PSYCHOSOCIAL FACTORS CONTRIBUTING TO RELAPSE AMONG ALCOHOLIC REHABILITEES IN SELECTED REHABILITATION CENTRES IN MERU COUNTY, KENYA

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DECLARATION AND RECOMMENDATIONS

Declaration

This thesis is my original work and has not been submitted for the award of a degree or diploma in this or any other University.

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Recommendations

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DEDICATION

This thesis is dedicated to my beloved mother, Mary Murithi, whose steadfast support in funding my education and her relentless encouragement have been pivotal in my academic journey. Her sacrifices and belief in my potential have been the foundation of my success. I also dedicate this work to my beloved sisters, Hellen Murithi and Elizabeth Mwende, whose daily motivation, unwavering support, and understanding during my study time gave me the strength and determination to persevere. Your constant presence and encouragement have been a wellspring of inspiration, making this accomplishment possible. To all of you, my deepest thanks for your boundless love and support.

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ABSTRACT

Relapses are a daunting challenge in the treatment of alcohol-related disorders. A relapse is viewed as when a person returns to using drugs or alcohol after a period of abstinence or sobriety. A relapse rate of 50-90% in many parts of the world is experienced by recovering rehabilitees after completion of inpatient treatment period in a drug rehabilitation facility. In Kenya, a relapse rate of 20-80% is experienced after completion of the inpatient treatment program. There have been immense efforts in the treatment of people with alcohol-related disorders in different rehabilitation facilities across the country. However, the majority of these recovering alcoholic rehabilitees end up relapsing. This study's main objective was to investigate the psychosocial factors contributing to relapse among alcoholic rehabilitees in selected rehabilitation centres in Meru County, Kenya. The prior studies had not carried out a detailed analysis of the extent and incidence of alcohol relapses in our country. They tended to focus on drug abuse and the effects of drugs from a general perspective, and fewer focused on relapse rates, failing to investigate the specific psychosocial causes of these relapse rates. A correlational research design was used, and interviews and questionnaires were used as data collection methods. Two theories were used in the study, Terence Gorski's Relapse Prevention Model and Marlatt's Cognitive-Behavioural Model of Relapse Prevention. The respondents were alcoholic relapsed rehabilitees undergoing treatment following a relapse in selected rehabilitation centres in Meru County, Kenya, namely, Holy Innocents BPSS Centre in Timau, Methodist Treatment Centre in Kaaga, and St Nicolas Rehabilitation Centre in Tigania West. A sample of 90 rehabilitees undergoing alcohol relapse inpatient treatment at the three selected rehabilitation centres were randomly selected from three facilities. The study used linear structured interview questionnaires and focus group discussions as data collection tools. It explored the factors influencing alcohol relapses among 90 respondents, focusing on the interplay of social, psychological, and environmental triggers. SPSS 27.0 was deployed in quantitative analysis (descriptive and multi-variate regression), while thematic extraction was deployed in qualitative analysis. It was found that social influences, such as peer behaviour and social support, and issues related to occupational stress and financial instability significantly impacted relapse perceptions. Emotional and psychological factors, including anxiety and cravings, were also pivotal. However, quantitative analysis done using multi-regression established that the influence of peers, social occupation, physiological stress, and intense physiological craving were not statistically significant predictors of alcohol relapse, which strongly conflicted with literature and qualitative analysis. A cross-examination established that differences in study population, culture, and nature of study accounted for such differences. Equally, the study noted that relapse behaviours were complex and hence recommended the need for personalized, comprehensive treatment approaches that address individualized risk profiles and promote resilience and well-being in recovery efforts. The study recommended peer support programs, employment-based rehabilitation, stress management interventions, craving management strategies, and holistic approaches to address relapse factors like peer influence, stress, and cravings. Further research should involve longitudinal and mixed-methods studies to better understand the complex relationships among these factors and recovery outcomes.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACRONYMS AND ABBREVIATIONS

AA	Alcoholics Anonymous
AUD	Alcohol Use Disorder
CBT	Cognitive-Behavioural Therapy
DALY	Disability Adjusted Life Years
FGD_S	Focus Group Discussions
JSDA	Journal of Studies on Alcohol and Drugs Abuse
MAT	Medication-Assisted Treatments
NA	Narcotic Anonymous
NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
NACOSTI	National Commission for Science Technology and Innovation
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NSDUH	National Survey on Drug Use and Health
RD	Road
RP	Relapse Prevention
SPSS	Statistical Software Package for Social Sciences
SUD	Substance Use Disorder
TUN	Tharaka University
UNODC	United Nations Office of Drugs and Crime
WHO	World Health Organization

CHAPTER ONE
INTRODUCTION

1.0 Introduction

This chapter provides an overview of the study by presenting the background and context, analysing the problem that prompted the study, stating the objectives and hypotheses, highlighting the significance of the study, specifying the scope and limitations of the study, and operationally defining terms.

1.1 Background of Study

Relapses are a daunting challenge in the treatment of Alcohol Use Disorder (AUD). It has long been known that addictive disorders are chronic and relapsing in nature. A relapse occurs when an individual starts using drugs or alcohol yet again after a period of abstinence or sobriety. Recently, attention has been drawn to lapse, where lapse is viewed as a brief “slip” where a person may drink or use alcohol but then immediately stops again; a relapse is therefore viewed as when a person makes a full-blown return to using alcohol or other drugs (National Institute on Drug Abuse Report 2018). McClintock (2019) also viewed relapse as returning to the use of alcohol or drugs after stopping for a while. In the context of this study, relapse is returning to abusing alcohol after complete recovery from it through inpatient or outpatient treatment in a drug and substance-related rehabilitation facility. It refers to a context where an individual who was engaged in abusing substances, especially alcohol, voluntarily or involuntarily with the help of their significant others sought rehabilitation services in the management of their alcohol abuse tendencies. However, after recovery and after being discharged from the rehabilitation centre, they returned to using the substance again.

Gorski's (2001) report on Adolescent Relapse Prevention carried out in Lexington, Kentucky, USA, found that 78% of those seeking inpatient treatment and rehabilitation services do relapse during the first six months of recovery. A similar study in Kerman (a Province in India) identified environmental factors such as peer groups who abuse drugs and availability of drugs and substances abuse to be the number one causes of relapse in alcoholic rehabilitees (Golestan, 2010). Golestan emphasized the need for self-help groups that give support to people with addiction and help family members understand addiction, hence avoiding relapses. An analysis report on the outcome of rehabilitation treatment among adults and adolescents in Philadelphia shows a 60% -

80% relapse rate within 90 days after treatment and a 34% relapse rate within three days after treatment (White, 2012). According to the National Survey on Drug Use and Health Report NSDUH (2006), a relapse rate of 50-90% occurs in America. In a similar study report by the National Institute on Drug Abuse (2018), it was noted that relapse rates for alcohol addiction resemble those of other chronic diseases such as diabetes, hypertension, and asthma; the statistics indicate that anywhere from 40 to 60 percent of people recovering from alcoholism will experience a relapse before their sixth month of sobriety.

In a study conducted by Kalani (2016) on the Prevalence of Relapse of Alcohol Use Disorder and the Association with Self-Efficacy and Perceived Social Support in Butabika Hospital in Uganda where he studied 269 respondents received treatment for AUD at Butabika Hospital in the period between 1st January 2016 and 31st December 2017, he found out that the prevalence of relapse of AUD among the 269 participants was 63.3% of the total respondent. The findings of Kalani (2016) were like a study carried out by Kabisa (2021) in South Africa on Determinants and Prevalence of Relapse among Patients with Substance Use Disorder conducted in Icyizere Psychotherapeutic Centre, whereby the prevalence of relapse among rehabilitees was 59.9 %.

The statistics on relapse align with findings from several Kenyan studies on alcohol relapse among individuals recovering from alcohol addiction. For instance, Githae (2016) conducted a study in Nairobi that revealed that 39.2% of individuals who had completed inpatient treatment in rehabilitation centres were readmitted within the first year after their inpatient treatment period. This high rate of readmission indicates that many people struggle to stay sober once they leave treatment facilities, contributing to the many cases of alcohol relapse. These findings by Githae (2016) suggest that the transition from inpatient care to everyday life is a vulnerable period for individuals to experience relapse, and the psychosocial factors contributing to relapse need to be well looked into to diminish the relapse rates.

Kuria's (2013) study on Factors Associated with Relapse and Remission of Alcohol Dependent Persons after Community-Based Treatment. Open Journal of Psychiatry 3, 264–272. provides further insight by examining relapse rates among individuals who received community-based treatment for alcohol dependence. The study found that relapse rates varied from 20% to 80%. The wide range of relapse rates underscores the

need for studying the psychosocial factors that contribute to relapse among recovering alcoholic rehabilitees.

Githae (2016) and Kuria (2013) reflect the significant challenges in the field of addiction treatment and the importance of robust, continuous support systems to reduce relapse rates among individuals recovering from alcohol dependence in Kenya. These findings also call for further research on the psychosocial factors that contribute to alcohol relapse to improve long-term outcomes for individuals in recovery, thereby informing the development of more effective rehabilitation programs in Kenya and beyond.

Alcohol relapses have some serious effects and according to a WHO (2022) report, the harmful use of alcohol is a causal factor in more than 200 disease and injury conditions. Overall, 5.1% of the global burden of disease and injury is attributable to alcohol as measured in disability-adjusted life. Alcohol use affects the user through serious negative effects such as alcohol dependence, liver cirrhosis, and injuries to self and others because of intoxicated behaviours. About WHO (2022) reports that 3 million deaths every year result from the harmful use of alcohol worldwide, this represents 5.3% of all deaths in early life in people aged 20-29 years approximately 13.5% of the total deaths are attributed to alcohol consumption.

According to a study published in the Journal of Studies on Alcohol and Drugs JSDA (2016), the prevalence of alcohol use in Kenya was high, with more than half of the population reporting drinking alcohol in the past years. This study also found that the prevalence of alcohol use disorder (AUD) among Kenyan adults was 6.9% with serious negative impacts on an individual's physical and mental health, as well as their relationships and social functioning according to a report by (NACADA, 2012).

The government of Kenya has shown commitment to end the menace of alcoholism in the country. Among the measures taken is the formulation of The National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) with the mission of attaining a drug-free society. NACADA has registered and accredited over 100 rehabilitation centres across the country by October 2022. Most of these rehabilitation centres are in urban areas with most of them providing inpatient and outpatient treatment services for addiction-related disorders among other services. In a bid to attain an alcohol-free society, NACADA has also established 24-hour hotline services for alcohol and drug users where free counselling to the affected is availed. In most cases, they also

make appropriate referrals for further management in various rehabilitation facilities across the country (NACADA Report, 2013).

Most previous studies in Kenya did not provide a detailed investigation of the extent and incidence of alcohol relapse, often focusing largely on drug abuse and its general effects rather than specifically on the root cause of relapse. This study aimed to address this gap by focusing on the psychosocial factors that contributed to alcohol relapse. By narrowing down to these specific factors, the research sought to contribute to reducing the problem of alcohol relapse both in Kenya and globally. The findings of this study were expected to improve follow-up care and encourage early intervention on the psychosocial factors that could lead to relapses among recovering alcoholics.

Furthermore, the study recognized the importance of investing in relapse prevention strategies rather than relying solely on the treatment approaches that had shown limited long-term success for many alcohol rehabilitees who ended up relapsing after treatment. There was also a significant lack of documented data on the rates, causes, and effective remedies for alcohol relapse in Kenya. This research, therefore, investigated the psychosocial factors contributing to relapse among recovering alcoholic rehabilitees, with a specific focus on selected rehabilitation centres in Meru County, Kenya. By examining these factors, the study aimed to provide valuable insights that could inform more effective relapse prevention strategies and ultimately support sustained recovery among alcohol rehabilitees.

1.2 Statement of the Problem

Substantial efforts have been made to treat individuals with alcohol-related disorders and relapse behaviours in various rehabilitation facilities across the country. However, despite these efforts, the majority of recovering alcoholics continue to relapse, with global statistics indicating a relapse rate of 50-90%. In Kenya, between 20-80% of rehabilitees experience relapses, leading to serious health, social, and economic repercussions.

While numerous initiatives have been implemented to address relapse, these have yielded limited success, as many rehabilitees relapse due to unaddressed psychosocial factors. If these contributing factors are not thoroughly investigated and adequately addressed, the harmful effects of alcohol relapse will likely have a more significant impact on the country's health system, economic productivity, and the social and family

lives of individuals. Additionally, the persistent high relapse rates may discourage those struggling with alcoholism from seeking help, as they may perceive treatment efforts as ineffective.

This study seeks to determine the psychosocial factors contributing to relapse among rehabilitees in selected rehabilitation centres in Meru County, Kenya. By identifying these factors, the study will play a critical role in improving the success of rehabilitation programs. It will provide rehabilitation centres and policymakers with valuable insights to develop targeted interventions that address not just the physical aspects of recovery, but also the underlying psychological and social contributors to relapse. Without this research, efforts to reduce relapse rates may remain inadequate, prolonging the cycle of addiction and its adverse consequences on individuals and society.

1.3 Purpose of the Study

The primary purpose of the study was to determine psychosocial factors that contribute to relapse among recovering alcoholic in selected rehabilitation centres in Meru County, Kenya.

1.4 Objectives of the Study

The study was guided by the following objectives.

i. To examine the influence of peers on relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.
ii. To establish how social occupation influences relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.
iii. To explore how psychological stress influences alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.
iv. To investigate how intense psychological cravings contribute to alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

1.5 Hypotheses of the Study

The following hypothesis guided the study.

H_{01}: There is no statistically significant relationship between peer influence and alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

H_{02}: There is no statistically significant relationship between social occupation and alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

H_{03}: There is no statistically significant relationship between psychological stress and alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

H_{04}: There is no statistically significant relationship between psychological alcohol cravings and alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

1.6 Significance of Study

This study was since establishing psychosocial factors contributing to relapse among recovering alcoholic rehabilitees is important in managing relapse rates in rehabilitation and treatment centres. The study therefore explored Psychosocial factors contributing to relapse among recovering alcoholic rehabilitees. It was hoped that from the study, rehabilitation centres may evaluate how effective their treatment programs are and address the significant challenges of relapse, enabling mental health practitioners to know psychosocial factors that contribute to alcohol relapse among rehabilitees and incorporating other treatment modalities to bridge the gap on the psychosocial issues affecting relapse.

It was anticipated that the findings of this study may help the government through the Ministry of Health, Public benefits organizations, mental health agencies, religious organizations, and other stakeholders in drug and rehabilitation services to review the existing programs to make them maximize recovery benefits to rehabilitees by designing different interventions that might address the psychosocial factors contributing to relapse post-treatment period to reduce cases of alcohol relapse.

The study might also equip social workers, psychologists, addiction counsellors and families of recovering alcoholics to understand the causes of alcohol relapse and how to help rehabilitees in their recovery process after their inpatient treatment period.

It was anticipated that more studies will be conducted in effective rehabilitation programs to enhance recovery and sober living among recovering alcohol addicts. It is

for this reason that this study on the psychosocial factors contributing to relapse among alcoholic rehabilitees in selected rehabilitation centres in Kenya was be conducted.

The study is hoped to help recovering alcoholic rehabilitees to be aware of the psychosocial factors that contribute to relapse giving them knowledge on how to address the challenge.

1.7 Scope of the Study

The study was confined to relapsed alcoholic rehabilitees in some selected rehabilitation centres in Meru County, Kenya, namely, Holy Innocents BPSS Centre Timau, Methodist Treatment Centre Kaaga, and St Nicolas Rehabilitation Centres. The three rehabilitation centres were noted to have the majority of recovery recovering alcoholic in the region.

Additionally, Meru County was noted to be among the regions that face a big challenge from alcohol abuse. Prudence (2023) reported that Meru County was the leading consumer of alcohol consuming Kenyan shillings of 4 billion worth of alcohol annually making Meru County the ideal place to study psychosocial factors contributing to alcohol relapse.

1.8 Limitations of the Study

The study was limited by the fact that some respondents found the study to be sensitive and were unwilling to give information freely, some were suspicious as to the purpose of the study where they believed it would interfere with their recovery duration at the treatment facilities. The researcher explained the purpose of the research to the respondents and how it would be used strictly for academics. The researcher also assured the respondents of the confidentiality of the information shared.

