), that point out on the essence of addiction counsellors engaging in helping activities in improving the recovering alcoholics' self-esteem and social standing. These activities were also noted to strengthen their support network and personal resolve to abstinence after their stay in rehabilitation (ibid). The findings agree with Adlerian theorists do not perceive alcoholics as ailing and in need of treatment, but favour the progression personality model rather than the sickness orientation (Basche, 2014). Counselling as a process places emphasis in the delivery of information, guiding, teaching and offering encouragement to discouraged alcoholics (ibid).

The relationship between addiction counsellor characteristics and recovering alcoholics competencies was determined using Pearsons correlation coefficient. All tests were done at coefficient alpha (α) equal to 0.05. Table 22 summarises the results.

Table 22

Relationship Between Addiction Counsellor Characteristics and Recovering Alcoholics Competencies in Rehabilitation Facilities

		Recovering Alcoholics Competencies
Addiction Counsellor Characteristics	Pearson Correlation	0.649
	Sig. (1 Tailed)	0.000

r = .649, Significance at .05

As indicated in Table 22, the Pearsons correlation coefficient yielded an r value of .649 and a p value of .000. On the basis of $p < .05$, the null hypothesis that stated that there was no statistically significant relationship between the addiction counsellor characteristics and recovering alcoholics' social and personal competencies in rehabilitation facilities was rejected. This implied that a statistically significant relationship exists between addiction counsellor characteristics and recovering alcoholic competencies. Table 22 above confirms that development of competencies among recovering alcoholics is positively and strongly associated with the addiction counsellor characteristics at a confidence level of 95% ($p=0.000<.05$). The strong positive association between addiction counsellor characteristics and the progress of recovering alcoholics competencies indicated that when favourable addiction counsellor characteristics increase, the process of enhancing social and personal competencies among recovering alcoholics is likely to increase.

These findings are supported by goals of Adlerian therapy that seek to help recovering alcoholics develop a more adaptive lifestyle when the addiction counsellor helps clients develop insight into the "basic mistakes" deeply held in their lifestyle that lead to alcohol addiction. Once this insight is achieved, alcoholics become naturally motivated to change in more constructive ways (Corey, 2009). Person-centered therapy on the other hand agrees on the importance of counsellor characteristics in promoting social and personal competencies, underscoring the importance of their role of assisting recovering alcoholics rediscover their natural propensity for growth. According to person centred therapy, this may be

accomplished by creating a therapeutic relationship characterised by genuineness or congruence and unconditional positive regard on the part of the counsellor (Mjwara, 2013). This leads to gaining of social and personal competencies that were previously not well organised in the recovering alcoholic during rehabilitation (Mwathi, 2013).

This hypothesis has therefore been supported by the findings by Mercer and Woody (1999), which indicate that addiction counselling gives the recovering alcoholic coping strategies and tools for recovery and promotes the 12-step ideology and participation. The findings also resonate with the U.S Department of Health and Human Services (2011), that prognosis for a favourable outcome for the alcoholic in recovery is highly dependent on the nature of the association established with the addiction counsellor. The study findings are further supported by Reading (2009), who contends that the observable presence of recovering addiction counsellors in rehabilitation centres tends to reassure alcoholics in recovery that they are under the care of persons that appreciate their needs and are in a position of providing genuine help. This further reassures the recovering alcoholic of the possibility of identifying with a counsellor who is a recovering alcoholic and subsequently begin to re-align their own behaviour based on the accomplishments of what they observe (ibid). Adams and Warren (2010), further indicate that the connections established between recovering addiction counsellors and their clients incorporate to the service the strong networks established with the recovering community during the course of establishing their own recovery. These contacts are also significant in building up the repute of the rehabilitation process as well as in improving the relationship and referral of recovering alcoholics who require assistance from other service providers (ibid). Masinde (2011), observes that behavioural theorists place emphasis on the relationship between the recovering alcoholic and addiction counsellor, since it is instrumental in offering support to the alcoholic through difficult times of change and discomfort.

4.8 Relationship between Recovering Alcoholics' Characteristics and Recovering Competencies

Recovering alcoholics are characterised by diverse psychological and physical symptoms which affect the persons' critical thinking, perceptions, attitudes and skills. The rehabilitation process therefore seeks to empower the recovering alcoholic regain normal functioning of human skills for the social, spiritual and economic life. The inventory seeking responses on

the relationship of the recovering alcoholics characteristics on development of competencies was developed from the reviewed literature. The inventory utilised a five-point likert scale using the metrics of strongly agree, agree, uncertain, disagree and strongly disagree in order to capture the responses on the characteristics of recovering alcoholics. To determine whether the data set for recovering alcoholics' characteristics was modelled for normal distribution, a normality test was employed. This employed the use of a graphical method for evaluating normality which included a histogram and normality plot. Figure 8 outlines that the data for this independent variable was normally distributed.

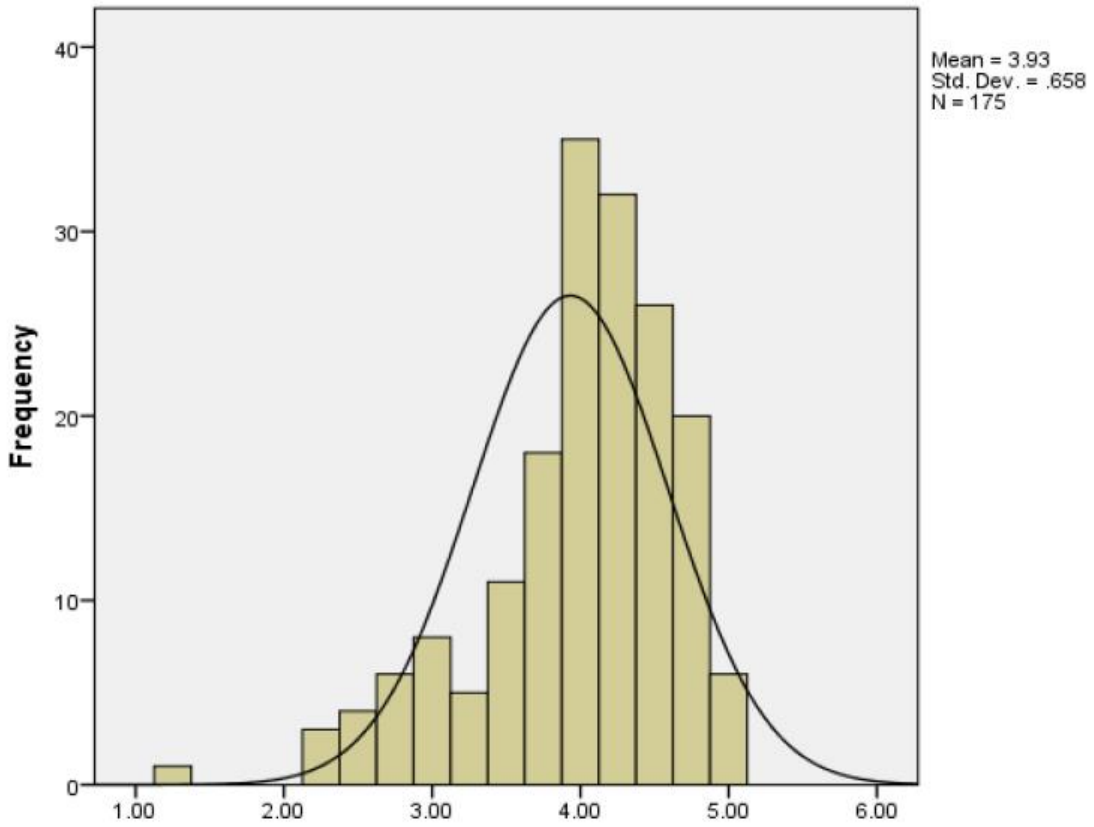

*Figure 8***.** Distribution of Responses for Recovering Alcoholics' Characteristics

Figure 8 shows a histogram as used to test normality of the data for recovering alcoholics characteristics. The data is skewed to the left meaning that the data had a longer tail to the left as compared to the right. This can be seen from the visual representation in the histogram.

In order to establish the relationship between alcoholics' characteristics and process of recovering social and personal competencies in rehabilitation facilities, the study used the perceptions of respondents on various indicators of the recovering alcoholics' characteristics.

These included level of education and exposure, relationship with counsellors, relationship with fellow alcoholics, group discussion contributions, the belief in God, their self-will to change and acceptance of their alcoholic status. Table 23 shows the results.