The sample size was relatively small, with only 90 participants drawn from three rehabilitation centres in Meru County, Kenya, which limits the generalizability of the results to other regions or rehabilitation facilities. Additionally, the use of self-reported data through interviews and questionnaires introduces potential bias, as participants may not have accurately recalled or may have underreported factors related to their relapse experiences due to stigma or social desirability. The correlational research design further limited the ability to establish causal relationships between the identified psychosocial factors and alcohol relapse, suggesting that longitudinal studies would be needed to understand how these factors influence relapse over time.

1.9 Assumptions of the Study

The study was carried under the following assumptions.

i. The respondents were willing to provide honest and accurate self-report data, crucial for the reliability of the results findings of this study.
ii. There was also an implicit assumption that the identified psychosocial factors influencing relapse in the chosen geographic context could be generalizable to other populations of recovering alcoholic across the country.
iii. That the rehabilitation centres provided the expected target respondents for this study.

1.10 Operational Definition of Terms

Alcohol dependence: In this study, alcohol dependence refers to an Individual's inability to cope without alcohol due to the withdrawal effects of alcohol.

Alcohol Withdrawal Effects: For this study Alcohol withdrawal effects will refer to the negative and uncomfortable body feeling that occurs when one is not intoxicated with alcohol.

Alcoholic rehabilitees: Alcoholic rehabilitees will refer to individuals who have been diagnosed with an alcohol use disorder and are seeking treatment in a rehabilitation program.

Peer: In this study, peers refer to individuals of similar age, status, or experience level as the subject, such as classmates, coworkers, or friends within the same social group.

Psychological Cravings: This will refer to a powerful and intense urge/ desire to consume alcohol.

Psychological factors: Psychological factors in this study will refer to the mental and emotional processes that can contribute to alcohol relapse.

Psychological Stress: It is the emotional strain or pressure that results from demanding or challenging situations, perceived threats, or major life changes. The level of psychological stress is usually measured using a standardized self-report scale, such as the Perceived Stress Scale (PSS), which assesses the frequency of stress-related feelings over a specified period.

Rehabilitation: For this study, rehabilitation refers to the process of treating substance use disorders and helping individuals recover from addiction to a drug and substance treatment facility.

Relapse: The study refers to relapse as the return to substance use after a period of abstinence.

Social factors: In this study, social factors denote the various social influences that can contribute to a person's likelihood of returning to substance use after a period of abstinence.

Social Occupation: It is defined as an individual's primary role in society, which includes professional roles, student status, or volunteer activities. It encompasses both paid and unpaid responsibilities that contribute to social identity

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

The chapter focuses on the current theoretical literature and empirical studies done relating to alcohol relapse among recovering alcoholic rehabilitees. The literature was reviewed as per the four objectives of the study. The theoretical framework was discussed chapter and served as a foundational review of two existing theories that helped the researcher introduce and explain the theory and why the research problem exists: Terence Gorski's Relapse Prevention Model and Marlatt's Cognitive-Behavioural Model of Relapse Prevention were adopted in this chapter. Finally, a conceptual framework was used to illustrate the expected relationships between the study variables.

2.1 Empirical Literature Review

Research on psychosocial factors contributing to alcohol relapse reveals several influential elements that affect individuals undergoing rehabilitation. Studies have consistently shown that peer influence plays a significant role in relapse risk. According to Majeke (2002), peers who engage in substance use or promote alcohol consumption can act as potent triggers for relapse, especially in early recovery stages. Swanepoel et.al. (2016) supported these findings, noting that positive peer relationships could foster sobriety, while negative influences from drinking peers could increase relapse vulnerability. This highlights the importance of supportive social networks in maintaining long-term recovery however, these studies do not sufficiently explore the influence of local cultural norms on peer dynamics, especially in Kenya, where social factors may differ considerably.

Social occupation, including employment and meaningful engagement in structured activities, is also linked to relapse risk. Turner (2020) suggested that having a stable social occupation reduces idle time and promotes a sense of purpose, which are protective factors against relapse. Henkel (2011) emphasized the relationship between unemployment and relapse, noting that unemployed individuals are at a higher risk due to boredom, low self-esteem, and social isolation. Similarly, Hodgson (2003) argued that employment provides a buffer against relapse by offering financial stability and social integration, which alleviate the psychological stress that can trigger alcohol use. These studies Despite these offer insights on relapse but a gap exists in understanding how

varying socioeconomic contexts, such as those in Meru County, specifically impact social occupation and relapse.

Psychological stress and cravings further contribute to relapse. DiClemente (2022) observed that high levels of stress and unmanaged cravings often precede relapse episodes. Stressful life events or chronic stress without adequate coping strategies can undermine recovery efforts. Moreover, psychological cravings, which can be intense urges to consume alcohol, are common among rehabilitees and are often linked to stress and exposure to alcohol-related cues. Nonetheless, there is a lack of longitudinal data to track how stress and cravings evolve over time during the recovery process, especially in rehabilitation settings in Meru County. Moreover, while interventions often address individual coping strategies, they do not adequately incorporate broader factors such as government policies or religious influences, which may play a pivotal role in shaping recovery outcomes

Intervening variables, such as religion and government policies, play a moderating role in relapse prevention. Religious involvement has been associated with lower relapse rates due to the social support and structured belief systems it provides (Joe et.al., 2022). Government policies that promote rehabilitation programs and support systems can also positively influence recovery outcomes by addressing systemic issues like unemployment, which contribute to relapse. These empirical findings underscore the multifaceted nature of alcohol relapse, involving individual psychological factors, social influences, and broader systemic conditions.

2.1.1 Influence of Peers on Relapse among Recovering Alcoholic Rehabilitees

The impact of peers on alcohol relapses among recovering alcoholic is deep-rooted, dictating the dynamics of their journey toward sustained recovery from alcohol abuse. According to Majeke (2002), the negative influence of peers on alcohol relapses among individuals in recovery is a considerable challenge in the journey of sobriety. Majeke (2002) further observed that peer relationships were a powerful trigger for alcohol relapses in cases where peers engaged in or encouraged substance abuse, especially alcohol. Indeed, it was found that Majeke's (2002) study concurred with the work of Swanepoel et. al. (2016) who found that peer relationships played a significant role amongst other roles in influencing a person's vulnerability to relapse to alcohol. Positive peer connection was anticipated to foster encouragement, understanding, and a positive sense of belonging in the individual regarding maintaining long-term sobriety. On the

contrary, negative peer influences, such as friends engaging in alcohol abuse or encouraging maladaptive drinking behaviours, escalated the risk of alcohol relapse among recovering alcoholic rehabilitees.

Positive peer pressure was found to play a vital role in encouraging healthy lifestyle choices and engaging in sobriety-focused activities, which serve as a strong protective factor against alcohol relapse. When individuals are surrounded by peers who depict healthy behaviours, they are more likely to adopt similar habits and attitudes. This supportive environment fosters a sense of belonging and accountability, making it easier for those in recovery to stay committed to their sobriety. Positive peer influences can provide the motivation and encouragement needed to pursue constructive activities, such as attending support group meetings, engaging in physical exercise, or participating in hobbies that do not involve alcohol. These activities not only occupy time that might otherwise be spent drinking but also reinforce a lifestyle that supports long-term recovery.

On the other hand, Swanepoel et. al. (2016) notes that peer influence was found to have a significant impact on decision-making in a negative context, particularly when individuals are exposed to friends who actively encourage or participate in alcohol-related activities. When surrounded by peers who drink or downplay the importance of sobriety, individuals in recovery may find it increasingly difficult to resist the temptation to abuse alcohol. The social pressure to conform to group behaviours can be strong, and for those in recovery, this pressure can undermine their resolve to stay sober. Negative peer influences can erode the progress individuals have made in their sobriety journey, making them more susceptible to relapse. This relapses not only reverses the hard-won gains achieved during recovery but can also lead to feelings of guilt, shame, and a sense of failure, which may further perpetuate the cycle of addiction (DiClemente 2022). Swanepoel et. al. (2016) emphasized that such negative peer influence is a critical factor that can derail an individual's efforts to maintain sobriety, highlighting the importance of cultivating a positive and supportive social network to protect against relapses.

Additionally, Chetty (2012) emphasized that the impact of social connections goes beyond direct peer influence, extending to the effects of isolation versus social engagement. When individuals in recovery experience loneliness and depression due to isolation, they face a significantly higher risk of alcohol relapses. This sense of isolation

can create a void that individuals may attempt to fill with alcohol, leading them back into old habits. On the other hand, maintaining positive peer connections plays a crucial role in combating these negative emotions, offering a supportive network that is essential in the journey toward sustained sobriety. Participation in recovery community programs, such as 12-step programs, was found to be particularly effective in fostering these positive relationships. According to Slate et. al. (2017), these programs enhance the likelihood of forming strong, supportive bonds with others who share similar struggles, thereby fostering accountability and mutual support. This collective environment often proves instrumental in helping individuals achieve and maintain long-term sobriety, as it provides both emotional support and practical strategies for coping with the challenges of recovery.

Kuria (2013) further highlighted the significant risk posed by socializing with friends who continue to use alcohol, identifying it as the number one risk factor for relapse. Kuria (2013) argued that friends who continue drinking often exert social pressure on individuals in recovery, subtly or overtly normalizing alcohol consumption. This normalization creates a challenging environment where the temptation to resume drinking becomes more pronounced and difficult to resist. Such associations expose individuals to high-risk situations and triggers that can easily undermine their commitment to sobriety. This perspective brings into line with Brand (2017), who argued that friends who use alcohol as a coping mechanism may unintentionally encourage similar maladaptive behaviours in those trying to recover, thus undermining their efforts to adopt healthier coping skills. Brand also concluded that a lack of support or understanding from friends, or even dismissive attitudes toward the individual's recovery efforts, contributes to feelings of isolation. This isolation diminishes the individual's resilience and increases their vulnerability to alcohol relapse. These findings underscore the critical importance of surrounding oneself with a supportive social network that fosters healthy behaviours and reinforces commitment to sobriety.

2.1.2 Influence of Social Occupation on Relapse among Recovering Alcoholic Rehabilitees

Lind W (2021) views social occupation among alcoholic rehabilitees to play a vital role in individuals' risk of going back to the usage of alcohol after rehabilitation. This includes factors related to the person's job, career, and broader social engagement. According to Lind W (2021), social occupation involves elements such as the stress of

the workplace, the nature of one's profession, working with colleagues, and on the whole proper and inappropriate social environment both within and outside the place of occupation. These social occupation elements can make individuals vulnerable to relapses by facing unnecessary job-related or occupational stressors and unsupportive work environments viewed to be risky factors towards alcohol relapse.

According to Turner (2020), social occupations help towards structured routine and stability and reduce idle periods that might attract elements of relapse fuelled by boredom. Additionally, such occupations lend purposeful, directional, and motivating goals geared towards a positive change in individuals' journey of sobriety. As per Ritvo (2023), the level of social occupation expressing participation in social activities and relationships is another significant factor that influences relapse rates among rehabilitated alcoholics. Lack of social occupation increases vulnerability to relapse as it predisposes the recovering individual to boredom, loneliness, and depression, all of which might be likely precursors to drinking. On the other hand, Ritvo (2023) found that despite having a strong social support network and meaningful occupational social activity, offers one level of true purpose, satisfaction as well as responsibility which in turn helps them to reduce the likelihood of a relapse. Rice (2021) believes rehabilitation programs should allow for social engagement and interaction, such as support groups, community service, and volunteering, to safeguard the condition of relapsing from knocking the sobriety journey of individuals (Rice, 2021).

Henkel (2011) highlights the critical role that social and occupational activities play in determining the likelihood of maintaining sobriety or experiencing relapse among recovering alcoholic rehabilitees. According to Henkel, the ability to sustain a change in alcohol-using behaviour is significantly influenced by the environment in which individuals live and work. He observed that relapse, particularly leading to heavy drinking, was more prevalent among unemployed individuals compared to those who were employed. The absence of structured daily activities, idleness, and the resulting low self-esteem were identified as major contributors to the increase in alcohol relapse among those who had undergone rehabilitation. The lack of a job or meaningful daily engagement can create a void in an individual's life, which they may attempt to fill with alcohol, leading to a dangerous cycle of relapse.

This observation is supported by a study conducted by Hodgson (2003), which also found a strong association between unemployment and alcohol relapse. Hodgson's research suggested that there is a causal connection between being unemployed and increased alcohol consumption, or conversely, that heavy drinking can lead to job loss, further perpetuating the cycle of unemployment and relapse. Unemployment not only deprives individuals of financial stability but also strips them of a sense of purpose and belonging, which are crucial for mental health and well-being. Hodgson pointed out that the detrimental effects of unemployment were widespread among those who relapsed after undergoing rehabilitation. The study showed that unemployment was more than just a lack of income; it created a host of negative emotional and psychological outcomes, including feelings of unhappiness, loneliness, and helplessness, all of which can drive individuals back to alcohol as a means of coping.

Hodgson (2003) further framed unemployment as a significant social problem, one that generates widespread misery and requires collective action to address. He argued that social problems like unemployment contribute to the conditions that make relapses more likely, emphasizing the need for broader societal efforts to tackle these issues. When individuals are unemployed, they often experience a profound sense of isolation and worthlessness, which can erode their resolve to stay sober. This sense of despair can make them more susceptible to seeking comfort in alcohol, further entrenching them in a cycle of addiction and relapse. Therefore, both Henkel and Hodgson underscore the importance of addressing unemployment and promoting active, meaningful engagement in occupational and social activities as essential components of supporting long-term recovery from alcohol addiction. By providing individuals with opportunities for employment and social interaction, it is possible to reduce the risk of relapses and support sustained sobriety.

Casac (2016) emphasizes that financial stability, which is often achieved through employment or ongoing educational pursuits, serves as a significant protective factor against alcohol relapses. This stability helps mitigate stressors related to economic uncertainty, which can be a major trigger for relapses. When individuals have a steady income or are engaged in educational activities, they are less likely to experience the anxiety and pressure that financial insecurity brings, thereby reducing the risk of turning to alcohol as a coping mechanism. Financial stability provides a sense of security and control over one’s life, which is crucial for maintaining sobriety.

Joe et.al., (2022) notes that social integration, which naturally comes with employment or participation in educational programs, plays a crucial role in recovery. Being part of a workplace or academic environment fosters positive connections with peers, colleagues, and mentors, which can reduce the feelings of isolation and loneliness that are common among those recovering from addiction. These social bonds provide emotional support, encouragement, and a sense of belonging, all of which are vital in preventing relapses. The interactions and relationships formed in these settings help create a supportive network that individuals can rely on during challenging times.

In addition to the social benefits, Casac (2016) complement that employment and education contribute to the development of important life skills. These include efficient time management, problem-solving abilities, and other competencies that are essential for a successful and balanced life. The opportunity to engage in occupational therapy—where work or educational activities are used as part of the treatment—also plays a critical role in recovery. Occupational therapy helps individuals develop new routines and habits that are conducive to a sober lifestyle, replacing the time and energy that might otherwise be spent on alcohol-related activities.

Casac (2016) also points out that these social occupations address not only the immediate physical aspects of addiction but also the broader, long-term needs of individuals in recovery. By helping individuals build a fulfilling and purpose-driven life, these activities make them less susceptible to the triggers that can lead to relapse. This holistic approach to recovery ensures that individuals are not just avoiding alcohol but are actively creating a life that supports their well-being and sustains sobriety. By promoting financial stability, social integration, skill development, and structured daily activities, this approach enhances the overall quality of life for those in recovery, making it easier for them to maintain their commitment to a sober lifestyle.

2.1.3 Influence of Psychological Stress on Relapse among Recovering Alcoholic Rehabilitees

Psychological stress is a significant trigger for alcohol relapses among individuals undergoing rehabilitation. Several key factors contribute to this stress, which often leads to a relapse. Among the most common sources are personal pressures, strained relationships, and financial instability, along with other health-related concerns. These stressors create a situation where individuals feel overwhelmed, leading them to seek solace in alcohol as a means of escape. The act of drinking in these circumstances is

often an attempt to numb the emotional pain or to temporarily forget about the challenges they are facing (Sinha 2012).

Sinha (2012) argues that when individuals experience stress, it can lead to a cascade of negative thoughts and emotions. If these emotions are not managed effectively, they can escalate into more severe mental health issues such as anxiety and depression. This escalation further increases the risk of relapse. The connection between stress and alcohol consumption lies in the fact that negative emotions often serve as powerful triggers. To cope, individuals may turn to alcohol as a form of self-medication, hoping to alleviate their distress, even if only temporary.

Ketcham (2011) underscores this point by highlighting how these negative emotional states can act as stimulus for alcohol consumption. The temporary relief provided by alcohol might seem appealing to someone struggling with intense stress, but this behaviour only serves to perpetuate a cycle of dependency and relapse. Thus, addressing the underlying sources of stress and developing healthy coping mechanisms are crucial components of successful rehabilitation. Without proper management of these stressors, individuals remain vulnerable to the temptation of using alcohol as a maladaptive coping strategy.

According to Kuria (2013), there is an association between Alcohol Dependence and depression before and after rehabilitation for Alcoholic. Kuria further states that there is a rate of (63.8%) of major depression among the alcoholic's rehabilitees. The rate was higher at (68%) of the estimated prevalence of co-occurrence of depression and alcohol dependence and it was noted that alcoholic experiencing highly threatening or chronic psychosocial stress following treatment are more likely to relapse than abstaining individuals not experiencing such stress (Ritvo, 2023). Expanding upon this stress-relapse hypothesis, the researcher predicted that individual risk and protective characteristics would contribute to vulnerability to relapse in alcoholics who are confronted with significant life adversity.

This agrees with the findings of a study conducted by Brown et. al. (2019) which aimed at determining whether alcoholics who experience high levels of stress following substance abuse treatment are more likely to relapse compared to those who do not experience significant stress. In Brown's study, a group of 67 abstinent alcoholics who had faced significant life adversity characterized by severe and/or chronic stressors

participated in the research. These individuals underwent a psychosocial assessment during their inpatient treatment for alcohol dependence, and the assessment was repeated at three months and one year following their discharge as outpatients.

The study's findings revealed a clear connection between psychosocial stress and relapse. Among the alcoholic men exposed to severe psychosocial stressors, those with higher psychosocial vulnerability scores indicating greater susceptibility to stress were more likely to relapse than those with lower vulnerability scores. This suggests that individuals who struggle to manage stress effectively are at a higher risk of returning to alcohol use after treatment. Furthermore, Brown et. al., (2019) discovered that men who demonstrated improvements in psychosocial functioning such as better stress management, enhanced coping mechanisms, and stronger social support during and after treatment had more favourable outcomes. These individuals were less likely to relapse compared to those whose vulnerability to stress remained unchanged or worsened over time.

Brown, et.al., (2019) concluded that poor coping skills, low self-efficacy, and a lack of social support were the most consistent predictors of relapses among the recovering alcoholics in his study, particularly for those who were severely stressed. These findings underscore the critical role of psychosocial factors in recovery and highlight the importance of addressing these issues through comprehensive treatment and aftercare programs that focus on enhancing coping abilities, building self-confidence, and establishing strong support networks to reduce the likelihood of relapse.

2.1.4 Influence of Intense Psychological Cravings on Relapse among Recovering Alcoholic Rehabilitees

According to Browne et. al., (2016) Intense psychological cravings are often a major factor contributing to alcohol relapse among individuals undergoing rehabilitation. These cravings are powerful urges or desires to consume alcohol, and they can be triggered by a variety of cues that remind individuals of their past alcohol use. Patracek (2023) agrees with Browne, et. al., (2016) where he notes that these cues can include anything from specific sights and smells to certain thoughts or emotions that are linked to previous drinking experiences. For instance, walking past a bar, smelling alcohol, or even experiencing stress or anxiety can evoke strong memories and associations with drinking, leading to an overwhelming desire to consume alcohol.

Patracek (2023) further explains that during these cravings, individuals may experience a profound sense of helplessness. This overwhelming feeling can make them feel as though they are being compelled by an external force to seek out and use alcohol, even if they intellectually know that doing so would be detrimental to their recovery. This sense of compulsion is particularly common among those who have recently quit drinking or are new to the recovery process. At this stage, they may not yet have fully developed the coping mechanisms needed to manage and resist these powerful cravings. Without effective strategies in place, such as mindfulness techniques, support from peers, or behavioural interventions, these individuals are at a high risk of relapses, as the craving can feel too strong to resist.

Tugade (2004) highlights that the early stages of recovery are especially vulnerable periods because individuals are still in the process of building resilience and learning how to cope with the intense emotions and urges that arise. The lack of established coping strategies makes it difficult for them to navigate these moments of intense craving without resorting to alcohol as a means of relief. This underscores the importance of comprehensive treatment programs that not only focus on abstinence but also equip individuals with the psychological tools and support systems necessary to manage cravings and maintain long-term sobriety. By understanding the nature of cravings and the triggers that provoke them, both individuals in recovery and their support networks can better anticipate and address these challenges, ultimately reducing the risk of relapse.

Luke (2019) in his work found out that alcohol cravings significantly contribute to the risk of relapses in individuals recovering from alcohol use disorder in that the neurological changes resulting from chronic alcohol use play a pivotal role, as the brain's reward system becomes conditioned to associate alcohol consumption with pleasure. Consequently, exposure to stress, emotions, or environmental cues can trigger strong cravings, prompting a desire to drink. Luke (2019) further found out that psychological triggers, such as anxiety or depression, can exacerbate these cravings, as memories linked to past drinking experiences. Impaired decision-making, a common consequence of prolonged alcohol use, was found to further hamper the ability to resist cravings rationally. Additionally, in Luke’s work stress responses, both psychological and psychological, often drive individuals to view alcohol as a coping mechanism.

Social and environmental influences, including exposure to drinking-related situations, can act as powerful triggers for cravings, as can the lack of effective coping strategies to deal with life challenges. People having physical dependence often experience withdrawal symptoms increasing cravings which make it more difficult to avoid giving in to the temptation to drink (Brooks & McHenry, 2015). In addition, addicted people should come up with a detailed relapse prevention plan that sees into the possible causes of relapse, changing lifestyle, social support, and getting professional help to reduce these risks. Cravings should be helped to be managed by healthcare professionals, therapists, and group support so that people in recovery may master ways of avoiding situations that precipitate relapses (Brooks & McHenry, 2015).

People rehabilitating must be provided with evidence-based treatment which would help them manage their cravings and hence stay sober. This may involve the application of therapies such as cognitive behavioural therapy that focus on the alteration of negative thought and behaviour patterns and prepare the individual on how to resist when the cravings are stronger. Additionally, involving people in aftercare support groups and offering them a strong support system from like-minded individuals may reduce relapses whilst always advocating for total recovery (Turner, 2020).

2.2 Theoretical Framework

The Theoretical framework is the conceptual foundation of a research proposal, providing a structured way to understand the research problem and the proposed study. It comprises existing theories, concepts, and definitions that help the researcher understand the phenomenon under investigation and inform the selection of variables, hypotheses, and research design. It offers a lens through which the researcher can interpret their findings and contribute to the existing body of knowledge in the field (Swanson, 2013). By integrating two theories in this study Gorski's Relapse Prevention Model (1986) and Marlatt's Cognitive-Behavioural Model of Relapse Prevention (1985), the researcher will gain a comprehensive understanding of the complex interplay between psychosocial factors and alcohol relapse.

2.2.1 Terence Gorski's Relapse Prevention Model

The model was developed by Terence Gorski in 1986 in his book Staying Sober. Terence Gorski's Relapse Prevention Model digs deeper into the details of recovery of addiction by providing a clear understanding of the stages leading to alcohol relapse and offering strategies to intervene effectively at any stage. The model recognizes that relapse is not a one-time event that appears but rather a process that unfolds over time, from the emotional and mental stages to the physical relapse stage (Gorski, 2007).

According to Gorski (2007), the very first stage of relapse is the emotional relapse stage, where the individual may not actively plan to use alcohol. However, their emotions and behaviours set the stage for potential alcohol relapses. Increased emotional vulnerability becomes evident, leading to increased feelings of anger, frustration, anxiety, and sadness. Isolation from others is a common tendency at this stage, encouraging a sense of loneliness and increasing the risk of alcohol relapses as a coping mechanism. Neglect of self-care activities, such as proper sleep and nutrition, was observed to contribute to an overall decline in the well-being of the recovering individual. Nostalgia and romanticizing past substance use, coupled with the resurfacing of unresolved issues, further complicate the emotional landscape compromising sobriety. Gorski (2007) therefore emphasizes the importance of recognizing signs of distress and initiating individual self-care practices. These may include maintaining healthy relationships, attending support groups, and engaging in activities that promote emotional well-being. By addressing emotional triggers proactively, Gorski (2007) believes individuals can disrupt the progression toward more advanced stages of alcohol relapse.

The second stage identified by Gorski in the Relapse Prevention Model is the mental relapse stage, where cognitive challenges become more rampant. During this phase, Gorski (2007) argues that individuals experience a tug-of-war between their commitment to staying substance-free and the resurfacing desire to engage in substance use. Cognitive conflicts intensify as cravings become more heightened, often triggered by individual stress levels, environmental challenges, or emotional distress. Gorski (2009) encourages the cultivation of coping skills such as cognitive restructuring and thought-stopping techniques to interrupt and redirect these destructive thought patterns once the self-defeating thoughts have been restructured the progression of alcohol relapse to the next phase is greatly hindered.

Physical relapses are the final stage, Gorski (2007) identified. In this stage, Gorski argues that it is the actual return to substance abuse. Physical relapses represent the actual return to substance abuse after progressing through earlier stages that were not well addressed. During a physical relapse, individuals lose control over their substance use, leading to an appearance of addictive behaviour. This stage is characterized by feelings of guilt and shame, a re-experience of negative consequences, and the cyclical nature of the relapse process Gorski (2007).

In his book Passage through Recovery, Gorski (2009) suggests that the goal of relapse prevention is to intervene at earlier stages, such as mental and emotional relapse, to prevent the progression to the physical relapse stage that has full effects of relapse to an individual. Strategies include ongoing psychotherapy support, developing coping with healthy skills, addressing underlying issues, and creating a supportive environment for sustained sobriety. Terence Gorski's Relapse Prevention Model addresses the interplay of psychosocial factors contributing to relapse among alcoholic rehabilitees. The model emphasizes the importance of a community support system comprised of family, friends, and peers, which is under study in this research. This social support network system has become a crucial source of encouragement and reinforcement for sobriety, helping during challenging periods that might be triggers to relapse. Lifestyle changes are advocated to modify daily routines and social environments, mitigating potential triggers for the relapse of Berberich (2020).

Gorski's Relapse Prevention Model is useful to this study for it offers the basis on which psychosocial factors contributing to alcohol relapse among recovering alcoholic

rehabilitees will be identified prompting the researcher to explore each psychosocial factor tied to psychological and social factors that contribute to relapse.

Additionally, the focus of the theory on teaching effective coping skills most of them from occupational activities is a key point for the study, for it allows for an investigation into how social occupation influences the development and utilization of coping mechanisms among relapsed rehabilitees. Lifestyle balance, another key aspect investigated by Gorski's model, will be examined to understand how psychosocial factors, including social support, and occupational, and recreational activities, contribute to or hinder the establishment of a balanced and healthy life post-rehabilitation period.

Gorski's Relapse Prevention Model offers valuable insights into the influence of peers on alcohol relapse among recovering alcoholic rehabilitees and how social occupation influences relapse. The model underscores the importance of social support networks and meaningful engagement in activities as protective factors against relapse. To explore how psychological stress influences alcohol relapses and investigate how intense psychological cravings contribute to relapse, the researcher adopted Marlatt's Cognitive-Behavioural Model of Relapse Prevention which provided a complementary perspective. Marlatt's model focuses on cognitive processes and coping mechanisms in managing stress and cravings, offering valuable insights into the psychological factors driving relapse behaviours. By integrating Marlatt's model into research on relapse prevention, researchers can explore the cognitive triggers and responses associated with stress and cravings, as well as implement cognitive-behavioural interventions to address these factors and mitigate relapse risk effectively a gap witnessed in Gorski's Relapse Prevention Model.

2.2.2 Marlatt's Cognitive-Behavioural Model of Relapse Prevention

The model Marlatt's Cognitive-Behavioural Model of Relapse Prevention is a relapse prevention model by Dr G. Alan Marlatt and Judith R. (Gordon, 2005). The model focuses on both triggers, whether internal and/or external, which may be attributable to the relapse. To empower individuals in recovery to attain sobriety, Marlatt’s model focuses on teaching a range of coping skills that comprise problem-solving skills, cognitive restructuring, and the cultivation of healthier alternatives to substance abuse (Marlatt, 2009). The model introduces the concept of the Abstinence Violation Effect, emphasizing the need for recovering individuals to manage emotional and cognitive

reactions after a perceived lapse to prevent a full relapse. Marlatt views relapses as a process rather than a single event and his model focuses on the importance of interrupting this process at early stages through timely interventions to prevent relapse (Marlatt & Donora, 2008).

In the work of Marcus, et. al., (2013) advocates for positive lifestyle changes as a crucial element in the recovery process. They emphasize the importance of altering daily routines and social networks in a way that supports sobriety. By making deliberate changes in their environment and the people they associate with, individuals in recovery can create a setting that not only reduces exposure to triggers but also fosters positive behaviours and attitudes that align with their sobriety goals. This approach involves more than just avoiding old habits; it encourages the adoption of new, healthier routines that support long-term recovery.

Kadden (2011) further highlights the critical role of self-efficacy in maintaining sobriety. He sees Self-efficacy as an individual's belief in their ability to succeed in specific situations—in this case, the ability to resist the urge to use substances and to handle high-risk situations without relapsing. Kadden's work argues that by reinforcing self-efficacy, individuals in recovery can strengthen their confidence in their ability to remain sober. This reinforcement can be achieved through various mindfulness-based practices that enhance one's awareness and control over one's thoughts and emotions. By improving individuals' perceptions of their own abilities, these practices help them develop the necessary skills to stay sober without relapsing, effectively manage stress, and navigate situations that might otherwise lead to alcohol relapses.

Moreover, Bhullar (2023) suggests that these positive lifestyle changes and the enhancement of self-efficacy are interconnected and mutually reinforcing. As individuals make healthier lifestyle choices and surround themselves with supportive social networks, their confidence in their ability to maintain sobriety increases. This, in turn, makes it easier for them to continue making positive choices and resist temptations. The focus on mindfulness in their approach is not only about achieving sobriety but also about sustaining it by cultivating a mindset that is resilient, self-aware, and capable of managing the challenges of recovery. Through these strategies, Bhullar (2023) offers a comprehensive approach to addiction recovery that empowers individuals to take control of their lives and build a future free from substance dependence.

The Cognitive-Behavioural Model of Relapse Prevention presented by Marlatt further gives a useful frame for understanding how the psychosocial factors leading to alcohol relapse may be addressed. Indeed, one of the outstanding points that could be noted within this model was identifying high-risk situations which in their case may include social contexts such as parties or social gatherings where instances of alcohol abuse may be rampant. Recognition of these social triggers is crucial for developing coping strategies. Social/ community support emerges as a key factor, with positive connections acting as a protective element against relapses (Witkiewitz & Marlatt, 2011). On the other hand, negative or unsupportive community environments may contribute to relapses, necessitating positive lifestyle modifications that involve engaging in alternative, non-alcohol-related social activities that increase the likelihood of sobriety (Witkiewitz & Marlatt, 2011).

Furthermore, Marlatt's model emphasizes coping skills to manage psychological stress, negative emotions, and intensified psychological cravings without resorting to alcohol abuse. Addressing cognitive factors, such as outcome expectancies, challenges unrealistic beliefs about the consequences of alcohol abuse (Brown, et. al., 2021). The Abstinence Violation Effect concept explores the emotional and cognitive reactions following a perceived lapse, addressing feelings of guilt, shame, or failure that can contribute to relapse. Mindfulness techniques and urge surfing promote a heightened awareness of psychological states and conscious management of cravings greatly reducing risks of alcohol relapse (Brown, et. al., 2021).