Table 23

Distribution of Responses on Recovering Alcoholics' Characteristics

	Percentages and Frequencies						
	SA	**A**	**U**	**D**	**SD**	**Mean**	**Std. Dev.**
Education level and exposure	26.9% 47	42.9% 75	17.1% 30	7.4% 13	5.7% 10	3.78	0.899
Relationship with counsellors	28.6% 50	49.1% 86	13.7% 24	3.4% 6	5.1% 9	3.93	0.812
Relationship with fellow alcoholics	18.9% 33	46.9% 82	23.4% 41	5.1% 9	5.7% 10	3.68	0.823
Ability to share alcoholics 'story and make contributions to group discussions	35.4% 62	40.6% 71	9.7% 17	5.1% 9	9.1% 16	3.88	1.014
Belief in God and other spirituality aspects	53.1% 93	23.4% 41	10.9% 19	5.1% 9	7.4% 13	4.10	1.03
Self-will to change	61.1% 107	24.0% 42	7.4% 13	2.3% 4	5.1% 9	4.34	0.864
Acceptance of alcoholic status	46.3% 81	32.6% 57	13.7% 24	4.0% 7	3.4% 6	4.14	0.827

The results displayed in Table 23 indicate that the level of education and exposure among recovering alcoholics achieved a mean of 3.78 and a standard deviation of 0.899. The mean of 3.78 implies that the respondents on average tended to agree that the level of education and exposure played a significant role in road to recovery and process of gaining competencies among recovering alcoholics. This is further supported by a cumulative percentage of 69.8 % of the respondents who selected the strongly agree and agree metrics respectively. A standard deviation of 0.899 indicated a moderate score spread from the mean, implying moderate consensus amongst the respondents in respect to the achieved average mean. This can be

attributed to significant scores of respondents who were undecided, disagreed and strongly disagreed with the metric at 17.1%, 7.4% and 5.7% respectively. The results posted with respect to this indicator were consistent with the findings of the report by SAMHSA (2012), which observe that recovery from addiction can be sustained though evidence-based practices that target the social determinants of health such as education, supported employment and housing. The study further agrees with the findings by Kurtz and Fisher (2003), who indicate that the involvement by recovering alcoholics in community activities has been strongly linked with higher prospects of alcohol reduction in the initial stages during treatment and recovery. Behavioural theories underscore the importance of learning during of therapy especially on key aspects that influence salient factors that can enhance behaviour change (Mcveigh, 2012).

The results on the relationship of recovering alcoholics and addiction counsellors reported a mean of 3.93 and a standard deviation of 0.812. A mean score of 3.93 indicated that the participants on average agreed on the significance of nurturing healthy relationships with addiction counsellors during the period of treatment. This was further supported by a relatively high score of 77.7% with respect to the participants who were in agreement as opposed 13.7%, 3.4% and 5.1% of the respondents who were uncertain, disagreed and strongly disagreed respectively. These findings are consistent with Githae (2015), who points out the important role played by addiction counsellors in facilitating recovery by providing an enabling environment where persons with alcohol addiction can make progress towards living a sober life. The training of addiction counsellors and their competencies serve as an important avenue in the formation of associations and implementation of modalities that seek to bring desirable change among recovering alcoholics that threatens their survival and growth (ibid). The study findings agree with the U.S Department of Health and Human Services (2011), which observes that the prospect of achieving a favorable outcome for the recovering alcoholic is highly dependent on the nature of the association established with the counsellor. In cases where the recovering alcoholic fails to gradually opens up in a group and is unable to express himself more openly, successful recovery may be problematic in the long run ultimately affecting the enhancement of social and personal competencies during rehabilitation. The study findings agree Cloete (2014), who observes that the relationship between the addiction counsellor and the alcoholic in recovery is an empowering one where

the alcoholic is assisted in discovering his strengths and optimising them towards self-actualization in his own life during the rehabilitation process.

Establishing good relations with fellow alcoholics during the period in rehabilitation has been observed as being a significant by respondents in the sampled rehabilitation centres. A mean score of 3.68 and a standard deviation of 0.823 was posted by this indicating that the respondents on average were in agreement on the ability of the rehabilitation of programme in enhancing the recovering alcoholics abilities to form strong bonds with fellow alcoholics. This is evidenced by participants who indicated strongly agree and agree at 18.9% and 46.9% respectively to this metric. A relatively small proportion of the respondents however reported sentiments of being uncertain, disagree and strongly disagree that stood at 23.4%, 5.1% and 5.7% respectively. These findings are consistent with Brower et al. (2013), which recognises the ability of the 12 steps approach in removing shortcomings in the recovering alcoholics' personality traits helping them make amends to wronged persons and in taking responsibilities to help other alcoholics. Gwinnell and Adamec (2006), observe that a key component in promoting healing from addiction is the attitude of significant stakeholders in the alcoholic's life that includes family, friends and society in general. Individuals with a support system comprising of members against alcohol abuse and report more support for maintaining abstinence are more likely to realise and sustain reduction (Wasserman et al. 2001). The study findings further agree with those by Zemore and Kaskutas (2008), that indicate recovering alcoholics offering help during treatment through volunteer service, provision of moral support and encouragement as well as sharing their understanding about how one may remain sober and resolve other problems are more likely to be involved in 12-step groups and achieve improvements in the short term during recovery. These helping activities can significantly improve the recovering alcoholic's self-esteem and social standing, strengthen their social network and provide a model for positive commitment to leading a sober life after discharge from the rehabilitation facility (Crape et al. 2002).

The results displayed in Table 23 indicate that the ability of respondents sharing their story on alcohol abuse and making contributions to group discussions achieved a mean of 3.88 and a standard deviation of 1.014. The mean of 3.88 implies that the respondents on average tended to agree that the ability to open up about their journey on the road to recovery made significant contributions to the process of developing their social and personal competencies

during rehabilitation. This is further evidenced by a cumulative percentage of 76% of the respondents who chose the strongly agree and agree metrics respectively. A standard deviation of 1.03 indicated a huge spread of data from the mean of 3.88. This can be attributed to significant scores of respondents who were uncertain, disagreed and strongly disagreed with the metric at 9.7%, 5.1% and 9.1% respectively. The results achieved in respect to this indicator agree with Moos (2010), who argues that recovering alcoholics that participate more in activities that are group related are more likely to socialise with close friends, attend cultural events, be involved in sports and engage in social activities and be more likely to attain and sustain abstinence.

The indicator on belief in God and other spirituality aspects posted a mean of 4.10 and a standard deviation of 1.03. The mean of 4.10 implied that the respondents on average tended to agree on the essence of spirituality in the road to recovery from alcohol addiction. A standard deviation of 1.03 indicated a huge spread of data from the mean of 4.10. This is further evidenced by a relatively high score of 76.5% in respect to the respondents who were in agreement as opposed 10.9%, 5.1% and 7.4% of the respondents who were uncertain, disagreed ad strongly disagreed respectively. These findings are consistent with Pardini et al. (2000), who observe that involvement by recovering alcoholics in religious and spiritual aspects has been shown to provide support and supervision as well as giving goal direction that is reflected in the development of a stronger purpose in life. Hollen (2009), observes that millions of alcoholics acknowledge the assistance given by the AA organisation in saving their lives and believe that its traditions are the only true pathway to recovery. This assertion however faces strong opposition from those that reject the spiritual aspects of AA that call for submission to a greater power. Findings from the study are further supported by Galanter (2007), who observes that the spiritual recovery movement that reinforces adherence with its rules by engaging recovering alcoholics in a caring and organised social system tends to support a new purpose in their lives and contributes to the recovery process.

The assessment of the recovering alcoholics aspect of their self-will to change during the course of their stay in the rehabilitation programme was noted as a significant characteristic critical in the enhancement of competences by respondents in the rehabilitation centres. This indicator posted a mean of 4.34 and a standard deviation of 0.864. The mean score of 4.34 in a five-point likert scale indicated that the respondents on average agreed with the

rehabilitation programme enhancing their self-will to change and in motivating their resolve to live an alcohol-free life. This was further supported by respondents who selected the responses of strongly agree and agree at 61.1% and 24.0% respectively. A notable proportion of respondents however expressed opinions of being uncertain, disagree and strongly disagree that stood at 7.4%, 2.3% and 5.1% respectively. Pagano et al. (2010), notes the assessment of the alcoholic's obligation for his or her actions of abusing alcohol is important so as to ascertain whether the alcoholic suffers from some kind of condition that weakens their capacity to regulate their own actions (Hyman, 2007). The findings agree with Cloete (2014), who observes that addiction weaken the alcoholics' ability to align his actions with their own evaluative judgments. The prevention and recovery methods that emphasise on the alcoholic mastering the will power to refuse alcohol, or by rebuking the addict for lack of willpower, are are unlikely to be sufficient in the absence of interventions intended at helping the alcoholic avoid the signals that initially activate cravings (ibid). Mercer and Woody (1999), view the recovering alcoholic as an effective agent of change making it imperative for the person to take responsibility for working on and succeeding with the programme of recovery.