Skills training sessions in Marlatt's model integrate psychosocial factors, equipping individuals with the tools to manage social situations and cope with psychological stressors effectively. The model's conceptualization of relapse as a process underscores the interplay between psychosocial factors, emphasizing the need to intervene early in the relapse process. Further, Marlatt's model provides a clear approach to relapse prevention strategies, recognizing the diverse influences on an individual's recovery journey and offering strategies to navigate the psychosocial factors contributing to alcohol relapse (Bowen, et. al., 2021).

The model is significant to this study because of its focus on the importance of cognitive processes in the relapse process, particularly in the perception and interpretation of high-risk situational factors. In this study on psychosocial factors leading to alcohol relapse

among recovering rehabilitees, this model results in the researcher exploring how psychosocial factors influence individuals' cognitive view of high-risk situations both internally and externally. The study sought to investigate how these factors impact risk perception, bringing out how the inter-relationship of psychological perceptions impacts the predisposition to alcohol relapse amongst the alcoholic rehabilitees.

Another essential aspect of Marlatt's model is the focus on teaching adaptive coping strategies as an important component of relapse prevention strategy. In this study, the model guides the exploration of psychosocial factors that contribute to the development, selection, and utilization of healthy coping mechanisms among recovering individuals by understanding how psychosocial factors influence coping strategies, the theory therefore offers insights into the adaptive or maladaptive responses recovering alcoholic rehabilitees employ to navigate challenges and stressors, impacting their alcohol relapse risk.

The Marlatt model stresses the significance of lifestyle factors and high-risk situation concepts as some of the contributors to alcohol relapses, which helped the researcher to look at how psychosocial factors contribute to an individual’s alcohol relapse lifestyle choices and the ability of addicted individuals to recognize situations that mount a risk for relapse. Marlatt's model also advocates for skills training as a preventive measure against alcohol relapses among recovering alcoholic. The researcher evaluated the effectiveness of psychosocial interventions to enhance occupational skills by aligning with Marlatt's focus on developing practical skills to prevent relapse. Therefore, the study assessed how these occupational skills impact the individuals’ ability to overcome challenges and maintain sobriety.

Finally, in recognizing the importance of social support in the life of recovering alcoholic rehabilitees, the study explored how psychosocial factors, including the availability of a social support system, influence the individual's ability to navigate through challenging situations and maintain sobriety. Investigating the interpersonal dimension of recovery helping the researcher provide valuable insights into the role of social connections in the fight against alcohol relapse and the potential impact of psychosocial factors on the support system of recovering alcoholic rehabilitees.

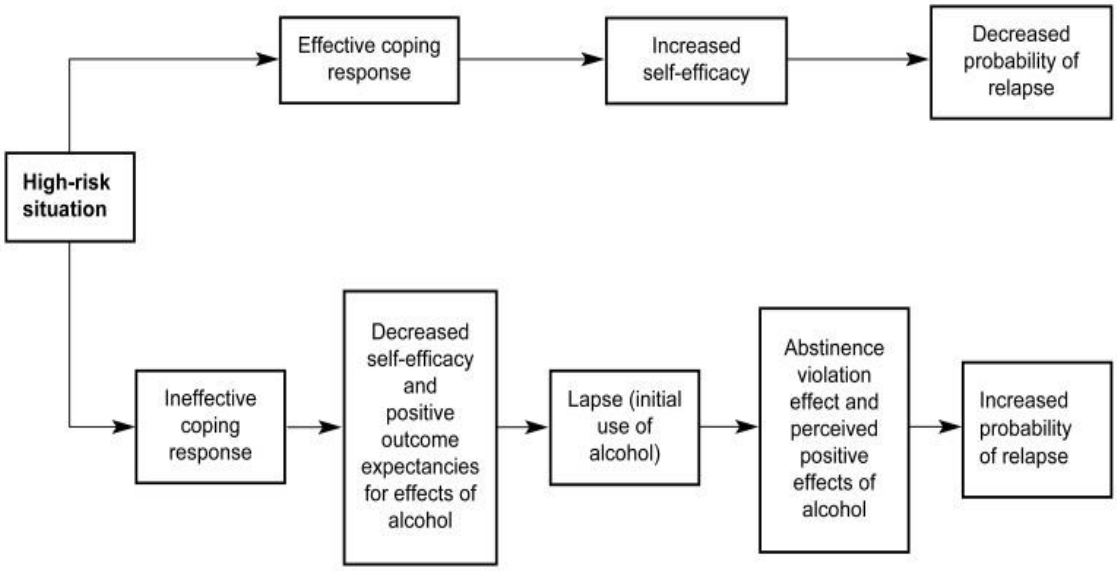

Figure 1: The Cognitive-Behavioural Model of the Relapse process (An overview of Marlatt's Cognitive-behavioural Model)

In Figure 1 above, the cognitive-behavioural model of the relapse process suggests that high-risk situations play a crucial role, and an individual's response to these situations is key. Effective coping strategies lead to increased confidence in one's ability to handle the situation, known as self-efficacy, thereby reducing the likelihood of relapse. Conversely, ineffective coping responses can decrease self-efficacy, coupled with the belief that alcohol use will yield positive outcomes, leading to an initial lapse. This lapse can trigger feelings of guilt and failure, known as the abstinence violation effect, which, along with positive outcome expectations, can escalate the risk of relapse.

2.3 Conceptual Framework

The following conceptual framework was adopted in the study. The conceptual framework has linked selected psychosocial factors to how they contributed to relapse among alcoholic rehabilitees in Meru County. Key variables for this study were categorized as independent variables, intervening variables, and dependent variables. The framework also incorporates Government Policy and Religion as intervening variables that may influence the relationship between the independent and dependent variables. Government policies can enhance recovery outcomes through supportive legislation, funding for rehabilitation services, and community programs, while religious beliefs and community support can provide emotional resilience and a sense of belonging, further mitigating the risk of relapse. This framework showed the relationship between the three variables. According to the figure below, the study hypothesized that there is a strong relationship between the independent variable, (Psycho-social factors) and the dependent variable (Relapse among recovering alcoholics rehabilitees). The conceptual framework is based on the literature review, and it shows how psychosocial factors indicated in the framework may contribute to alcohol relapse among recovering alcoholic rehabilitees.

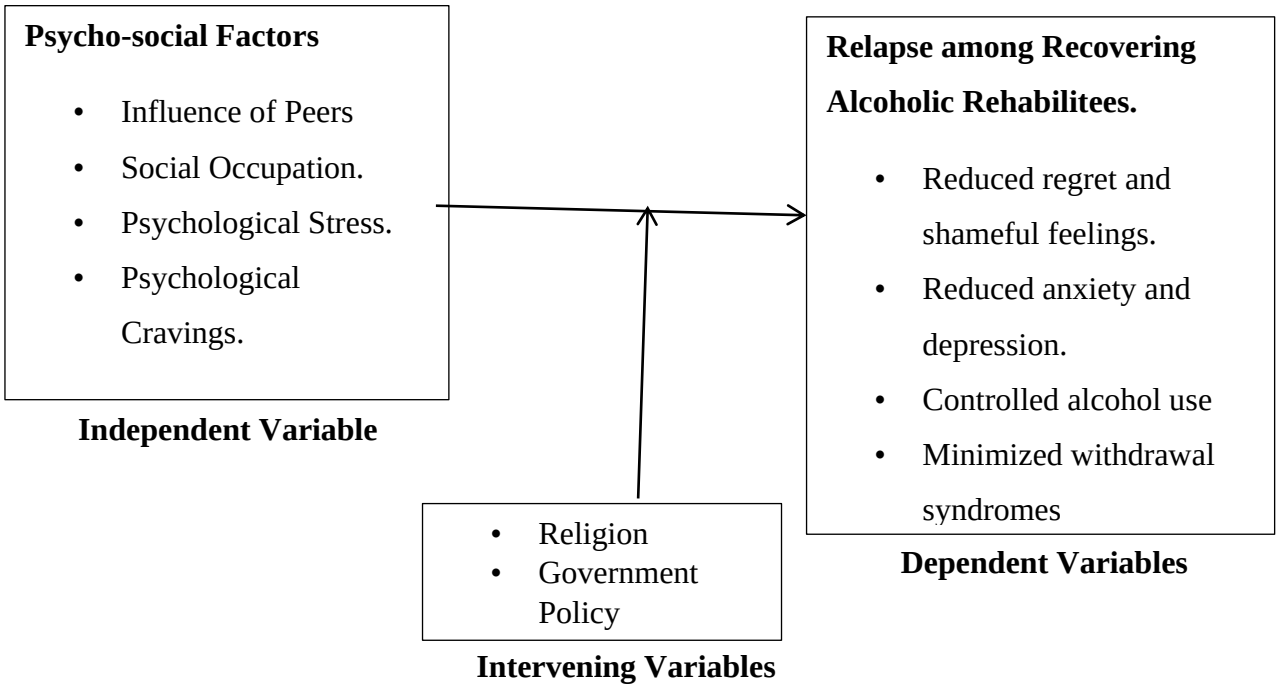

Figure 2:Conceptual Framework

CHAPTER THREE
RESEARCH METHODOLOGY

3.0 Introduction

The chapter explains the study's methodology, including the research design, study area, sampling techniques, data collection tools, how data was analysed, ethical considerations, and operationalization of the variables.

3.1 Research Design

This study adopted a correlational research design. Through the correlational design, the researcher collected data on psychosocial factors such as peer influence, social occupation, psychological stress, and intensity of psychological cravings among relapsed alcoholic rehabilitees. Using correlational analysis techniques such as Pearson's product-moment correlation coefficient, the researcher assessed the strength and direction of relationships between psychosocial factors and alcohol relapse. This analysis allowed the researcher to explore the relationships between psychosocial factors and alcohol relapse, providing valuable insights into factors that may influence relapse among rehabilitees in the selected rehabilitation centres.

3.2 Location of Study

The research was conducted at three rehabilitation centres in Meru County namely, Holy Innocents BPSS Centre in Timau, Methodist Treatment Centre in Kaaga, and St Nicolas Rehabilitation Centre in Tigania West Kianjai targeting rehabilitees who have been on the treatment program for more than once. The respondents were both rehabilitation rehabilitees and addiction counsellors. These rehabilitation centres were chosen because they admit the highest number of people with substance use disorder across the county.

3.3 Target Population

A target population is a group of individuals that have common characteristics from which samples are taken for measurement. The target population in this study consisted of individuals who had experienced relapses after completing their inpatient program and were seeking rehabilitation services for the second time. The targeted number of relapsed rehabilitees was derived from the three rehabilitation centres' databases. Holy Innocents BPSS Centre Timau had a total number of 42 inpatient rehabilitees who had relapsed; Methodist Treatment Centre has an estimated of a total of 32 rehabilitees seeking rehabilitation services more than once while St. Nicholas Rehabilitation Centre

has an estimate of total of 19 inpatient rehabilitees seeking rehabilitation services for more than once. Therefore, the target population for this study was 93 alcoholics rehabilitees seeking rehabilitation services after relapse.

3.4 Sample Size and Sampling Technique

The criteria for participant inclusion involved individuals who had completed a minimum of three months in rehabilitation centres on an inpatient basis and relapsed after the treatment period. On the 93 respondents targeted, purposive sampling was employed to ensure a comprehensive exploration of psychosocial experiences that lead to relapses after inpatient treatment. This approach allowed for the targeted examination of psychosocial factors such as the influence of peers on relapse, the influence of social occupation on relapse, the interplay of psychological stress and alcohol relapse, and psychological cravings influence on alcohol relapse providing an in-depth insight into the challenges faced by recovering alcoholic rehabilitees in their post-treatment phase. Purposive sampling was chosen for its suitability in capturing the specific characteristics and experiences essential to addressing the research objectives, aligning to the unique psychosocial factors contributing to alcohol relapse among the rehabilitees.

3.5 Sampling Frame

Table 1:

A Sampling Frame Table.

Centre Name	Total Rehabilitees.	Male Rehabilitees	Female Rehabilitees	Sample Size
St Nicholas Rehabilitation Centre	19	11	8	19
Methodist Treatment Centre	35	29	6	35
Holy Innocents BPSS Centre Timau	42	33	9	39
Totals		73	23	93

3.6 Data Collection Instruments

3.6.1 Questionnaires

Structured questionnaires were designed to quantify the psychosocial factors that contribute to relapse. According to O'Cathain, et. al., (2004), structured questionnaires can increase response rates and allow respondents to elaborate on closed-question responses, as well as identify new issues that might not have been initially considered.

These questionnaires incorporated Likert scales and multiple-choice questions to gather data aligned with the study objectives, such as the influence of peers, social occupation, psychological stress, and cravings on alcohol relapse. Brief demographic information was also collected to contextualize responses. The questionnaires were distributed to all eligible respondents at the three rehabilitation centres under study.

3.6.2 Focus Group Discussions (FGDs) Among Relapsed Alcoholics Rehabilitees

According to Rivaz, et. al., (2019), focus group discussions are a type of qualitative method of data collection. They are useful in exploring people's beliefs, perceptions, and attitudes about a topic. The Focus Group discussion starts broadly and gradually narrows down to the focus of the research. Rivaz, et. al., (2019) explained that focus groups typically consist of 8-12 people, with a moderator who focuses the discussion on relevant topics in a nondirective manner.

Focus Group Discussion as a tool for data collection from the respondent enabled them to share their personal experiences, challenges, and how they coped before their relapse occurred. Open-ended prompts were used to elicit more openness in considering the psychosocial dynamics, moving beyond surface descriptions of addiction and revealing common factors of relapse for people who are in repeating need of rehabilitation treatment.

3.6.3 Interviews

To gain a clinical perspective on the psychosocial factors contributing to alcohol relapse, interviews were conducted with the heads of clinical services at the rehabilitation centres. These structured interviews provided an opportunity to explore in greater depth the complex interplay of factors leading to relapse. The researcher aimed to uncover gaps in existing relapse prevention strategies and to identify potential areas for improvement in the rehabilitation process. Insights from these key informants were

crucial in developing a more comprehensive understanding of the challenges in preventing relapse within the Kenyan context.

3.7 Data Collection Procedures

3.7.1 Obtaining Ethical Clearance

The researcher obtained an introductory letter from the Director of Postgraduates at Tharaka University, introducing the study and its objectives. Subsequently, ethical clearance was sought from both the Tharaka University ethics committee and a research permit from The National Commission for Science Technology and Innovation (NACOSTI) to ensure the rights and well-being of the participants are safeguarded throughout the research process and that the study adheres to ethical guidelines and standards

3.7.2 Site Visit and Consent Acquisition

Following the acquisition of ethical clearances, the researcher conducted site visits to the selected rehabilitation facilities. The researcher met with the management of the facilities to explain the purpose and objectives of the study. Consent to carry out the study was obtained from the management of the selected rehabilitation centres, ensuring cooperation and support for participant recruitment. Subsequently, informed consent was obtained from individual participants, emphasizing voluntary participation and the right to withdraw from the study at any time. This step ensured that participants were fully informed about the study and its implications before agreeing to participate.

3.7.3 Participant Recruitment

The researcher collaborated with Holy Innocents BPSS Centre, Methodist Treatment Centre, and St. Nicholas Rehabilitation Centre for participant recruitment. Eligible participants, who were individuals undergoing rehabilitation program for the second time or more after a relapse, were identified based on inclusion criteria. Questionnaires were distributed to eligible participants, providing clear explanations of the terminologies and purposes of each questionnaire. Participants were requested to complete the questionnaires within a designated timeframe of one week, after which time the researcher picked them for analysis.

3.7.4 Data Collection

To ensure data collection proceeds smoothly, the researcher facilitated Focus Group Discussions and life history interviews in groups to gather qualitative data. These

discussions and interviews provided valuable insights into participants' experiences and perspectives regarding psychosocial factors and alcohol relapse. Semi-structured interviews were conducted with the clinical services coordinators to gather insights into institutional practices, current alcohol relapse prevention strategies, and the perceived effectiveness of psychosocial interventions in alcohol relapse prevention. From the interviews Participants' perspectives and experiences were captured through detailed notetaking during the interviews, ensuring thorough documentation of responses and observations.

3.8 Piloting

The researcher conducted a pilot study at Harmony Therapy Centre in Nkubu Meru County to cross-check the questionnaire design and get rid of errors to promote response validity. Following collaborative discussions with the centre's administration, ethical considerations and informed consent processes were addressed. A small sample of individuals meeting the study criteria were then recruited for the pilot study. The data collection instruments, including structured interviews and surveys, were modified based on feedback from Harmony Therapy Centre staff and participants, emphasizing clarity, cultural relevance, and participant comprehension. Engaging in discussions with participants and centre staff provided valuable insights, allowing adjustments to the study protocol and ensuring that the finalized data collection procedures were optimized for cultural sensitivity and operational efficiency. The piloting process was documented in a comprehensive report, informing the subsequent main study and contributing to the overall success of the research endeavour.

3.9 Reliability and Validity Analysis

To measure the internal consistency of the survey tool, Cronbach's alpha was used. A Cronbach's alpha is a common way of assessing validity by comparing the extent of shared (co)variances among the items that make up the survey instruments to the overall variances. According to Collins (2007), if the instrument is reliable, there should be a great deal of variances among the items relative to the variance since items measure closely related items. In his classification, Collins (2007) suggested that reliability values exceeding 0.6 show a relatively good internal consistency, while values above 0.7 exceed expectations for good internal consistency among the constructs. From Table 4 the overall reliability based on all 20 items was 0.780, indicating an acceptable level of consistency. These coefficients signify that the items used in the survey questionnaire

exhibited an acceptable degree of internal consistency therefore suggesting good reliability of the survey questionnaire used for this study.

Table 2:

Reliability Analysis

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.780	.777	20

On the other hand, validity was assessed through the Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy and Bartlett's Test of Sphericity. The KMO measure of sampling adequacy tests the suitability dataset for factor analysis, that is a measure of how all 20 items included in this survey can be decomposed into a few independent variables used in this study. According to Kaiser (1974), KMO values beyond 0.5 are generally acceptable for factor analysis. Results shown by Table 4 show a KMO measure of adequacy as 0.789, implying that the dataset was well suited for factor analysis.

A test of whether the matrix is an identity matrix was assessed using Bartlett's test of sphericity. The Bartlett's Test was significant, $\chi^2 = 1508.092$, $p=0.000$, indicating that the correlation matrix is not an identity matrix thereby confirming that the dataset was suitable for factor analysis. Hence, favourable outcomes for the KMO Measure of sample adequacy and Bartlett's Test of Sphericity validate the appropriateness of the data collected for factor analysis as well as conducting a robust assessment of principal component analysis (PCA).

Table 3:

KMO and Bartlett's Tests for Validity

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		**.789**
Bartlett's Test of Sphericity	Approx. Chi-Square	1508.092
	Df	210
	Sig.	.000

3.10 Data Analysis

This study utilized correlation analysis and regression to analyse the data collected through questionnaires and focus group discussions. Correlation analysis was be used to examine the relationships between the psychosocial factors (peer influence, social occupation, psychological stress, and psychological cravings) and alcohol relapses. Correlation analysis helped in understanding the strength and direction of the relationships between the variables, providing insight into which factors could have been more strongly associated with alcohol relapse.

Regression analysis further explored the predictive power of these factors on alcohol relapse. The statistical software package for Social Sciences (SPSS) version 27 was used for data analysis. Regression analysis, on the other hand, allowed the researcher to assess the combined effect of multiple psychosocial factors on alcohol relapse, enabling the researcher to identify significant predictors. Using SPSS ensured accurate and efficient data analysis, facilitating the testing of hypotheses and drawing valid conclusions. In this study peer influence, social occupation, psychological stress, and psychological cravings were regressed against alcohol relapse.

$Y=\beta 0+\beta 1X1+\beta 2X2+\beta 3X3+\beta 4X4+\varepsilon$

Where:

Y is the dependent variable (alcohol relapse).

$X1$, $X2$, $X3$, and $X4$ are the independent variables (peer influence, social occupation, psychological stress, and psychological cravings).

$\beta 0$ is the intercept (the value of Y when all independent variables are zero).

$\beta 1$, $\beta 2$, $\beta 3$, and $\beta 4$ are the regression coefficients (the change in Y associated with a one-unit change in each independent variable, holding other variables constant).

ε is the error term (the difference between the observed and predicted values of Y).

Table 4:

A summary of Statistical Analysis Used.

Hypothesis	Independent Variables	Dependent Variables	Test
H_{01}: There is no statistically significant relationship between peer influence and alcohol relapse.	Peer influence	Alcohol relapse	Regression analysis Thematic analysis
H_{02}: There is no statistically significant relationship between social occupation and alcohol relapse.	Social occupation	Alcohol relapse	Regression analysis Thematic analysis
H_{03}: There is no statistically significant relationship between psychological stress and alcohol relapse	Psychological stress	Alcohol relapse	Regression analysis Thematic analysis
H_{04}: There is no statistically significant relationship between psychological alcohol cravings and alcohol relapse.	Psychological alcohol cravings	Alcohol relapse	Regression analysis Thematic analysis

The researcher then presented the findings using tables, charts, and graphs to illustrate key results effectively. Quantitative findings were presented first, followed by qualitative findings from Focus Group Discussions and life history interviews. Interpretations of

the findings were provided, highlighting their implications for theory, practice, and future research in the field of alcohol relapse and rehabilitation.

3.11 Ethical Considerations

The study prioritized ethical considerations by carrying ethical clearance from the TUN ethical commission and NACOSTI. An introductory letter explaining the study's purpose was used to address the ethical issues that could emerge. The respondents were informed of their rights to withdraw from the study at any stage if they felt that they no longer wanted to participate in the study. The data collected was treated with utmost confidentiality during and after the research and was used only for the intended academic purpose. To increase the degree of confidence among the respondents, no names or identification details were needed on the questionnaires they filled out. These ethical safeguards ensured participant well-being and contributed to the trustworthy conduct of research on psychosocial factors contributing to relapse among recovering alcoholics rehabilitees.

CHAPTER FOUR

PRESENTATION OF FINDINGS, INTERPRETATION AND DISCUSSION

4.0 Introduction

This chapter presents the research findings for data collected on the relationship between the influence of peers (IP), the influence of social occupation (ISO), the influence of psychological stress (IPS), and the influence of intense psychological cravings (IIPC) on alcohol relapses. The results were presented systematically and in various subsections. The first section of this analysis entailed pilot testing and checking for the reliability and validity of the survey tool. The Cronbach's alpha and KMO Bartlett's test for sphericity were used for the reliability and validity of the scales used respectively. This was followed by summary statistics which included both demographic and descriptive statistics summary of all variables involved in the study. Lastly, the study dived into regression analysis to analyse the key influences of alcohol relapses among the participants. This allowed the research to gather substantial and worthwhile findings that may aid in alcohol relapse among the participants in various centres across the country.

4.1 Response Rate

Table 5:

Response Rate

Group	Target sample	Responses	Response rate
Recovering Rehabilitees	93	90	96.77%
Head of Clinical Services	3	3	100.00%
Total	96	93	96.88%

The sample included 93 relapsed recovering alcoholic rehabilitees and 3 heads of clinical services. Both groups participated in the survey, with 93 questionnaires distributed to the rehabilitees. Remarkably, 90 out of 93 questionnaires were returned fully completed, resulting in a response rate of 96.77%. Additionally, all 3 heads of clinical services also completed their surveys, achieving a response rate of 100%. Overall, the research

achieved a response rate of 96.88%, as shown in Table 5. This response rate significantly exceeds the 70% threshold recommended by Mugenda and Mugenda (2018) for accurate population representation. The robust participation of the respondents not only underscores the relevance of the study but also enhances the credibility of the findings, providing a strong foundation for the research conclusions.

4.2 Demographic Analysis

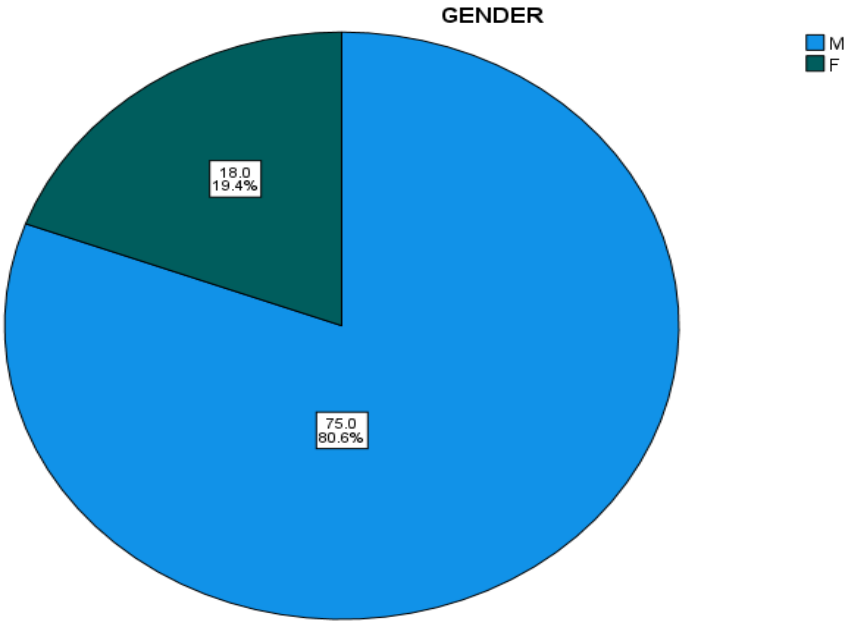

Figure 3:Composition by gender

Figure 3 shows that demographic composition of the participants consisted of 80.65%(n=75) males and 19.35%(n=18) females. Such imbalanced composition shows great disparities by gender experienced in most rehabilitation centres which suggest that males are more susceptible to alcohol use than their female counterparts. The greater prevalence of alcohol use among males could be attributed to various factors, such as social and cultural influences that may encourage drinking behaviours more among men than women. However, the existence of both genders was essential for diverse opinions based on the two divides. These findings agree to a study by Walitzer (2006) on *Gender Differences in Alcohol and Substance use Relapse in Kenya,* where he found out that men are more likely to consume alcohol than women, and to be negatively impacted by it.

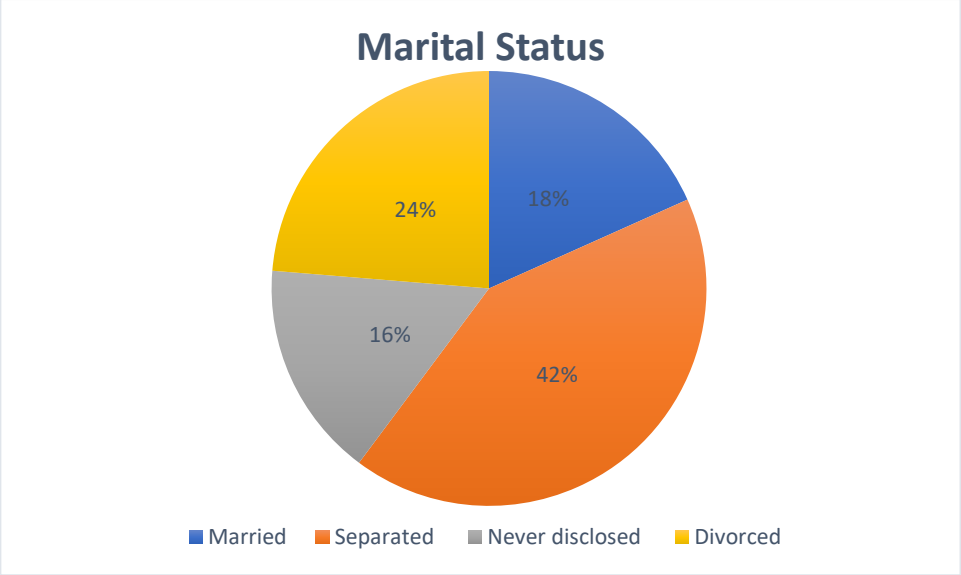

Figure 4: Marital Status

The sample analysis indicated that 18.3% of the participants were married, 23.7% (n=22) were divorced, 41.9%(n=39) were separated and 16.1% never disclosed their marital status or their information regarding their marital status was missing. These figures reveal a possibility that married individuals may benefit from emotional support and stability, which could potentially reduce relapse risk. However, if marital relationships are strained, they might contribute to stress and increase the likelihood of alcohol use. Divorced individuals might experience heightened emotional distress, loneliness, and financial strain, which could drive them to use alcohol as a coping mechanism. Similarly, separated individuals often face ongoing psychological stress, including feelings of loss and instability, making them more vulnerable to relapse .These findings were in agreement to a study finding by Virginia (2020) on her study on *Factors influencing alcohol relapse among patients in alcohol and substance abuse treatment and rehabilitation programme (ASATREP) in Kiambu county, Kenya* where in her study she found a significant association between marital status and alcohol relapse. Specifically, patients who were not married were more likely to experience a relapse compared to those who were married. Her findings suggests that marital status plays a role in influencing the likelihood of alcohol relapse, with married individuals potentially having more social support or stability that helps them maintain sobriety. Therefore, addressing the unique needs of unmarried patients during treatment and rehabilitation may be important in reducing relapse rates. The 16.1% of participants with missing or undisclosed marital status may indicate complex or unstable relationship situations,

which could also influence alcohol use patterns. This diversity in marital status among participants highlights how relationship dynamics and personal circumstances significantly impact alcohol use and relapses, emphasizing the need for tailored support based on individual relationship contexts.

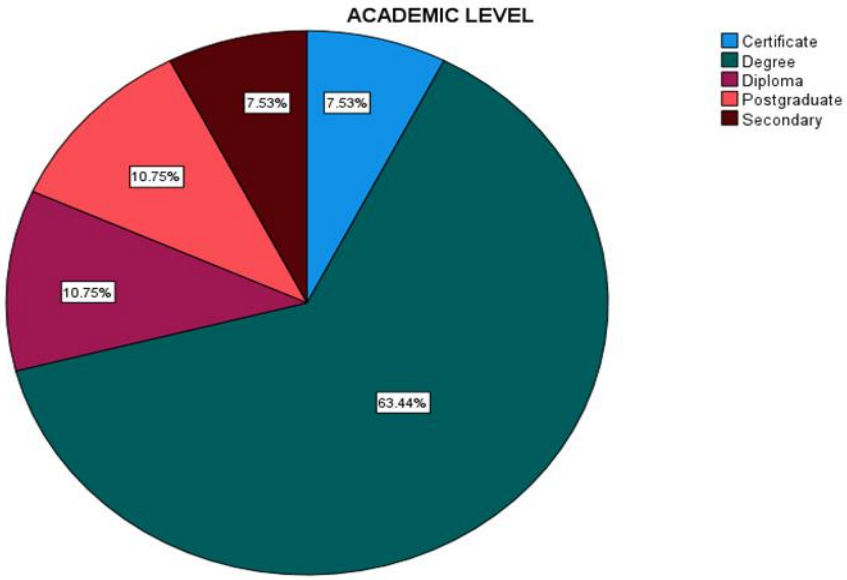

Figure 5:Composition of demography by education level

Figure 5 shows that 63.4% (n=59) rehabilitees were degree holders,7.5% (n=7) had secondary education, 7.5 % (n=7) held a certificate, and 10.8 % (n=10) had post-graduate education. The predominance of degree holders in the sample may reflect unique stressors associated with higher education, such as career pressures, financial strain from educational investments, or challenges in finding suitable employment. These factors can contribute to increased stress and potentially lead to alcohol use as a coping mechanism. In contrast, individuals with only secondary education or vocational certificates may face different socio-economic challenges, such as lower earning potential or specific job-related stressors, which also contribute to alcohol use but are less represented in this sample. Those with post-graduate education, despite their advanced qualifications, may experience significant stress from high career expectations or maintaining professional status, leading to similar substance use issues. With the majority group being degree holders, there is a need to assess what causes such disparities, notably socioeconomic differences such as unemployment or accessibility to alcohol by the participants. Wainaina, V. N. (2020) found out that there is no significant association between education level and alcohol relapse among patients treated at the

Alcohol and Substance Abuse Treatment and Rehabilitation Programme (ASATREP) in Kiambu County. The analysis indicated that patients who relapsed did not differ significantly in terms of education level compared to those who did not relapse within the six months following treatment. Therefore, education level was not a predictor of alcohol relapse in this study, unlike other factors such as marital status, trouble sleeping, and the use of other substances, which were found to influence relapse outcomes. This suggests that while certain demographic and personal factors impact relapse risk, education level does not play a significant role in influencing the likelihood of relapse for individuals undergoing treatment for alcohol use disorder.