The results displayed in Table 23 indicate that the aspect of acceptance of respondents' alcoholic status achieved a mean of 4.14 and a standard deviation of 0.827. The mean of 4.14 implies that the respondents on average tended to agree that the acceptance of one's alcoholic status on the gaining of competencies on the path to sobriety. This is further supported by a cumulative percentage of 78.9% for the respondents who selected the strongly agree and agree metrics respectively. A standard deviation of 0.827 indicated a moderate spread of data from the mean of 4.14. This can be attributed to the presence of relatively fewer scores of respondents who disagreed and strongly disagreed with the metric at 4.0% and 3.4% respectively. The study findings agree with Gwinnell and Adamec (2006), who indicate that the acceptance by an individual of their addiction problem becomes the cornerstone of their path to recovery. These findings are consistent with Pagano et al. (2010), that credit the success of 12-step facilitation model for encouraging the aspect of surrender during the rehabilitation process. This is because the ability of an alcoholic to accept their identity as an alcoholic and their loss of control over their life marks the start of the recovery process (ibid).

The relationship between recovering alcoholics characteristics and recovering alcoholics competencies was determined using Pearsons correlation coefficient. All tests were done at coefficient alpha (α) equal to 0.05. Table 24 summarises the results.

Table 24

Relationship Between Recovering Alcoholics Characteristics and Recovering Alcoholics Competencies in Rehabilitation Facilities

		Recovering Competences
Recovering Alcoholic	Pearson Correlation	0.580
Characteristics	Sig. (1 tailed)	0.000

r = .580, Significance at .05

As indicated in Table 24, the Pearsons correlation coefficient yielded an r value of .580 and a P value of .000 . On the basis of $p < .05$, the null hypothesis that stated that there was no statistically significant relationship between recovering alcoholics characteristics and recovering alcoholics' competencies in rehabilitation facilities was rejected. This implied that a statistically significant relationship exists between recovering alcoholics characteristics and recovering alcoholics social and personal competencies. Table 24 above confirms that development of competencies among recovering alcoholics is positively and moderately associated with recovering alcoholics characteristics at a confidence level of 95% ($p=0.000<.05$). The moderate positive association between competencies and recovering alcoholics' characteristics indicated that when favourable recovering alcoholics characteristics increase, the gaining of social and personal competencies among recovering alcoholics is likely to increase.

These findings are consistent with Kuria (2015), who observes that one of the most essential skills is the individual's capacity to make choices and use judgment at personal and interpersonal levels that strongly affects the quality of life. This awareness alone however, is not sufficient but forms a necessary element of overcoming an addiction (Gwinnell & Adamec, 2006). The enhancement of this skill may therefore play a key role in the prevention of relapse during rehabilitation. Coombs and Howatt (2005), observe that recovering alcoholics with the help of addiction counsellors can become motivated to better their lives by following guidelines of a well-laid plan of action with set goals aimed at the realisation of

chosen outcomes. A recovering alcoholic who implements a noble plan of action begins to experience achievements, making modifications as they progress during their stay in rehabilitation (ibid). Stokes et.al (2018), assert that people can make a comeback from alcoholism with empowerment which helps make sense of their predicament and sets them onto the recovery path by making a commitment to a new way of life. Such commitment involves a change in the psychological mind-set where acceptance of addiction as a disease is made that entails a lifelong care and integration of a new faith-based character (ibid).

4.9 Relationship between Family Level Support and Process of Recovering Alcoholic's Competencies

The inventory seeking responses on the relationship of family level support and recovering alcoholics' competencies was developed from the reviewed literature. The inventory utilised five-point likert scale using the metrics of strongly agree, agree, uncertain, disagree and strongly disagree in order to capture the responses on family level support. Normality test was used to determine whether the data set for family level support was modelled for normal distribution. This involved the use of a graphical method for evaluating normality which included a histogram and normality plot. Therefore, the data for this independent variable was normally distributed as verified by the histogram in Figure 9.

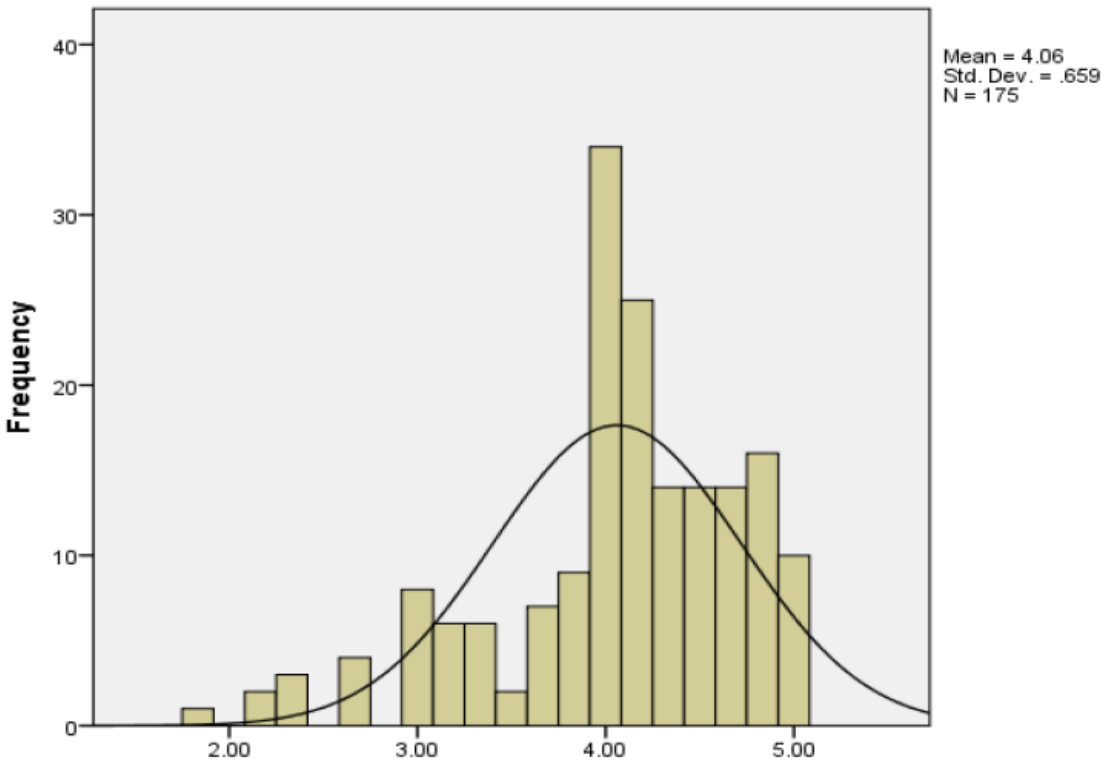

Figure 9. Distribution of Responses for Family Level Support

Figure 9 shows responses as used to test normality of the data for family level support. The data is skewed to the left meaning that the data had a longer tail to the left as compared to the right. This can be seen from the visual representation in the histogram.

This study further sought to establish the relationship between the level of family support and recovering alcoholics' competencies in rehabilitation facilities. The indicators measuring family support comprised family acceptance of the recovering alcoholic, provision of a listening ear to the alcoholics' efforts and challenges in recovery process, active participation in treatment programmes and encouragement in involvement in health supporting behaviours such as sports. Table 25 shows the results.

Table 25

Distributions of Respondents Level of Family Support

	Percentages and Frequencies						
	SA	**A**	**U**	**D**	**SD**	**Mean**	**Std. Dev.**
Family acceptance of the alcoholic	44.0 % 77	37.1% 65	9.7% 17	4.0% 7	5.1% 9	4.11	1.075
Provision of a listening ear to alcoholics' efforts and challenges in recovery process	37.1% 65	42.9% 75	10.9% 19	5.1% 9	4.0% 7	4.04	1.025
Active participation in treatment programmes	36.0 % 63	48.0% 84	8.6% 15	4.0% 7	3.4% 6	4.09	0.955
Encouragement in involvement in health supporting behaviours such as sports	36.0 % 63	44.0% 77	12.6% 22	3.4% 6	4.0% 7	4.05	0.993

The results presented in Table 25 indicate that family acceptance of the recovering alcoholic achieved a mean of 4.11 and a standard deviation of 1.075. The mean of 4.11 implies that the respondents on average tended to agree that being accepted by family played a key role in the road to recovery by the respondents during their stay in rehabilitation. This is supported by a cumulative percentage of 81.1% of the respondents who chose the strongly agree and agree metric respectively. A standard deviation of 1.075 indicated a huge score spread from the

mean. This can be attributed to significant scores of respondents who were undecided, those that disagreed and strongly disagreed with the metric at 9.7%, 4.0% and 5.1% respectively. The results achieved in respect to this indicator are consistent with those of Brown et al. (2012), that view family support as a major factor in the recovering alcoholic success in the rehabilitation process and prevention of relapse occurrence. This has been attributed to the fact that alcoholism has sometimes been linked to dysfunction within the family (ibid). The level of family support in the recovery process is essential since alcoholism often destroys critical family relationships as a result of violence, marital satisfaction inadequacies, economic challenges and general family unhappiness (Peter, 2015). The findings agree with Githae (2015), which points out on the significance of a supportive family being the greatest source of identity and social support for recovering alcoholics and being linked with better prospects and successful rehabilitation efforts. Bauer (2015), notes that hostility amongst family members that places blame on the alcoholic tends to be counterproductive towards their recovery. In this context, attitudes such as criticism and emotional over-involvement may lead to the alcoholics' relapsing into alcoholism. The findings are congruent with Coombs and Howatt (2005), who observe that love and support provided by family to recovering alcoholics has been identified as aiding in their recognition of self-defeating behaviour related to their alcohol dependence.