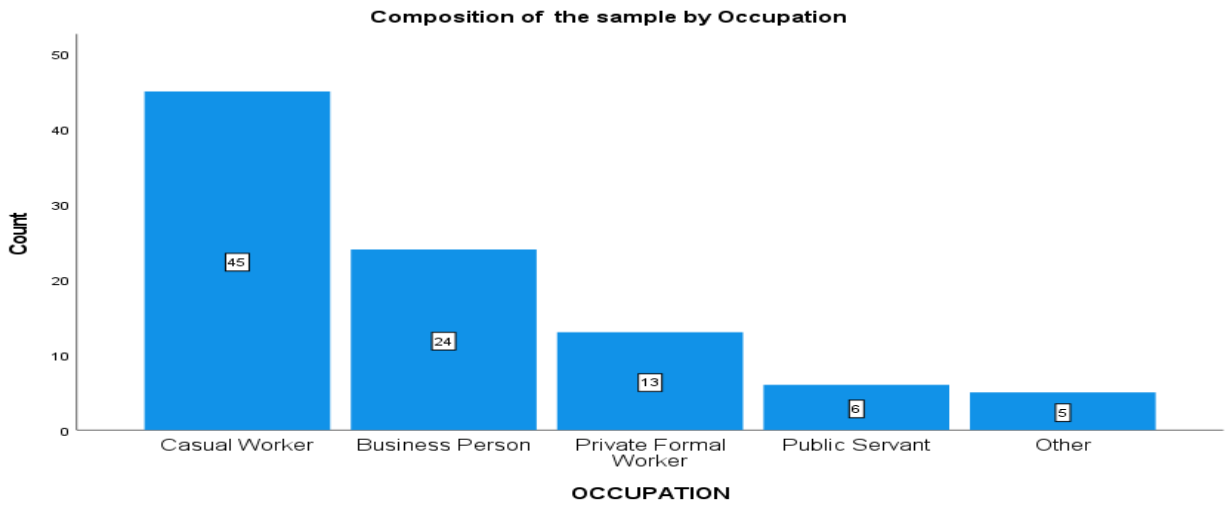

Figure 6:Composition of the sample by Occupation

Figure 6 shows the composition of sample by occupation. The majority (48.4%, n=45) of rehabilitees were casual workers. The analysis also showed that rehabilitees consisted of businesspeople (25.8%, N=24), private formal workers (14.0%, N=13), and public servants (6.5%,N=6) while 5.3% formed rehabilitees from other occupations. This can be used to explain the role of occupation in alcohol use and how the state of employment contributes to drug use and subsequent rehabilitation processes.

These findings suggest that occupation plays a significant role in alcohol use and the likelihood of relapsing. Casual workers, who often face job instability, low wages, and a lack of benefits, may experience higher levels of stress and financial insecurity. These conditions can lead to increased vulnerability to alcohol use as a coping mechanism. The

high representation of casual workers among the rehabilitees reflects how economic hardship and unstable employment can contribute to substance abuse.

Similarly, businesspeople and private formal workers, although more secure in their employment, may still face significant pressures related to performance, competition, and financial risk. These stressors can also lead to alcohol relapses to manage anxiety and stress. Public servants, while fewer in number, may face unique challenges such as high job demands and public scrutiny, which could also contribute to alcohol consumption. These findings were in agreement to a study by Muchiri, B. N. (2021) on *Effects of Alcohol Abuse on Family Stability in Nyeri County, Kenya* where he found out that lack of occupation and financial stability was associated with alcohol abuse.

Overall, the data underscores the impact of occupational stress and job-related factors on alcohol use, highlighting how the nature and stability of one's employment can influence the risk of alcohol relapse.

Table 6:

Demographic Information Summary

Item	Options	N	Percentage (%)	Accumulated Percentage (%)
Gender	Male	75	80.6	80.6
	Female	18	19.4	100.0
Marital status	Married	17	18.3	18.3
	Divorced	22	23.7	42.0
	Separated	39	41.9	81.9
	Undisclosed	15	16.1	100.0
Level of Education	Secondary	7	7.5	7.5
	Certificate	7	7.5	15.0
	Diploma	10	10.8	25.8
	Degree	59	63.4	89.2
	Postgraduate	10	10.8	100.0
Occupation	Casual worker	45	48.4	48.4
	Businessperson	24	25.8	74.2
	Private formal worker	13	14.0	88.2
	Public servant	6	6.5	94.7
	Others	5	5.3	100.0

The demographic information of the participants consisted of gender, marital status, academic level and occupation. Table 6 summarizes the general demographic analysis of the participants' demography.

4.3 Presentation of Findings

This section presents the findings and interpretations of the descriptive statistical analysis of the data. Means, standard errors of the mean, and standard deviation were among the descriptive statistics used. The adoption of mean, standard error, and standard deviation was useful in coming up with basic characteristics of the research population and formed a solid foundation for quantitative analysis. It presents the response descriptive summary of the influence of peers (IP), the influence of intense psychological cravings (IIPC), the influence of social occupancy (ISO), and the influence of psychological stress (IPS), which primarily formed part of an independent variable while alcohol relapses (relapse score) were used as a measure of the dependent variable. In both cases, a 5 -5-point Likert scale was used, where 1=strongly disagree; 2=disagree;3=Neutral ,4=Agree, and 5=strongly agree was used to establish a respondent opinion on alcohol relapse, the influence of peers, the influence of intense psychological cravings, the influence of social occupancy, and influence of psychological stress

4.3.1 Influence of Peers on Relapse among Recovering rehabilitees

The study examined the influence of peer relationships on alcohol relapses, to understand how various sub-themes contribute to the relapse.

Table 7:

Peer Relationships Descriptive Summary

	N	Mean		Std. Deviation
	Statistic	Statistic	Std. Error	Statistic
I feel that hanging out with friends who abused alcohol contributed to my relapse.	90	3.30	.113	1.091
Being away from my friends contributed to my relapse.	90	3.57	.127	1.228
I feel participating in the 12-step programs of AA could have sustained my sobriety.	90	3.52	.128	1.230
The lack of support from my friends led to my relapse.	90	3.46	.116	1.119
Valid N (listwise)	90			

Table 7 summarizes the summary statistical findings. It was established that the rehabilitees felt that hanging out with friends who abused alcohol contributed to the relapse (M=3.30, SD=1.091), which indicates a moderate level of agreement and some variability in responses. Rehabilitees also agreed that being away from their friends contributed to their relapse (M=3.57, SD=1.228). This was the highest scoring factor, suggesting that respondents felt this was a more significant factor in their relapse. Participating in the 12-step programs of AA could have sustained was agreed as the possible measure in increasing sobriety (M=3.52, SD+1.230), showing a majority agreed to its influence in the relapse while lack of support (M=3.46, SD=1.119) was also suggested as possible cause of relapse among rehabilitees.

Overall, the mean scores for all subitems under peer influence show that a state of loneliness or being away from friends contributes more to relapse than any other aspects included in this study. These findings are consistent with Majeke (2002) who observed that peer relationships were a powerful trigger for alcohol relapses in cases where peers engaged in or encouraged substance abuse, especially alcohol. Essentially, this suggests that rehabilitees must be constantly engaged to reduce relapses.

4.3.2 Influence of Social Occupation on Relapse among Recovering Rehabilitees

Table 8 summarizes the four factors that were used to define the influence of social occupation or employment status.

Table 8:

Descriptive Summary of Social Occupation

	N	Mean		Std. Deviation
	Statistic	Statistic	Std. Error	Statistic
I felt stressed at my workplace contributing to my relapse.	90	3.29	.128	1.239
Lack of work contributed to my relapse.	90	3.12	.120	1.160
I feel financial instability contributed to my relapse.	90	3.34	.118	1.137
Boredom because of the free time I had contributed to my alcohol relapse.	90	3.34	.127	1.229
Valid N (listwise)	90			

Collectively, they provide insights into the perceived work-related factors contributing to relapses. With a mean of 3.29, SD=1.239, it can be concluded that rehabilitees agreed that they usually feel stressed at their workplace which contributes to relapse. Lack of work (M=3.12, SD=1.160), a feeling of financial instability (M=3.34, SD=1.137), and boredom because of free time (M=3.34, SD=1.229) were agreed as a significant factor contributing to relapse.

Conclusively, financial instability and boredom due to a lot of free time or not being engaged sometimes stood out as the most influential social occupations included in this research. This is consistent with the research by Turner (2020), who suggested that social occupations help towards structured routine and stability and reduce idle periods that might attract elements of relapse fuelled by boredom. These findings highlight the significant role of work-related stress, employment status, financial instability, and boredom in the rehabilitee's relapse and are crucial in the inferential analysis of the influence of social occupation on alcohol relapse at the later stage of this thesis. Equally, financial instability greatly contributes to stress while boredom further escalates the feeling of being stressed, which further amplifies the influence of social occupation on relapses.

4.3.3 Influence of Psychological Stress on Relapse among Recovering Rehabilitees

The findings of psychological stress that can trigger alcohol relapses were analysed and summarized in Table 9.

Table 9:

Influence of Psychological Stress

	N	Mean		Std. Deviation
	Statistic	Statistic	Std. Error	Statistic
I felt stressed before my alcohol relapse.	90	3.54	.099	.951
Feeling overwhelmed led to my relapse.	90	3.76	.111	1.067
Poor responses to stress led to my relapse.	90	3.92	.087	.837
I am more likely to drink again when I feel stressed.	90	3.59	.097	.935
Valid N (listwise)	90			

The rehabilitees agreed that they felt stressed before their alcohol relapses (M=3.54, SD=0.951). Lack of supportive care including poor stress response (M=3.92, SD=0.837) was viewed as greatest psychological support issues and explained why feeling of being overwhelmed (M=3.76, SD=1.067) leads to relapse. These findings suggest that physical social support plays a great role in mitigating alcohol relapses which call for rehabilitation centres to provide adequate support to mitigate alcohol relapses. Additionally, psychological issues have a domino effect on relapse with rehabilitees agreeing that they were more likely to drink again when they feel stressed (M=3.59, SD=0.935). These findings suggest a significant role of stress and emotional overwhelm in contributing to relapses, highlighting the need for effective stress management and coping strategies to support sustained sobriety, which is consistent with Brown, et. al., (2019) who pointed out that poor coping, low self-efficacy, and lack of social support most consistently predicted relapse among the recovering alcoholics from his sample of severely stressed abstaining alcoholics individuals.

4.3.4 Influence of Intense Psychological Cravings on Relapse among Recovering Rehabilitees

Analysis carried out on the intensity and nature of psychological cravings suggested that rehabilitees agreed that alcohol cravings after my rehabilitation program contributed to relapse (M= 3.67, SD=1.116). Equally, rehabilitees agreed to statements that seeing friends who drink alcohol made cravings stronger (M=3.51, SD=0.985), some depression levers triggered their alcohol cravings (M=3.96, SD=0.846), and exposure to alcohol by friends who used it triggered cravings (M=3.70, SD=1.091), led to an alcohol relapse (Table 10).

Table 10:

Psychological Craving

	N	Mean		Std. Deviation
	Statistic	Statistic	Std. Error	Statistic
Alcohol cravings after my rehabilitation program contributed to my relapse.	90	3.67	.116	1.116
Seeing friends drink alcohol made my cravings stronger, which led to my relapse.	90	3.51	.102	.985
I experienced some depression levers that triggered my alcohol cravings.	90	3.96	.088	.846
Exposure to alcohol by friends who used it triggered my cravings, which led to my relapse.	90	3.70	.113	1.091
Valid N (listwise)	90			

These findings of all psychological cravings ranged from M=3.51 to M=3.96, indicating a generally high level of agreement in these sub-factors. This data highlights the significant role of alcohol cravings, social exposure to alcohol, and emotional triggers such as depression in contributing to relapses. Patracek (2023) explains that during cravings, people may experience a feeling of helplessness and be forced from outside to obtain and use the substance. Hence, the findings emphasize the need for targeted interventions that address both the psychological and social aspects of recovery to support sustained sobriety.

4.3.5 Alcohol Relapse

The data collected from 90 respondents provides insights into the perceived outcomes related to alcohol relapses, as summarized in Table 11.

Table 11:

Alcohol Relapse

	N	Mean		Std. Deviation
	Statistic	Statistic	Std. Error	Statistic
Experienced a significant reduction in feelings of regret and shame related to alcohol use.	90	3.04	.079	.765
Reduce levels of depression.	90	3.14	.058	.563
Better control over my alcohol use	90	3.10	.073	.708
Minimized the withdrawal symptoms	90	3.19	.080	.770
Valid N (listwise)	90			

The statement regarding experiencing a significant reduction in feelings of regret and shame related to alcohol use had a mean score of 3.04 with a standard deviation of 0.765, indicating a moderate level of agreement and relatively low variability in responses. The reduction in levels of depression had a slightly higher mean score of 3.14 and a lower standard deviation of 0.563. Better control over alcohol use after rehabilitation had a mean score of 3.10 and a standard deviation of 0.708 while minimization of withdrawal symptoms had the highest mean score of 3.19 and a standard deviation of 0.770. These results suggest that reduced levels of depression and better control of alcohol use were the key aspects in reducing alcohol relapse among the four included in this study. Reduced depression and better control methods for part of physio-social support intervention alcohol relapse interventions.

Existing literature supports these results, with numerous studies demonstrating the benefits of various interventions in recovery. For instance, participation in support groups has been shown to significantly improve emotional health (Gorski, 2007), while mindfulness-based interventions and cognitive-behavioural therapy have proven effective in enhancing emotional well-being and helping individuals gain control over their alcohol use (Berberich,2020). This finding provides new findings on effective and nonpharmaceutical methods of reducing alcohol relapse in rehabilitation and provides

further insights into the importance of social engagement and mental wellness in reducing alcohol relapse. Despite the challenges posed by relapse triggers, respondents also identified positive outcomes following rehabilitation that contributed to their recovery efforts. Participants reported moderate agreement (M= 3.04 to 3.19) regarding reductions in feelings of regret and shame, alleviation of depressive symptoms, improved control over alcohol use, and minimized withdrawal symptoms. The findings agree with findings by Brooks and McHenry, (2015) who formulated a multifaceted nature of recovery trajectories and the importance of recognizing and reinforcing positive outcomes in addiction treatment. Therefore, effective recovery programs should emphasize strengths-based approaches that enhance individuals' resilience and self-efficacy in maintaining sobriety.

4.4 Interpretation of Findings

The study sought to investigate the nature and strength of the relationship between alcohol relapses and its four predicting variables. A regression analysis was carried out with alcohol relapses (relapse score) as an independent variable. The influence of peers, the influence of intense psychological cravings, the influence of social occupancy, and the influence of psychological stress formed part of an independent variable. Table 12 summarizes the regression coefficients of the regression analysis.

Table 12:

Regression Coefficients

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	3.650	.391		9.339	.000
	Influence of peers	-.050	.081	-.076	-.626	.533
	Influence of Social Occupancy	-.017	.085	-.024	-.197	.845
	Influence of psychological stress	-.121	.120	-.179	-1.004	.318
	Intense psychological cravings	.039	.105	.067	.372	.711

a. Dependent Variable: Relapse Score

The intercept of the regression model, with an unstandardized coefficient of 3.650 and a standard error of 0.391, is statistically significant ($t = 9.339$, $p < 0.001$). This indicates that the baseline relapse score, when all independent variables are held at zero, is 3.650. The significant interception suggests that there could be other factors (not part of the ones included) contributing to the relapse score that is not captured by the independent variables in this model.

4.4.1 Findings on Influence of Peers on Alcohol Relapse

In line with the study objective one, which was to examine the influence of peers on alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya the following null hypothesis was formulated.