The indicator that provision of a listening ear to the recovering alcoholic's efforts and challenges in the recovery process reported a mean of 4.04 and a standard deviation of 1.025. The mean of 4.04 implied that the respondents on average tended to agree that having a family member listen to various concerns related to their addiction was indeed instrumental in the gaining of competencies during rehabilitation. This is further evidenced by relatively high scores of 37.1% and 42.9% respectively in respect to respondents who strongly agreed and agreed as opposed 10.9%, 5.1% and 4.0% of the respondents who were uncertain, disagreed ad strongly disagreed respectively. A standard deviation of 1.025 indicated a huge score spread from the mean. These findings are consistent Habibi (2016), who observes that family support of the recovering addict leads to improved communication levels as well as presenting a motivation for positive behaviour change for the alcoholic. The findings agree with Saatcioglu et al. (2006), which present evidence supporting the effectiveness of family interventions in alcoholism treatment, demonstrating that family interventions for alcoholics are effective in cultivating overall family interactions and functioning. These findings are

consistent Gwinnell and Adamec (2006), that highlight the importance of the attitude of key stakeholders in the alcoholic's life that includes family and friends. The findings agree with Wasserman et al. (2001), that observed individuals with a support system comprising of members against alcohol abuse and who reported more support for maintaining abstinence were more likely to realise and sustain reduction in alcohol use.

The indicator on active participation of recovering alcoholics in treatment programmes posted a mean of 4.09 and a standard deviation of 0.955. The mean of 4.09 implied that the respondents on average tended to agree on the essence of respondents being actively involved in various activities designed for recovery from alcohol addiction. This is further evidenced by relatively high scores of 36.0% and 48.0 % respectively in respect to the respondents who strongly agreed and agreed. A standard deviation of 0.955 indicated a moderate spread of data from the mean of 4.09. This can be attributed to significant scores of respondents who were undecided, disagreed and strongly disagreed with the metric at 8.6%, 4.0% and 3.4% respectively. These findings are consistent with Morgenstern et al. (2014), which observe that participation by family in improving competencies of recovering alcoholics is based on the willingness of family members, intended goals that need to be achieved and provisions for involvement of family members in the rehabilitation centres amongst other factors.

The aspect of encouragement of recovering alcoholics in involvement of health supporting behaviour such as sports reported a mean of 4.04 and a standard deviation of 0.993. The mean of 4.04 implied that such engagements by recovering alcoholics in health-related activities during rehabilitation strengthened the process of social and personal competencies. This is further supported by relatively high scores of 36.0% and 44.0% respectively in respect to the respondents who strongly agreed and agreed as opposed 12.6%, 3.4% and 4.0% of the respondents who were uncertain, disagreed and strongly disagreed respectively. A standard deviation of 0.993 indicated a moderate spread of the scores from the mean. These findings are consistent with findings by Coombs and Howatt (2005), which recommend recovering alcoholics receive assistance from addiction counsellors in developing healthy activities in place of their former addiction through planning. Crape et al. (2002), notes that engagement in such sporting activities can have a lasting improvement in the recovering alcoholics' self-esteem and social standing, strengthen their social network and provide a model of positive commitment to leading a sober way of life after discharge from the rehabilitation facility.

The relationship between family level support and recovering alcoholics competencies was determined using Pearsons correlation coefficient. All tests were done at coefficient alpha (α) equal to 0.05. Table 26 summarises the results.

Table 26

Relationship between Level of Family Support and Recovering Alcoholics Competencies

		Recovering Competencies
Family Level Support	Pearson Correlation	0.600
	Sig. (1 tailed)	0.000

r = .600, Significance at .05

As indicated in Table 26, the Pearsons correlation coefficient yielded an r value of .600 and a P value of .000 . On the basis of $p < .05$, the null hypothesis that stated that there was no statistically significant relationship between family level support and recovering alcoholics' competencies in rehabilitation facilities was rejected. This implied that a statistically significant relationship exists between level of family support and recovering alcoholic competencies. Table 26 above confirms that process of recovering competencies among alcoholics is positively and strongly associated with the family level support at a confidence level of 95% ($p=0.000<.05$). The strong positive association between recovering alcoholics competencies and family level support indicated that when the level of family support increases, the gaining of social and personal competencies among recovering alcoholics is likely to increase.

Previous studies on the process of recovering competencies indicate that as addiction becomes the focus of an addict's world, the alcoholic becomes progressively disinterested in interacting with the people who care the most about them. (Gwinnell & Adamec, 2006). Masinde (2011), observes that development of social and personal competencies reflects adjustment of the alcoholic to deal with issues in the family, school and workplace and in the wider society. This hypothesis has therefore been supported by the findings that show that a key component in promoting healing from addiction is the attitude of key stakeholders in the alcoholic's life that includes the family (Gwinnell & Adamec, 2006). The findings also resonate with Templeton et al. (2010), that point on the involvement of family members in treatment having a major influence on the recovering alcoholic's drive to make changes and

maintain abstinence. Studies by Saatcioglu et al. (2006), further indicate that the involvement of family members in the treatment programme provides a rich foundation of information about the actual life connections and experiences of the alcoholic that may have an influence to effective planning of treatment and the prevention of relapse. A vigilant examination of the social dynamics of the family often points out to the changes that need to be made not only in the person showing the most maladaptive behaviour but in the other family members (Martin et al., 2010). Hollen (2009), points out on the need to provide comprehensive programmes that offer support and counselling to families could help them achieve normal functioning and help deal with the foreseeable disruption and anger that alcohol addiction builds in a family. The level of family support has been cited as an important factor in the successful treatment of alcohol addiction as well as in helping in the prevention of relapse (ibid).

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

The purpose of the study was to determine the relationship between selected rehabilitation factors and recovering alcoholics' social and personal competencies in Central and Nairobi regions in Kenya. Data was collected using a structured questionnaire for the recovering alcoholics and addiction counsellors in 17 rehabilitation facilities employing the 12-step facilitation approach. This chapter presents the findings of this study in a summary form as well as the conclusions. Recommendations for policy making and for further research also falls under this chapter. The study employed the following objectives in order to achieve the purpose of the study:-

i. To describe recovering alcoholics social and personal competencies in relation to demographic characteristics (Gender, Age, Education level, Length of stay in rehabilitation and Region) in rehabilitation facilities in Central and Nairobi regions.
ii. To determine the relationship between the Alcoholic Anonymous' 12 steps facilitation and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.
iii. To establish the relationship between addiction counsellors' characteristics and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.
iv. To establish the relationship between recovering alcoholics' characteristics and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.
v. To establish the relationship between level of family support and development of recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions.

5.2 Summary of Findings

This section is organised according to the research objectives of this study. The summary is discussed with a view of making conclusions for the study.

5.2.1. Recovering Alcoholics' Social and Personal Competencies in Relation to Demographic Characteristics

The first objective of the study sought to describe recovering alcoholics social and personal competencies in relation to demographic characteristics in rehabilitation facilities in Central and Nairobi regions This objective was determined through the crosstabulation of recovering alcoholic respondents' demographic attributes against social and personal competencies. These analyses were based on the aspects of gender, age, education level, length of stay in rehabilitation and region of the rehabilitation centre. The study revealed significant proportions of male respondents seeking treatment for alcohol dependency in the sampled rehabilitation centres as opposed to female respondents with the former registering high and moderate levels of recovering competencies in comparison with the latter. The findings indicated that most of the recovering alcoholics (79.4%), reported high levels of recovering competencies. The age groups with the highest levels of recovering competencies were those aged between 25 to 35 years and 36 to 45 years with 29% affirming to having realised significant change during their stay in rehabilitation. Low and moderate levels of recovering competencies had few respondents with 3.7% for the age groups between 25 to35 years, while the age groups between 36 to 45 years and between 46 to 55 years reported the least proportions at 1.9% respectively.