H_{01}: There is no statistically significant relationship between peer influence and alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

A regression analysis carried out suggests that there exists a weak, negative relationship between the influence of peers (β=-0.050, p=0.533) and alcohol relapses, which was insignificant. This suggests that there is insufficient evidence to reject the null hypothesis(H_{01}), which leads to the conclusion that there is no statistically significant relationship between peer influence and alcohol relapse among recovering alcoholic rehabilitees in selected rehabilitation centres in Meru County, Kenya.

Therefore, the presence of peers does not appear to significantly affect the likelihood of relapse in this study. However, the literature review underscores the profound impact of peers on the recovery journey. Studies by Majeke (2002), Swanepoel, et. al., (2016), and Kuria (2013) collectively argue that negative peer pressure, such as friends engaging in alcohol consumption, significantly heightens the risk of relapse. On the other hand, positive peer support systems, such as those found in recovery community programs, are seen as protective factors that enhance sobriety.

In recovery settings, supportive peer relationships can provide accountability and encouragement, which participants highlighted as vital to staying sober. From the focus groups, peer noted that,

"Positive peer influences were crucial. Being part of a recovery group where everyone was supportive helped me stay on track."

This sentiment reflects the beneficial role that recovery-focused peer groups play by creating a shared experience and mutual support network, which can anchor individuals through the challenges of recovery. Conversely, the respondents also revealed the risks of negative peer influence. As one respondent candidly stated,

"Being around friends who still drank heavily made it very hard to resist,"

This emphasizing how social circles that normalize alcohol use can counteract recovery efforts. Other participant echoed such sentiments, explaining that distancing from such social groups is often challenging but necessary, as peer dynamics in these circles tend to undermine progress toward sobriety. Such finding are best explained by *High-Risk Situations and Triggers* in Gorski's model which posits that certain high-risk situations, such as social gatherings or stressful work environments, significantly increase relapse risk. These qualitative insights suggest that the disconnect with quantitative findings may stem from the nature and context of peer relationships specific to Meru County.

Factors like the accessibility of structured recovery groups, the prevalence of social gatherings cantered on drinking, and cultural attitudes toward addiction may vary widely, impacting how peer influence operates in this region. Additionally, quantitative methods may fail to capture the intensity or subtlety of peer-related challenges faced by individuals in recovery.

While the regression analysis suggests no statistically significant relationship, the literature suggests that peer dynamics are critical in the recovery process. Hence, factors such as the nature of peer relationships, the context of the study, and the specific population sampled may contribute to these differences. The regression analysis may have been limited by a small sample size or specific demographic characteristics that do not capture the broader dynamics of peer influence. Additionally, Swanepoel, et. al., (2016), indicate that peer pressure can vary significantly depending on individual circumstances, such as prior experiences, social environments, and the presence of supportive recovery communities, which could significantly affect outcomes of different studies as witnessed in this case. These differences suggest that while peer influence is a critical factor in relapses, the specific dynamics and contexts of peer relationships need further exploration to understand their full impact on recovery outcomes.

4.4.2 Findings on Influence of Social Occupation on Alcohol Relapse

In response to the study objective two, which was to establish how social occupation influences relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya the second hypothesis was formulated which stated.

H_{02}: There is no statistically significant relationship between social occupation and alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

A multi-regression analysis summarized in Table 11 shows that the influence of social occupancy (β=-0.017, p= 0.845) had no significant relationship with alcohol relapses. This is because there was no sufficient evidence to reject the null hypothesis, H_{02}, which leads to a conclusion that there is no statistically significant relationship between social occupation and alcohol relapse among recovering alcoholic rehabilitees in selected rehabilitation centres in Meru County, Kenya. The negative coefficient between social occupation and alcohol suggests that an increase in social occupation helps in decreasing

alcohol relapse and hence such a relationship suggests that social occupancy can be used as an alcohol abuse strategy in rehabilitation centres.

Conversely, literature presents a contrasting view, asserting that social occupation is vital in influencing relapse risk. For instance, Lind (2021) highlights that factors related to one's job and social engagement can either contribute to relapsing through stress and unsupportive environments or promote recovery by providing structure and purpose. Additionally, Turner (2020) emphasizes that social occupations help create a routine that counters boredom and idleness, which can lead to relapse, while Ritvo (2023) discusses how meaningful social engagement can reduce feelings of loneliness and depression, thereby lowering relapse risk.

Qualitative findings, however, emphasize that social occupation and social occupation can significantly impact recovery. For many participants, employment or structured social activities provided a necessary routine and purpose, reinforcing their commitment to sobriety. A critical response from FGD shows a need for social engagement as a aid to relapse recovery as noted below;

> "A stable job provides structure and a sense of purpose, which helps rehabilitees stay focused on their recovery."

Such insights align with research that underscores the protective role of stable social occupation in maintaining recovery, as work can create a sense of responsibility and accomplishment that aids in sustaining sobriety.

Contrastingly, FGDs also noted that their;

> "..... job was very stressful and didn't offer any support, which contributed to my relapse,"

which highlighting how occupational stress without adequate support can erode recovery efforts. For others, job instability created additional challenges, as the lack of routine or financial security triggered stress that often led to relapse. This finding highlights a need of providing coping mechanism as suggested by Marlatt's Cognitive-Behavioural Model of Relapse Prevention (*provision of coping skills in high-risk situations*). According to the theory, lack of effective coping strategies in high-risk situations is a primary contributor to relapse. The qualitative data reflect this, with

participants reporting challenges in managing cravings and stress during critical moments. For instance, an interviewee stated,

"During high-stress situations, the urge to drink was overwhelming,"

This illustrated Marlatt's view that individuals need robust coping mechanisms to prevent lapses.

The divergence between the research (qualitative and quantitative) and literature findings stems from several factors. One potential reason is the specific context of the study (conducted in Meru County, Kenya), which may not fully reflect or greatly differ from the broader dynamics of social occupation as seen in other contexts of literature analysis. Also, unique sociocultural issues such perception on alcoholism and norms and connection of Meru people greatly differ from other world societies while the literature draws on a wider range of studies and theoretical frameworks. This underscores the importance of social connections and occupational engagement in recovery, suggesting that the differences witnessed may not have been captured in the regression analysis.

4.4.3 Findings on Influence of Psychological Stress on Alcohol Relapses

The following hypotheses was formulated from the third objective of the study which was to explore how psychological stress influences alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya. The hypotheses stated.

H_{03}: There is no statistically significant relationship between psychological stress and alcohol relapse among recovering rehabilitees in selected rehabilitation centres in Meru County, Kenya.

It was found out that psychological stress (β=-0.121, p=0.318) had no significant relationship with alcohol relapses. This means that that there was insufficient evidence to reject the null hypothesis and hence retained, leading to a conclusion that there is no statistically significant relationship between psychological stress and alcohol relapse among recovering alcoholic rehabilitees in selected rehabilitation centres in Meru County, Kenya. A negative coefficient suggests that any increase in psychological stress by one unit leads to a reduction in alcohol relapse by a factor of 0.121, suggesting a weak influence. This suggests that while psychological stress decreases the relapse score, this effect is not statistically significant.

However, the qualitative findings strongly indicate that psychological stress is a central trigger for relapse, revealing a disconnect between the statistical data and lived experiences of the participants. For many individuals, stress from personal, financial, or occupational sources was often the direct cause of their relapse. One respondent stated,

> "The pressure to meet deadlines and perform well at work caused immense stress, leading to my relapse."

Another shared,

> "Personal loss and grief were major stressors that led to my relapse. I found it hard to cope without alcohol."

The qualitative responses suggested that participants experiencing lapses felt discouraged and unsupported, which could exacerbate feelings of failure. This finding underlines the need for relapse-prevention programs to include training on positive self-attribution and strategies to manage minor lapses constructively, as Marlatt's model suggests.

These insights resonate with literature that consistently associates psychological stress with higher relapse risk. The literature findings highlight psychological stress as a significant factor contributing to alcohol relapse, especially in cases involving personal work, relationships, and financial issues. According to Kuria (2013) and Ritvo (2023), stress and depression are linked to alcohol dependence, both before and after rehabilitation, suggesting a stronger connection between stress and relapse than what the research in Meru County found. The literature further insists that stress significantly impacts alcohol relapse, with studies such as those by Brown, et. al., (2019) demonstrating that individuals with higher stress vulnerability are more likely to relapse. Brown's research also found out that poor coping mechanisms, low self-efficacy, and lack of social support are consistent predictors of relapse among recovering alcoholics facing severe stress contrary to study findings.

The differences in findings may stem from variations in the study populations, methodologies, and variation study in stress definition which may not be consistent with population characteristics of rehabilitees in Meru County, which could lead to an underestimation of the impact of psychological stress on relapse rates. Additionally, the methodologies employed in the studies may differ; for instance, the literature reviews

such as Brown, et.al., (2019) include qualitative assessments and longitudinal studies that capture the complexities of stress and relapse over time, while these findings solely rely on quantitative measures that do not fully address the variation in psychological stress. The contrast between quantitative and qualitative findings could also stem from the variance in how stress is experienced and defined across different individuals and contexts. Quantitative metrics may fail to account for the intensity or recurrence of stressors, especially in populations where stress management resources are scarce. Further, cultural factors in Meru County may influence how stress is perceived and managed, potentially affecting the relationship between stress and relapse in ways that are not captured in the existing literature.

4.4.4 Findings on Influence of Intense Psychological Cravings on Alcohol Relapse

The analysis showed that intense psychological cravings (β=0.039, p=0.711) has no significant relationship with alcohol relapse among the recovering alcohol rehabilitees. Such findings show that there was not enough evidence to reject the null hypothesis, H04, which is retained. This leads to a conclusion that there is no statistically significant relationship between psychological alcohol cravings and alcohol relapse among recovering alcoholic rehabilitees in selected rehabilitation centres in Meru County, Kenya. However, weak and positive coefficient between psychological cravings and alcohol relapse suggest linear relations showing that intense craving leads to increase in alcohol relapse.

Despite this finding, qualitative responses emphasized that cravings play a critical role in relapses, with many participants describing cravings as overwhelming and difficult to control. For example, respondents from the FGD explained that they,

"…. experienced intense cravings after treatment, especially when alone or stressed."

These cravings were described as intense, persistent, and mentally consuming, making it challenging for individuals to focus on recovery efforts. Respondents from focus groups further shared that craving often became more pronounced during high-stress situations or in environments where alcohol was present. One respondent explained that,

"…. During high-stress situations, the urge to drink was overwhelming,"

This suggests that without effective coping strategies, cravings could easily lead to relapses; implies that cravings might fluctuate in intensity based on contextual factors, a complexity that quantitative measures might not capture fully. From Gorski theory, there is a need of identifying early warning signs, which often include increased stress or cravings that can escalate into a relapse if unaddressed. In the qualitative responses, participants mentioned feeling "overwhelmed by intense cravings," especially when alone or under pressure, which resonates with Gorski's view that cravings are a critical warning sign. This model, therefore, helps contextualize the impact of cravings and stressors, highlighting the importance of monitoring these early signs in recovery.

While the research findings suggest a weak positive correlation between cravings and relapse, ultimately, significant relationships are not supported. In contrast, the literature findings emphasize that intense psychological cravings are a significant contributor to alcohol relapse. Patracek (2023) highlights that craving, often triggered by cues related to past alcohol use, can lead individuals to relapse, especially those who have recently quit and lack coping mechanisms. Luke (2019) also supports this by explaining how neurological changes and psychological triggers, such as stress and anxiety, exacerbate cravings, increasing the risk of relapse. The literature further stresses the importance of addressing cravings through various interventions. Brooks and McHenry (2015) argue that social and environmental influences, as well as the lack of effective coping strategies, can intensify cravings, making relapse more likely and recommends a detailed relapse prevention plans, professional help, and support systems to manage cravings effectively. Turner (2020) also suggests evidence-based treatments like cognitive behavioural therapy (CBT) and aftercare support groups to help individuals resist cravings and maintain sobriety.

The differences between the research and literature findings stems from various factors such as demographic information and treatments of the psychological craving for this study and other research findings in literature .For instance Brooks and McHenry(2015) isn't confined to any group or population, it considers broad group of people as opposed to the study which is confined to Meru County and probably among people of Meru ethnic diversity .In regions like Meru County, where rehabilitation resources might lack personalized craving-management interventions, these challenges can be even more pronounced, underscoring the need for structured, evidence-based craving management and coping mechanisms within recovery programs.

Additionally, the literature by Turner (2020) and Patracek (2023), (which are books) consists of wide ranges a wider range of studies and perspectives, which may include diverse populations and settings, thus presenting a more comprehensive view of the relationship between cravings and relapse. Furthermore, this research didn't account for other psychological or social factors that can influence cravings, such as stress or lack of coping mechanisms, which are emphasized in literature.

From the above findings, the model governing the relationship between alcohol relapses and the four independent variables (influence of peers, the influence of intense psychological cravings, the influence of social occupancy, and the influence of psychological stress can be represented as.

$$Y=3.650 -0.050X_1-0.017X_2 -0.121X_3+0.039X_4.$$

Where,

- Y is the relapse score
- X_1, X_2, X_3, and X_4 represent the influence of peers, the influence of intense psychological cravings, the influence of social occupancy, and the influence of psychological stress respectively.

4.5 Conclusion Summary

In this discussion, several sets of descriptive statistics and regression analysis results related to factors influencing alcohol relapse among a sample of 90 respondents. The descriptive statistics reveal moderate to strong levels of agreement among respondents on various factors contributing to alcohol relapse. Social influences, such as hanging out with friends who abused alcohol and lack of support, had notable impacts, with mean scores ranging from 3.30 to 3.57. Work-related stressors like workplace stress, financial instability, and boredom due to free time also showed moderate agreement, with mean scores from 3.12 to 3.34. Emotional and psychological factors, including stress, feeling overwhelmed, poor stress responses, and likelihood of drinking when stressed, had high levels of agreement, with mean scores from 3.54 to 3.92, indicating significant contributions to relapse. Triggers such as alcohol cravings post-rehabilitation, seeing friends drink, experiencing depression, and exposure to alcohol by friends had mean scores ranging from 3.51 to 3.96, highlighting their strong influence. Positive outcomes

post-rehabilitation, like reduced feelings of regret and shame, reduced depression levels, better control over alcohol use, and minimized withdrawal symptoms, had mean scores from 3.04 to 3.19, showing moderate agreement on these beneficial effects.

The regression analysis, however, indicated that none of the assessed variables (influence of peers, social occupancy, psychological stress, and psychological cravings) had statistically significant effects on the relapse score. The significant intercept ($\beta = 3.650$, $p < 0.001$) suggests that other factors not included in the model might better explain the variations in relapse scores. This comprehensive analysis underscores the complexity of relapse triggers and highlights the need for a multifaceted approach in addressing and supporting recovery efforts, as well as the importance of considering additional variables that may influence relapse outcomes.

Qualitative surveys and focus groups reveal the dual role of peer influence in alcohol addiction recovery. While positive peer support in recovery groups and mentorship provides accountability and encouragement, negative peer influences, such as social circles that normalize alcohol consumption, significantly contribute to high relapse rates. Respondents highlighted that peer relationships play a crucial role in either supporting or hindering recovery efforts. Furthermore, the intense psychological cravings experienced during recovery can be overwhelming and persistent, often leading individuals to relapse. Effective behavioural strategies, support systems, and accessible therapy options are essential to help manage these cravings and maintain sobriety.

The social and occupational environment also significantly impacts recovery outcomes. Stable employment and supportive social networks act as protective factors, while stressful and unsupportive work environments contribute to relapse. Additionally, social gatherings where alcohol is present pose significant challenges for rehabilitees. Effective stress management skills are critical as psychological stress is a major trigger for relapses. Addressing underlying psychological issues, such as anxiety and depression, is essential for sustained recovery. Comprehensive treatment programs should integrate mental health support and provide customized relapse prevention plans, including follow-up sessions and well-rounded aftercare programs, to address the multifaceted nature of alcohol addiction recovery.

CHAPTER FIVE:
SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter builds from the research findings to draw conclusion and summary findings. It synthesizes and interprets the findings from a study exploring various factors influencing alcohol relapses among a sample of 90 respondents. Further, the research aimed to deepen understanding of the complex interplay between social, psychological, and environmental factors in shaping relapse behaviours by revisiting the research questions, presents a comprehensive analysis of the results, discusses their implications for theory and practice, and outlines recommendations for future research.