Study findings on the relation between the period of stay in the rehabilitation facilities and recovering alcoholics competencies revealed high level competencies being achieved among the respondents. The period between 31 to 49 days registered the highest levels of recovering competencies with 33.6%, with the periods between 50 to 69 days and 70 to 90 days reporting 20.6% and 25.2% responses respectively. This pointed out that the different periods of stay in the rehabilitation had varying inputs in promoting recovering competencies among alcoholics. The findings brought to light that Central region posted a larger proportion of 53.7% of the recovering alcoholic respondents with high-level recovering competencies while Nairobi had a proportion of 26.2% respectively. Respondents with moderate levels of

recovering competencies from Nairobi region fared slightly higher than those from Central accounting for 7.5% and 5.6% respectively.

The findings indicated that recovering alcoholics with a graduate level of education formed the largest proportion of 33.6% with high-level recovering competencies, followed by those with secondary level qualification with 23.4% respectively. Recovering alcoholics with diploma level and post graduate qualifications formed the proportions with the least number of respondents reporting 16.8% and 5.6% respectively. Findings on recovering alcoholics who had never sought help for alcohol dependency reported the highest levels of recovering competencies at 34.6% while those who had previously sought help in rehabilitation facilities accounted for 24.3% respectively. The findings revealed lower responses for those who had sought help twice or more times accounting for 10.3% respectively for high competency levels.

5.2.2 AA 12 Steps Facilitation and Recovering Alcoholics' Competencies

The second objective was determined through the null hypothesis that there was no statistically significant relationship between the Alcoholic Anonymous' 12 steps facilitation and recovering alcoholics' social and personal competencies in rehabilitation facilities in Central and Nairobi regions. This hypothesis was tested using the Pearson correlation coefficient so as to give the direction and magnitude of the relationship between the AA 12-step facilitation and recovering alcoholics' competencies. The findings indicated a positive relationship between AA 12-step facilitation and recovering alcoholics' competencies ($r=0.491$) and showed statistical significance of the two variables ($p=0.000<0.05$). This resulted in the rejection of the null hypothesis. The findings therefore adopted the research hypothesis that there was a statistically significant relationship between AA 12-step facilitation and recovering alcoholics' social and personal competencies. The moderate positive association between development of competencies and AA 12-step facilitation indicated that when the AA 12-step facilitation increases, social and personal competencies among recovering alcoholics is likely to increase.

5.2.3 Addiction Counsellor's Characteristics and Recovering Alcoholics' Competencies

The third objective was tested through a hypothesis tested using the Pearson correlation coefficient so as to give the direction and magnitude of the relationship between addiction

counsellor's characteristics and recovering alcoholics' competencies. The findings indicated a positive relationship between addiction counsellor's characteristics and recovering alcoholics' social and personal competencies (r=0.649) and showed statistical significance of the two variables (p=0.000<0.05). The findings therefore accepted the research hypothesis that there was a statistically significant relationship between addiction counsellor's characteristics and recovering alcoholics' competencies. The strong positive association between development of competencies and addiction counsellor characteristics indicated that when favourable addiction counsellor characteristics increase, social and personal competencies among recovering alcoholics is likely to increase.

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5.2.4 Recovering Alcoholics' Characteristics and their Competencies

This hypothesis was tested using the Pearson correlation coefficient so as to give the direction and magnitude of the relationship between recovering alcoholics' characteristics and recovering alcoholics' social and personal competencies. The findings indicated a positive relationship between recovering alcoholics' and recovering alcoholics' competencies (r=0.580) and showed statistical significance of the two variables (p=0.000<0.05). The findings therefore accepted the research hypothesis that there was a statistically significant relationship between recovering alcoholics' characteristics and recovering alcoholics' competencies. The moderate positive association between development of competencies and recovering alcoholics' characteristics indicated that when favourable recovering alcoholics characteristics increase, social and personal competencies among recovering alcoholics is likely to increase.

5.2.5 Levels of Family Support and Recovering Alcoholics' Competencies

This hypothesis was tested using the Pearson correlation coefficient so as to give the direction and magnitude of the relationship between levels of family support and recovering alcoholics' social and personal competencies. The findings indicated a positive relationship between recovering alcoholics' and recovering alcoholics' competencies (r=0.600) and showed statistical significance of the two variables (p=0.000<0.05). The findings therefore accepted the research hypothesis that there was a statistically significant relationship between level of family support and recovering alcoholics' competencies. The strong positive association between development of competencies and family level support indicated that

when the level of family support increases, social and personal competencies among recovering alcoholics is likely to increase.

5.3 Conclusions of the Study

The study made important findings on the relationship between selected rehabilitation factors and development of recovering alcoholics social and personal competencies in Central and Nairobi regions in Kenya.

i. The findings indicated that most of the recovering alcoholics reported high levels of recovering competencies, confirming that the varying periods of stay in rehabilitation centres enhanced social and personal competencies among the alcoholics in recovery. This indicates that the commitment to adhere to set guidelines during the period of stay in rehabilitation centres results in positive outcomes in terms of enhanced social and personal competencies among the recovering alcoholics. The findings point out on the key role played by education in the transmission of knowledge on health-related issues and in enhancing cognitive skills that affect people's decisions in reducing alcohol abuse and promoting sobriety. This is in congruence with the high-level recovering competencies noted among respondents with secondary and graduate level qualifications. The manifestation of periodic occurrences of relapses among the alcoholics in recovery should not be viewed as a failure but should be used to draw important lessons to prevent such setbacks in the future.
ii. The AA 12-step facilitation approach was established to having a moderate influence on recovering alcoholics social and personal competencies. The recovering competencies can therefore be enhanced by forging positive relations with addiction counsellors and fellow recovering alcoholics and adhering to the guidelines provided during treatment. The enhancement of social and personal competencies should therefore provide alcoholics in recovery with more options of responding to pressures and stresses associated with modern living and mechanisms of abstaining from alcohol.
iii. The presence of addiction counsellors that are recovering alcoholics is a strong pillar that provides reassurance among recovering alcoholics that sobriety is indeed possible. This aspect tends to provide valuable support among the alcoholics in recovery when undergoing periods of discomfort. Addiction counsellor characteristics

were established to strongly influence social and personal competencies among recovering alcoholics

iv. The enhancement of competencies in the making choices among alcoholics in recovery with regard to the uptake of alcohol is critical in making positive strides towards sobriety. Recovering alcoholics' characteristics were moderately established in influencing recovering alcoholics competencies in rehabilitation facilities. The enhancement of the capacity to make choices is key in realising lasting change and better management of the recovering alcoholic during and after the period of rehabilitation.

v. The level of family involvement provides a strong backing for the recovering alcoholics building social and personal competencies that aid in the better management of their lives during and after the period of rehabilitation. This concept of family involvement needs to be formally structured and incorporated in rehabilitation programmes as its influence on enhancing recovering alcoholics competencies was strongly established.

5.4 Recommendations of the Study

From the conclusions, the following recommendations are made;

i. The study recommends the need for rehabilitation centres to consider tailoring treatment of recovering alcoholics based on gender so as to consciously address the low number of women currently receiving treatment in alcohol rehabilitation.

ii. The need to enhance levels of education among recovering alcoholics that may serve to raise their awareness and understanding of the undesirable effects brought about by alcohol abuse and serve to build the capacity of individuals in managing alcoholism.

iii. The study recommends the use of the 12-step facilitation approach in alcohol rehabilitation and the strengthening of key steps established to positively contribute towards the social and personal competencies.

iv. The study recommends the need for rehabilitation centres engaging addiction counsellors with better understanding of the rehabilitation process, addiction counsellors that are recovering alcoholics as well as strengthening counselling services in rehabilitation centres.

v. Finally, the study recommends enhanced family support for recovering alcoholics as well as the need for rehabilitation centres to actively incorporate families during

treatment as it serves as a source of identity and social support for recovering alcoholics

5.5 Suggestions for Further Studies

This study makes the following recommendations for further studies;

i. Since this study was done in Central and Nairobi regions, it would be of interest to further research in other parts of the country to generate empirical data that may provide findings that may allow for comparison with the findings from this study.
ii. The study recommends further studies on aspects of the 12-step facilitation model that did post significant responses related to recovering alcoholics social and personal competencies. These include aspects such as coping with alcoholism challenges, regaining control over alcoholism, mending broken relationships and creation of new ones.
iii. The study recommends a further study on social and personal competencies enhanced during the period of rehabilitation and monitor their progress on recovering alcoholics following their discharge from rehabilitation centres.
iv. It would be of interest to consider a comparative study between the influences of AA 12-step facilitation and other approaches embraced in the rehabilitation of alcoholics on social and personal competencies among recovering alcoholics.

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APPENDIX

APPENDIX I: INTRODUCTORY LETTER

Dear Participant,

My name is Waweru Muriithi, currently undertaking a Doctorate degree in Counselling Psychology at Egerton University. You have been selected as part of the study entitled **"Relationship between Selected Rehabilitation Factors and Process of Recovering Alcoholics Competencies in Central and Nairobi Regions, Kenya".** I am inviting you to participate in the research by completing the attached questionnaire.

The questionnaire will not take more than 20 minutes. The information that you will share with me will not be discussed or accessed by any other person apart from the researcher and the people directly involved in the project. Your participation is voluntary and you can withdraw at any time without penalty. Your answers will be kept confidential. There is no financial compensation for participating in this study. The outcome of this research may be used for academic and general purposes such as research reports, conference papers, or books. By completing the questionnaire, you indicate that you voluntarily participate in this research.

If you agree to participate in this study, please sign below

Name (Optional)……..Signature……Date……..

APPENDIX II: QUESTIONNAIRE FOR BOTH RECOVERING ALCOHOLICS AND ADDICTION COUNSELLORS

Instructions: Please complete the following questionnaire appropriately.

Confidentiality: The responses you provide will remain strictly confidential. No reference will be made to any individual(s) in the report of the study.

Please tick or answer appropriately for each of the Question provided.

PART A: BACKGROUND INFORMATION

1)	What is your Gender?	Male	[ ]
		Female	[ ]
2)	Which of the following best describes you?	Recovering Alcoholic	[ ]
		Addiction Counsellor	[ ]
3)	What is your age bracket?	Below 25 Years	[ ]
		25-35 Years	[ ]
		36-45 Years	[ ]
		46-55 Years	[ ]
		Over 55 Years	[ ]
4)	What is your highest education level?	Post Graduate	[ ]
		Graduate Level	[ ]
		Diploma Level	[ ]
		Secondary School	[ ]
		Primary School	[ ]
5)	How long have you battled alcoholism?	Below a year	[ ]
		1-5 Years	[ ]
		6-10 Years	[ ]
		Over 10 Years	[ ]
		Non Applicable	[ ]

6)	How long have you stayed in the rehabilitation Center?	31-49 days	[ ]
		50-69 days	[ ]
		70-90 days	[ ]
		Non Applicable	[ ]
7)	How many times have been committed to Rehabilitation facility before?	Never before	[ ]
		Once	[ ]
		Twice	[ ]
		More than twice	[ ]
		Non Applicable	[ ]
8)	What is your marital status?	Single	[ ]
		Married	[ ]
		Divorced	[ ]

PART B: ALCOHOLIC ANONYMOUS 12 STEPS FACILITATION MODEL

The following are items in relation to the alcoholic anonymous 12 steps facilitation model. In a scale of 1-5; where 5= Strongly Agree (SA); 4=Agree (A); 3= Uncertain; 2=Disagree (D) and 1=Strongly disagree (SD), please tick (√) where appropriate, the level that best explains your situation.

	The Alcoholic Anonymous 12 step facilitation model helps the alcoholic;	**1**	**2**	**3**	**4**	**5**
9)	Self acceptance as an alcoholic					
10)	Acknowledgement need help to get better					
11)	Taking stock of past and admit wrong doing					
12)	Mend broken relationships					
13)	Commit to continuing to seek help to get better					
14)	Cope with alcoholism challenges such as loneliness & Isolation					
15)	Regain control over personal responsibility over daily living dynamics e.g. diet, hygiene, sleep etc					
16)	Maintain sobriety through support system in the AA community					
17)	Strengthen resolve to stay sober through helping others stay sober					

18)	Create new social structure and friends that help recovery					

PART C: ADDICTION COUNSELLORS' CHARACTERISTICS

The following are items in relation to the addiction counsellors' characteristics role in gaining of competencies. In a scale of 1-5; where 5= Strongly Agree (SA); 4=Agree (A); 3= Uncertain; 2=Disagree (D) and 1=Strongly disagree (SD), please tick (√) where appropriate, the level that best explains your situation.

	The following counsellor's characteristics have been instrumental to the alcoholic development of competencies;	**1**	**2**	**3**	**4**	**5**
19)	Understanding of the alcoholic's social economic background and its contribution to my alcoholism					
20)	Understanding of the behavioural, psychological, physical health, and social effects of alcoholism on the alcoholic's well being					
21)	Recognition of the importance of family, social networks, and community systems in the treatment and recovery process.					
22)	An understanding of a variety of helping strategies for reducing the negative effects of substance use, abuse, and dependence.					
23)	Tailoring helping strategies and treatment modalities to the alcoholics' stage of dependence, change, or recovery.					
24)	Understand the need for and the use of methods for measuring treatment outcome.					
25)	Understand the importance of self-awareness in one's personal, professional, and cultural life.					
26)	Understand the importance of ongoing supervision and continuing education in the delivery of client services					
27)	The attitude of the counsellor towards the alcoholics' recovery and behaviour					
28)	The counsellor's facilitation model among the group discussions					

PART D: RECOVERING ALCOHOLICS' CHARACTERISTICS

The following are items in relation to the recovering alcoholics' characteristics role in gaining of competencies. In a scale of 1-5; where 5= Strongly Agree (SA); 4=Agree (A); 3= Uncertain; 2=Disagree (D) and 1=Strongly disagree (SD), please tick (√) where appropriate, the level that best explains your situation.

	The following alcoholics' characteristics are instrumental in their acquisition of competencies;	**1**	**2**	**3**	**4**	**5**
29)	Education level and exposure					
30)	Relationship with counsellors					
31)	Marital and family status					
32)	Relationship with fellow alcoholic					
33)	Ability to share alcoholics' story and make contributions to group discussions					
34)	Belief in God and other spirituality aspects					
35)	Self-will to change					
36)	Acceptance of alcoholic status					
37)	Socio economic aspects					

PART E: FAMILY LEVEL SUPPORT

The following are items in relation to the family level support on the recovering alcoholic development of competencies. In a scale of 1-5; where 5= Strongly Agree (SA); 4=Agree (A); 3= Uncertain; 2=Disagree (D) and 1=Strongly disagree (SD), please tick (√) where appropriate, the level that best explains your situation.

	The following aspects of family support have been instrumental to the alcoholic's development of competencies;	**1**	**2**	**3**	**4**	**5**
38)	Family acceptance of the alcoholic					
39)	Provision of listening ear to alcoholics' efforts and challenges in recovery process					
40)	Verbally expressing support and encouragement on recovery progress					
41)	Active participation in treatment programmes					

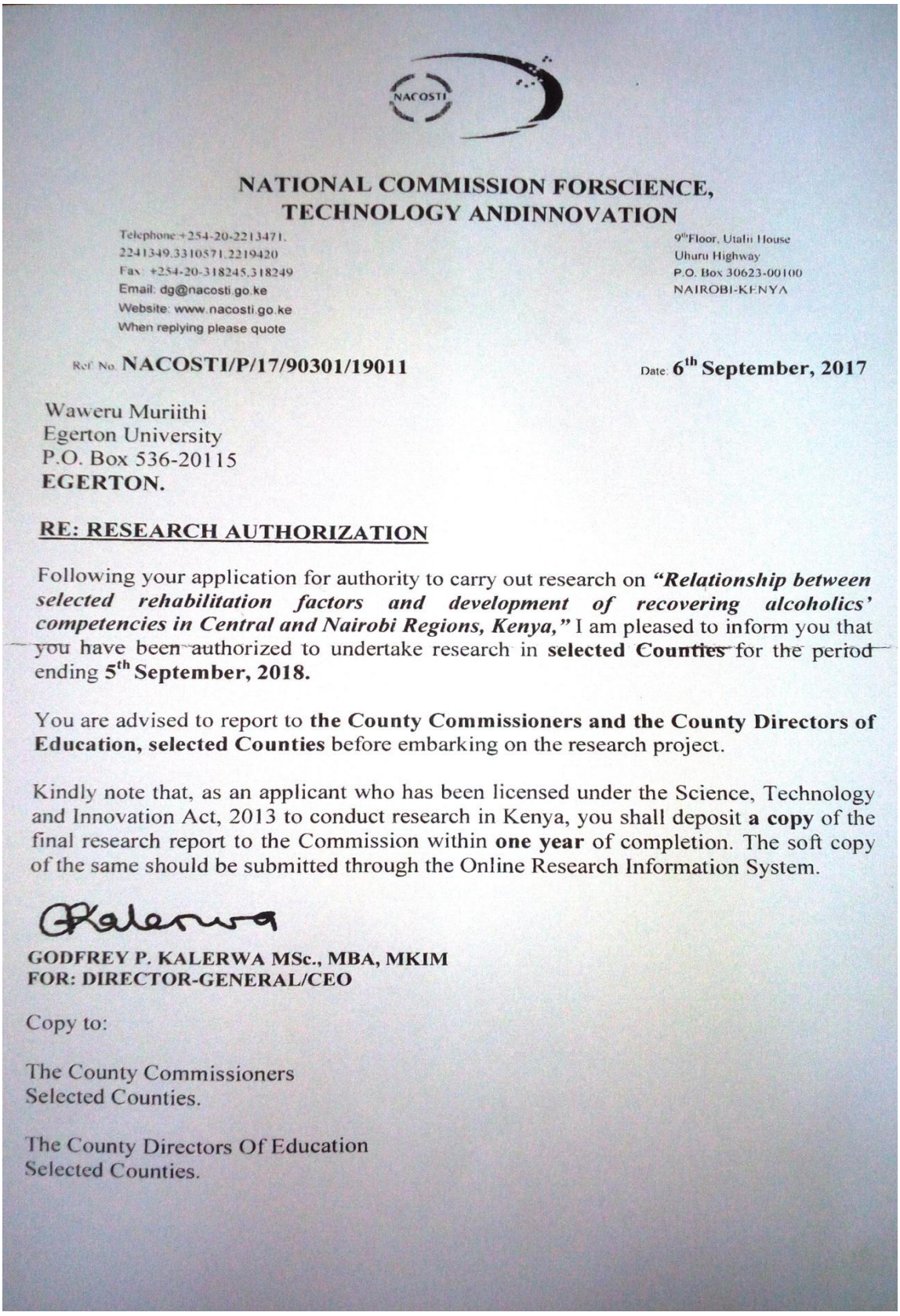
42)	Encouragement in involvement in health supporting behaviours such as sports					
43)	Encouragement in mending of broken family & social relations					
44)	Provision of financial support for the rehabilitation programme					
45)	Provision of personal effects such as soap, clothes etc					
46)	Visiting alcoholic in the rehabilitation centre					
47)	Seeking and involving me in family affairs and decisions					

PART D: RECOVERING COMPETENCIES

The following are critical competencies that the recovering alcoholic need to develop from rehabilitation to prevent relapse. In a scale of 1-5; where 5= Strongly Agree (SA); 4=Agree (A); 3= Uncertain; 2=Disagree (D) and 1=Strongly disagree (SD), please tick (√) where appropriate, the level that best explains your situation.

	The following are critical competencies that the alcoholic need to acquire from the rehabilitation programme;	**1**	**2**	**3**	**4**	**5**
48)	Positive Management of peer pressure					
49)	Enhancing ability to ask for help when in need					
50)	Explore new enjoyments without alcohol					
51)	Better involvement in life aspects e.g. work					
52)	Dealing with urge to take alcohol					
53)	Dealing with change					
54)	Improvement of self esteem aspects					
55)	Creation of new social structures without alcohol					
56)	Decision making capabilities					
57)	Problem solving skills					

APPENDIX III: RESEARCH AUTHORIZATION



NATIONAL COMMISSION FORSCIENCE, TECHNOLOGY ANDINNOVATION

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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/17/90301/19011**

Date: **6th September, 2017**

Waweru Muriithi
Egerton University
P.O. Box 536-20115
EGERTON.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Relationship between selected rehabilitation factors and development of recovering alcoholics' competencies in Central and Nairobi Regions, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **selected Counties** for the period ending **5th September, 2018.**

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

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

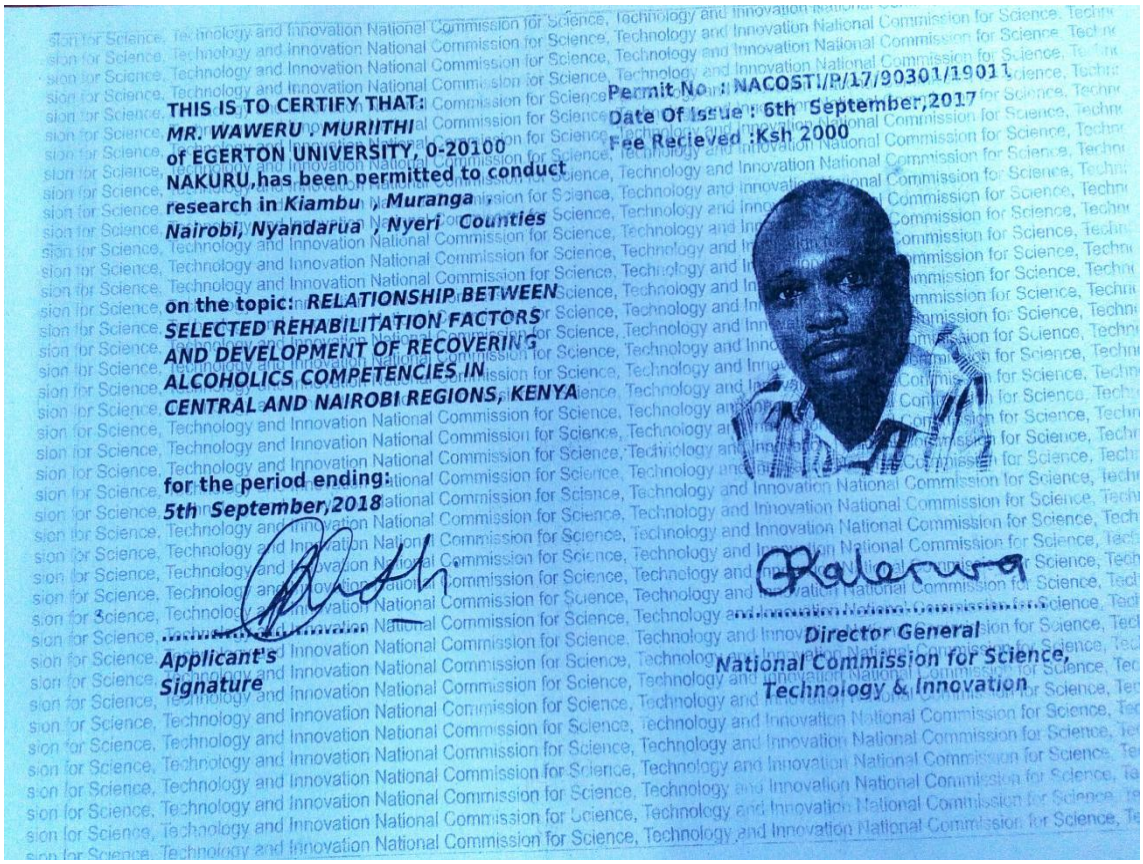
GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioners
Selected Counties.

The County Directors Of Education
Selected Counties.

APPENDIX IV: RESEARCH PERMIT



THIS IS TO CERTIFY THAT:
MR. WAWERU MURIITHI
of EGERTON UNIVERSITY, 0-20100
NAKURU, has been permitted to conduct
research in Kiambu, Muranga,
Nairobi, Nyandarua, Nyeri Counties
on the topic: RELATIONSHIP BETWEEN
SELECTED REHABILITATION FACTORS
AND DEVELOPMENT OF RECOVERING
ALCOHOLICS COMPETENCIES IN
CENTRAL AND NAIROBI REGIONS, KENYA
for the period ending:
5th September, 2018

Permit No : NACOSTI/P/17/90301/19011
Date Of Issue : 6th September, 2017
Fee Recieved :Ksh 2000

Applicant's
Signature

Director General
National Commission for Science,
Technology & Innovation

APPENDIX V: NACADA AUTHORIZATION LETTER

NATIONAL AUTHORITY FOR THE CAMPAIGN AGAINST ALCOHOL AND DRUG ABUSE (NACADA)

Telegraph Address: "Rais"
Telephone: 0202721997/ 2721993/ 2737679/2722138
Fax: 2721994
E-mail: info@nacada.go.ke
Website: www.nacada.go.ke
When replying please quote

Chief Executive Officer
P. O. Box 10774 – 00100
NAIROBI.
NSSF Building, 18th Floor,
Eastern Wing Block A.

Ref. No. NACADA 7/4 6TH October 2017

TO WHOM IT MAY CONCERN

The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) is a state corporation mandated to coordinate public education and awareness aimed at prevention, control and mitigation of alcohol and drug abuse in Kenya.

NACADA has committed to support Masters and PhD students from Kenyan Universities undertaking research on alcohol and drug abuse. In this regard, the Authority has received a request from a PhD student from Egerton University undertaking a study on "*Relationship between selected rehabilitation factors and development of recovering alcoholics' competencies in Central and Nairobi Regions, Kenya.*"

This is therefore to inform you that Mr. Waweru Mureithi from Egerton University has been authorized by NACADA to conduct the above mentioned survey. This authorization is valid from **16th October 2017 – 27th April 2018.**

Please accord him the necessary support.

VICTOR G. OKIOMA, EBS
AG. CHIEF EXECUTIVE OFFICER

for

APPENDIX VI: ETHICAL APPROVAL OF RESEARCH PROJECT

EGERTON UNIVERSITY

TEL: 051-2217808
Fax: 051-2217942
e-mail: eurec@egerton.ac.ke

P. O. BOX 536-20115
EGERTON
website: www.egerton .ac.ke

RESEARCH ETHICS REVIEW COMMITTEE

EU/RE/DVC/009 **22nd August, 2017**

Mr. Waweru Mureithi,
P. O. Box 3602,
Nakuru.

Dear Mr. Waweru,

RE: APPLICATION FOR ETHICAL APPROVAL OF RESEARCH PROJECT

Reference is made to your application for ethical clearance of your Research proposal entitled: **'Relationship between Selected Rehabilitation Factors and Development of Recovering Alcoholics Competences in Central and Nairobi Regions, Kenya.'** The Egerton University Research Ethics Committee met on 25th July, 2017 and discussed the protocols of research in your proposed study.

It was observed:

- That this is a PhD study and the duration: August - October 2017.
- That it is under the Supervision by two senior lecturers from Egerton University.
- That Application form dully filled, and the funding is declared.
- That the study location and sites clearly indicated.
- That there is no monetary compensation to participants.
- That coding of the questionnaires will be used to enhance privacy.
- That the benefits envisaged include: boost to rehabilitation process and free counselling sessions for participants.
- That consent form and an introductory letter are provided.

Verdict

This study is non-invasive study and therefore has minimal risks. Therefore, the Committee approved your research proposal for implementation. Please further note that you are required to apply for a research permit from the National Commission for Science, Technology and Innovation (NACOSTI) prior to commencing data collection. You will also be expected to submit progress report after every six months.

Prof. J. K. Kipkemboi
CHAIRMAN: RESEARCH ETHICS COMMITTEE

cc: DVC (R &E) - to note in file
JKK/ejc

APPENDIX VII: ABSTRACT OF IISTE JOURNAL ARTICLE

Research on Humanities and Social Sciences www.iiste.org

ISSN 2224-5766 (Paper) ISSN 2225-0484 (Online) DOI: 10.7176/RHSS
Vol.9, No.10, 2019 pp.48-56

Relationship Between Alcoholics Anonymous 12 Steps Facilitation and Development of Competencies in Rehabilitation Facilities in Central and Nairobi Regions, Kenya.

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P.o. Box 536 Egerton
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Abstract

Helping an alcoholic overcome addiction calls for an appropriately planned and skillfully managed processes that offer personal support and guidance, necessitating effective approaches in the treatment of alcohol rehabilitation. Despite the growth of rehabilitation facilities in the recent past, statistics indicate that approximately 90% of alcoholics are likely to experience at least one relapse over a four-year period after treatment. This is an indication that recovering alcoholics may have not gained sufficient competencies while in rehabilitation to avoid the relapse. An understanding of how the AA 12 steps facilitation influence the development of competencies among recovering alcoholics is therefore key to their reintegration into society. The study adopted behavioural, Adlerian and person centred theories for its theoretical framework. The study employed the ex-post- facto correlational research design with an accessible population of 202 recovering alcoholics and 81 addiction counsellors in 17 rehabilitation facilities in Central and Nairobi regions employing the 12 step facilitation approach. Census sampling method was used for the addiction counsellors with the entire population participating in the study. A sample size of 134 respondents calculated using Yamane simplified formula was used for the recovering alcoholics. Data was collected using a structured questionnaire for the recovering alcoholics and addiction counsellors. The instruments were validated and adjustments done after the pilot study, while reliability was determined using the Cronbach's Alpha Coefficient at 0.898. The data was analysed using the IBM Statistical Package for Social Sciences (SPSS) version 22.0. Pearson correlations were used to test the relationship between the dependent variable (recovering alcoholics competencies) and the independent variable (AA 12 steps facilitation). The 12 steps facilitation was established to be statistically significant at $p=0.000<0.05$ with a moderate positive association ($r=0.491$). The study recommends strengthening of key indicators under the AA 12 steps facilitation model established to positively contribute towards the development of competencies. These comprised of the aspects of self-acceptance of the person as an alcoholic, acknowledgement and the commitment of the alcoholic to continue seeking help that would promote high levels of rehabilitation success among alcoholics.

Keywords: Alcoholics Anonymous, 12 Steps Facilitation, Recovering Alcoholics, Competencies, Rehabilitation

APPENDIX VIII: ABSTRACT OF AJADA JOURNAL ARTICLE

AJADA -African Journal of Alcohol & Drug Abuse Edition 1- July 2019
A publication of the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA).
ISSN Online: 2664-0066 ISSN Print: 2664-0058 , *pp. 12-22.*

RELATIONSHIP BETWEEN RECOVERING ALCOHOLICS CHARACTERISTICS AND DEVELOPMENT OF COMPETENCIES IN REHABILITATION FACILITIES IN CENTRAL AND NAIROBI REGIONS.

Waweru Muriithi, Owen Ngumi & Catherine K. Mumiukha
Department of Psychology, Counselling & Educational Foundations, Egerton University
P.o. Box 536 Egerton, Kenya

* E-mail of the corresponding author: wawerum2001@gmail.com

ABSTRACT

The assessment of an alcoholic's commitment for his actions of abusing alcohol is a critical step in determining whether the person suffers from some kind of condition that weakens their capacity to regulate their own actions. Addiction to alcohol weakens the capacity to align actions with a person's own assessment of issues. An understanding of how the characteristics of recovering alcoholics influence the development of their competencies during rehabilitation is therefore key to their reintegration into society. The study adopted behavioural, Adlerian and person centred theories for its theoretical framework. The study employed the ex-post- facto correlational research design with an accessible population of 202 recovering alcoholics and 81 addiction counsellors in 17 rehabilitation facilities in Central and Nairobi regions employing the 12 step facilitation approach. Census sampling method was used for the addiction counsellors with the entire population participating in the study. A sample size of 134 respondents calculated using Yamane simplified formula was used for the recovering alcoholics. Data was collected using a structured questionnaire for the recovering alcoholics and addiction counsellors. The instruments were validated and adjustments done after the pilot study, while reliability was determined using the Cronbach's alpha coefficient at 0.747. The data was analysed using the IBM statistical package for social sciences (SPSS) version 22.0. Pearson correlations were used to test the relationship between the dependent variable (recovering alcoholics competencies) and the independent variable (alcoholics characteristics). Recovering alcoholics competencies was established to be statistically significant at $p=0.000<0.05$ with a moderate positive association ($r=0.580$). The study established that salient indictors observed to facilitate development of competencies among the recovering alcoholics that would require focus during therapy include the belief in God and other spirituality aspects, self-will to change and acceptance of alcoholic status as well as sharing of their story during group therapy. These factors may provide support and direction and aid in development of a resilient determination in life among recovering alcoholics.

Keywords: Recovering Alcoholics', Characteristics, Competencies, Rehabilitation Facilities, Addiction Counsellors

APPENDIX IX: ABSTRACT OF IJCR JOURNAL ARTICLE

International Journal of Current Research
Vol. 11, Issue, 05, pp.4162-4168, May, 2019

DOI: https://doi.org/10.24941 **ISSN: 0975-833X**

RELATIONSHIP BETWEEN ADDICTION COUNSELLORS CHARACTERISTICS AND DEVELOPMENT OF COMPETENCIES IN REHABILITATION FACILITIES IN CENTRAL AND NAIROBI REGIONS, KENYA

***Waweru Muriithi, Owen Ngumi and Catherine K. Mumiukha**

Department of Psychology, Counselling & Educational Foundations, Egerton University, P.o. Box 536 Egerton

ABSTRACT

The regaining of the social and personal competencies lost during the alcoholic's life is critical in the rehabilitation process and is instrumental in prevention of relapsing back into alcoholism. An understanding of how addiction counsellors characteristics influence the development of competencies among recovering alcoholics is therefore key to their reintegration into society. The range of competencies include specific skills and abilities to general constructs such as self-esteem that reflect an improved adjustment to deal with issues in the family, school, work and in society at large The study adopted behavioural, Adlerian and person centred theories for its theoretical framework. The study employed the *ex-post-facto* correlational research design with an accessible population of 202 recovering alcoholics and 81 addiction counsellors in 17 rehabilitation facilities in Central and Nairobi regions employing the 12 step facilitation approach. Census sampling method was used for the addiction counsellors with the entire population participating in the study. A sample size of 134 respondents calculated using Yamane simplified formula was used for the recovering alcoholics. Data was collected using a structured questionnaire for the recovering alcoholics and addiction counsellors. The instruments were validated and adjustments done after the pilot study, while reliability was determined using the Cronbach's Alpha Coefficient at 0.860. The data was analysed using the IBM Statistical Package for Social Sciences (SPSS) version 22.0. Pearson correlations were used to test the relationship between the dependent variable (recovering alcoholics competencies) and the independent variable (addiction counsellors characteristics). Addiction counsellors characteristics were established to be statistically significant at $p=0.000<0.05$ with a strong positive association ($r=0.649$). The study recommends the need for rehabilitation centres engaging addiction counsellors' with better understanding of the rehabilitation process as well as strengthening counselling services in an attempt to improve recovering competencies of the alcoholics in their facilities.

Keywords: Addiction Counsellors**,** Recovering Alcoholics', Characteristics, Competencies, Rehabilitation