5.1 Summary of Key Findings.

5.1.1 Relationship between Peer Influence and Alcohol Relapse

The regression analysis failed to show a statistical significance influence between relapse and influence of peers which aligned to qualitative dual findings suggesting that negative peer influences, such as social circles that normalize alcohol consumption, significantly contribute to high relapse rates. Literature analysis contrasts the study findings on the influence of peers in relapsed context, which is attributed to several factors. This shows that even if peer influence contributes to relapses, lack of secondary support could increase relapses, which calls for composite understanding of influence of peers and other confounding variables.

5.1.2 Relationship Between Social Occupation and Alcohol relapse

The study showed that there existed an insignificant relationship between social occupation and alcohol relapses, which was not consistent with literature analysis and findings from focus groups and literature analysis. The literature review, key informant interviews and focus groups suggest that social and occupational environment significantly affects recovery outcomes, especially for stable employment and supportive social networks which were viewed as protective factors

However, not all occupational environments are supportive, which helps explain why such variation existed.

5.1.3 Influence of Psychological Stress on Triggering Alcohol Relapse

Analysis of the relationship between psychological stress and alcohol relapse suggest that there existed no significant relationship between them among the recovering alcohol rehabilitees in Meru County, Kenya; a finding which greatly contradicted literature analysis and key finding from qualitative analysis. Most respondents in the interview

key informants and focus group discussion suggested that psychological stress is a major cue for relapses and suggests that development of good stress management skills is critical to the maintenance of sobriety. Such differences are attributed to differences in study design and study definition of psychological stress as well as study population covered by the study. Future research should explore longitudinal designs to explain why such variations in relationships existed and the dynamic interplay of factors that influence trajectories over time.

5.1.4 Influence of Intense Psychological Craving on Alcohol Relapse

A multivariate regression failed to establish any significant relationship between alcohol relapses and intense psychological cravings among the studies sample. Contrastingly, qualitative findings from key informant and focus group interviews suggested that neurological changes and psychological triggers, such as stress and anxiety, exacerbate cravings, increasing the risk of relapse, which was consistent with literature review findings .This shows that qualitative analysis and literature agreed , while regression finds sharply contrasted the findings ;suggesting possible interplay of other confounding effects , study designed and operational differences between literature analysis and regression analysis involved in this study.

5.2 Conclusion

The findings of this study contradict the existing literature on addiction and relapses, creating a new context for future analysis. Most of the previous studies and qualitative findings consistently highlighted the multifactorial nature of relapse triggers, emphasizing the roles of social influences, stressors, emotional states, and environmental cues in shaping substance use behaviours. However, the non-significant results in the regression analysis contribute to new insights by challenging simplistic causal relationships and advocating for comprehensive, person-cantered approaches in addiction treatment.

The discrepancy between perceived influences and statistically significant predictors observed in this study underscores the need for diverse interpretations and targeted interventions tailored to individual needs and contexts. Effective addiction interventions should consider the complex interactions between biological, psychological, social, and environmental factors influencing relapse risk. By integrating findings from this study with evidence-based practices, clinicians and policymakers can enhance treatment efficacy and promote long-term recovery outcomes.

5.3 Recommendations

Based on the key findings from the study, the complex interplay of psychosocial factors such as peer influence, social occupation, psychological stress, and psychological cravings play a crucial role in alcohol relapses. While quantitative and qualitative analyses sometimes yielded differing results, the overall insights highlight the need for targeted interventions and further exploration into these areas. The following recommendations are designed to address the gaps identified in the study, providing a framework for both policy improvements and future research efforts aimed at reducing alcohol relapse rates and enhancing the effectiveness of rehabilitation programs.

5.3.1 Policy Recommendations

1. Integrated Peer Support Programs: Although the study's quantitative findings show no statistical significance between peer influence and alcohol relapse, its qualitative findings suggest that negative peer influence remains a substantial factor. Therefore, policies should support the development of peer-based recovery programs that encourage positive social circles and provide secondary support to those at risk of relapse. Community-based support groups, mentorship programs, and structured peer networks could offer recovering individuals a stable environment to counteract negative peer pressure.

2. Employment-Based Rehabilitation Support: Since literature review and focus group discussions indicate that stable employment and supportive social networks act as protective factors, policies should focus on creating employment programs for recovering individuals. Initiatives could include job training, skills development, and partnerships with employers who provide supportive occupational environments. Such programs should target casual workers and individuals transitioning from rehabilitation, ensuring they have access to stable, supportive workplaces.

3. Psychological Stress Management Interventions: Given that qualitative findings highlight the significant role psychological stress plays in alcohol relapse, stress management programs should be incorporated into rehabilitation processes. Policies should mandate integrating mental health services, including counselling and stress management workshops, as part of comprehensive

rehabilitation programs. These interventions would equip individuals with the skills needed to navigate stressors and reduce the risk of relapses.

4. Craving Management and Neurological Support: Although multivariate regression did not establish a link between intense psychological cravings and relapses, qualitative data suggests cravings are a significant risk factor. Rehabilitation centres should incorporate neurological and psychological craving management strategies, such as mindfulness, cognitive-behavioural therapy (CBT), and medication-assisted treatments (MAT), to help individuals manage cravings more effectively. Policy initiatives should ensure funding and support for these evidence-based practices.

5. Holistic Rehabilitation Approaches: The study's mixed results across quantitative and qualitative analyses suggest a need for more holistic approaches in rehabilitation policy. Rehabilitation programs should consider not only individual factors like peer influence, occupation, stress, and the broader context, including social, psychological, and environmental variables. Policies should support research-based, multifaceted approaches to treatment that address the diverse factors contributing to relapse.

5.3.2 Recommendations for Further Research

1. Longitudinal Studies on Peer Influence: Further research should explore the long-term impact of peer influence on alcohol relapses using longitudinal designs. This approach would allow researchers to understand better the complex relationship between peer networks, recovery, and relapses, especially considering positive and negative peer influences.

2. Occupational Environment and Recovery Outcomes: Future research should investigate the role of different occupational environments in recovery outcomes. This research could identify which types of work environments are most conducive to long-term sobriety, providing valuable insights for designing employment support programs for recovering alcoholics.

3. Comprehensive Study on Psychological Stress and Alcohol Relapse: Given the contradictory findings between the study's quantitative analysis and literature on the role of psychological stress, future research should employ comprehensive and more refined definitions of stress. Studies should examine the dynamic

interplay between stress, coping mechanisms, and alcohol use over time, using larger sample sizes and diverse study populations to better capture these relationships.

4. Research on Craving and Neurological Interventions: Given the strong qualitative evidence for the role of cravings in relapse, future research should explore the neurological and psychological mechanisms behind cravings. Studies should focus on how cravings trigger relapses and the effectiveness of various interventions in managing them, potentially offering insights into more tailored craving management strategies in rehabilitation.

5. Mixed-Methods Research to Reconcile Differences: Future studies should use mixed-method approaches to bridge the gap between quantitative and qualitative findings. This could help reconcile the inconsistencies observed in peer influence, psychological stress, and cravings, offering a more nuanced understanding of the factors that contribute to relapse. Longitudinal and mixed-methods designs would be particularly useful in uncovering the interactions between social, psychological, and environmental variables over time.

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APPENDICES

Appendix I: Letter of Introduction

Dear respondent,

Re: Research

I am a student at Tharaka University pursuing a master's degree in counselling psychology. The university expects me to submit a research project to fulfil the degree requirement partially.

To fulfil this requirement, I have decided to carry out a study on Psychosocial Factors Contributing to Relapse among Alcoholic Rehabilitees in Selected Rehabilitation Centres in Meru County, Kenya.

Please complete the attached questionnaire to the best of your knowledge. The information provided will be treated with utmost confidentiality and used only for academic purposes.

Please do not indicate your name or any other identifying information when participating in this study. I highly appreciate your participation in its success. Thank you in advance for your kind participation.

Sincerely Yours,

Kelvin Mwega

AMT230569122

Appendix II: Institutions (Rehabilitation Centres) Consent Form

Dear Sir/Madam

RE: REQUEST TO DO RESEARCH IN YOUR INSTITUTION

I am Kelvin Mwega, a postgraduate student pursuing a Master degree in Counselling Psychology at Tharaka University admission AMT23/05691/22. I am writing to request permission to conduct research within your esteemed rehabilitation facility on **PSYCHOSOCIAL FACTORS CONTRIBUTING TO RELAPSE AMONG ALCOHOLIC REHABILITEES IN SELECTED REHABILITATION CENTERS IN MERU COUNTY, KENYA.**

This study aims to provide valuable insights into relapse dynamics, especially on the psychosocial aspects that contribute to relapse, potentially informing improvements to rehabilitation centre programs. The research will be conducted ethically, with utmost respect for respondent privacy and your institution's rules and regulations. If approved, I am committed to collaborating closely with your administration and other staff to minimize disruptions.

I can provide further details and discuss these research requirements at your convenience. Thank you for considering my request; I look forward to the possibility of collaborating with your institution to conduct the research.

Sincerely,

Kelvin Mwega

Master degree in Counselling Psychology

Tharaka University

Appendix III: Respondent Informed Consent Form

Title: PSYCHOSOCIAL FACTORS CONTRIBUTING TO RELAPSE AMONG RECOVERING ALCOHOLIC REHABILITEES.

Student: Kelvin Mwega Murithi

University: Tharaka University

Course: master's in counselling psychology.

Introduction:

Thank you for considering participating in this research study. This form provides information about the study's purpose, procedures, risks, benefits, and your rights as a participant. Please read this form carefully, and feel free to ask any questions before deciding on your participation.

Purpose:

The main purpose of this study is to investigate psychosocial factors contributing to relapse among recovering alcoholics rehabilitees undergoing rehabilitation treatment for the second time or more after a relapse in Meru County, Kenya.

Procedures:

If you agree to participate, you will be asked to complete questionnaires and potentially engage in interviews or discussions about your experiences before relapse. Your participation is entirely voluntary, and you can withdraw at any time without explanations.

Risks and Benefits:

There are minimal risks associated with this study, such as potential discomfort in discussing personal experiences that might have contributed to your relapse. The benefits include contributing valuable insights to the understanding of relapse among recovering individuals and potentially benefiting future rehabilitation programs to focus on better relapse prevention strategies.

Confidentiality:

Your privacy is important. Your identity will be kept confidential to the researcher. Data will be anonymized, and only authorized personnel will have access.

Voluntary Participation:

Your participation is voluntary, and you can withdraw at any time without explanation. Your decision and participation will not affect your current or future care at this rehabilitation facility.

Contact Information:

If you have any questions about the study or your rights as a participant, please contact Kelvin Mwega at 0743435975

Consent:

I have read and understood the information provided in this consent form. I agree to participate voluntarily in this study.

Please tick one.

YES () **NO ( )**

Appendix IV: Respondent Questionnaires

The researcher is a master's student taking Counselling Psychology at Tharaka University researching "Psychosocial factors contributing to alcohol relapse among recovering alcoholic rehabilitees in Meru County, Kenya." This is to kindly request you to tick or fill in blank spaceswith your most suitable answer or response. The information provided will be treated with confidence and only used for academics.

Section A. Demographic information

A. Gender:

(i) Male [ ]

(ii) Female [ ]

(iii) Other ----------

B. Marital status:

(i) Married ( )

(ii) Single ( )

(iii) Divorced ( )

(iv) Separated ( )

C. Occupation:

(i) Public Servant ( )

(ii) Private Formal Worker ( )

(iii) Casual worker ( )

(iv) Business person ( )

(v) Other (s) specify----------
-

D. Academic qualification:

(i) Degree ( )

(ii) Secondary ( )

(iii) Other(s) specify……

E. Have you been treated previously in a rehabilitation centre and relapsed?

Yes ( ) No ( )

SECTION B: Questions.

(Please react to these statements by indicating whether you strongly agree, Agree, or Disagree.

Alternatively, I strongly disagree with the following factors?)

INFLUENCE OF PEERS ON ALCOHOL RELAPSE AMONG RECOVERING ALCOHOLIC

Influences of Peers on Alcohol Relapse	**5 Strongly Agree**	**4 Agree**	**3 Neutral**	**2 Disagree**	**1 Strongly Disagree**
I feel that hanging out with friends who abused alcohol contributed to my relapse.					
Being away from my friends contributed to my relapse.					
I feel participating in the 12-step programs of AA could have sustained my sobriety.					
Lack of support from my friends led to my relapse.					

INFLUENCE OF SOCIAL OCCUPATION AND ALCOHOL RELAPSE

Influence of Social Occupation.	**5 Strongly Agree**	**4 Agree**	**3 Neutral**	**2 Disagree**	**1 Strongly Disagree**
I felt stressed at my workplace contributing to my relapse.					
Lack of work contributed to my relapse.					
I feel financial instability contributed to my relapse.					
Boredom because of free time I had contributed to my alcohol relapse.					

INFLUENCE OF PSYCHOLOGICAL STRESS ON ALCOHOL RELAPSE

Influence of Psychological Stress.	**5 Strongly Agree**	**4 Agree**	**3 Neutral**	**2 Disagree**	**1 Strongly Disagree**
I felt stressed before my alcohol relapse.					
Feeling overwhelmed led to my relapse.					
Poor stress response led to my relapse.					
I am more likely to drink again when I feel stressed.					

INFLUENCE OF INTENSE PSYCHOLOGICAL CRAVINGS AND ALCOHOL RELAPSE

Intense Psychological Cravings.	**5 Strongly Agree**	**4 Agree**	**3 Neutral**	**2 Disagree**	**1 Strongly Disagree**
Alcohol cravings after my rehabilitation program contributed to my relapse.					
Seeing friends drink alcohol made my cravings stronger, which led to my relapse.					
I experienced some depression levers that triggered my alcohol cravings.					
Exposure to alcohol by friends who used it triggered my cravings, which led to my relapse.					

Other Issues Related to Relapse

1. Since participating in the rehabilitation program, I have experienced a significant reduction in feelings of regret and shame related to my alcohol use.

   Strongly Disagree

   Disagree

   Neutral

   Agree

   Strongly Agree

2. The rehabilitation program has helped me reduce my levels of anxiety and depression.

   Strongly Disagree

   Disagree

   Neutral

   Agree

   Strongly Agree

3. I feel that I have better control over my alcohol use since starting the rehabilitation program.

   Strongly Disagree

   Disagree

   Neutral

   Agree

   Strongly Agree

4. The rehabilitation program has effectively minimized the withdrawal symptoms I experience.

    Strongly Disagree

    Disagree

    Neutral

    Agree

    Strongly Agree

Appendix V: Focus Group Discussions Guide questions

Each participant briefly shared their experience with alcohol rehabilitation, highlighting key challenges and successes

Share with group members how your social occupation situation might have influenced your relapse

Did you experience psychological stress before your relapse? Kindly share the situation.

To what extent have peer influences affected your recovery process? Tell me about it.

Have you experienced any intense cravings to engage in alcohol abuse after your previous treatment? If so, say something about it.

Reflecting on your rehabilitation experience, what aspects of the treatment program were particularly helpful or lacking in addressing psychosocial factors that lead to relapse?

Based on your experiences, what strategies could be effective in preventing relapse?

Appendix VI: Key Informant Interview Guide

i. Can you describe your observations or experiences regarding the influence of peer relationships on alcohol relapse among rehabilitees? How significant do you perceive peer influence to be in the context of relapse prevention?

ii. In your opinion, how does social occupation or employment status impact the likelihood of alcohol relapse among rehabilitees? Can you provide examples or instances where social occupation has facilitated or hindered relapse prevention efforts?

iii. From your perspective, what role does psychological stress play in triggering alcohol relapse among rehabilitees? How do rehabilitees typically cope with psychological stressors during their recovery journey?

iv. Can you describe the intensity and nature of psychological cravings experienced by rehabilitees during their recovery process? How do rehabilitees manage or cope with intense psychological cravings to prevent relapse?

v. Based on your experience and insights, what support systems or interventions do you believe are most effective in addressing psychosocial factors and preventing alcohol relapse among rehabilitees? Are there any specific recommendations you would propose to enhance relapse prevention strategies in rehabilitation centres?

Appendix VII: Maps

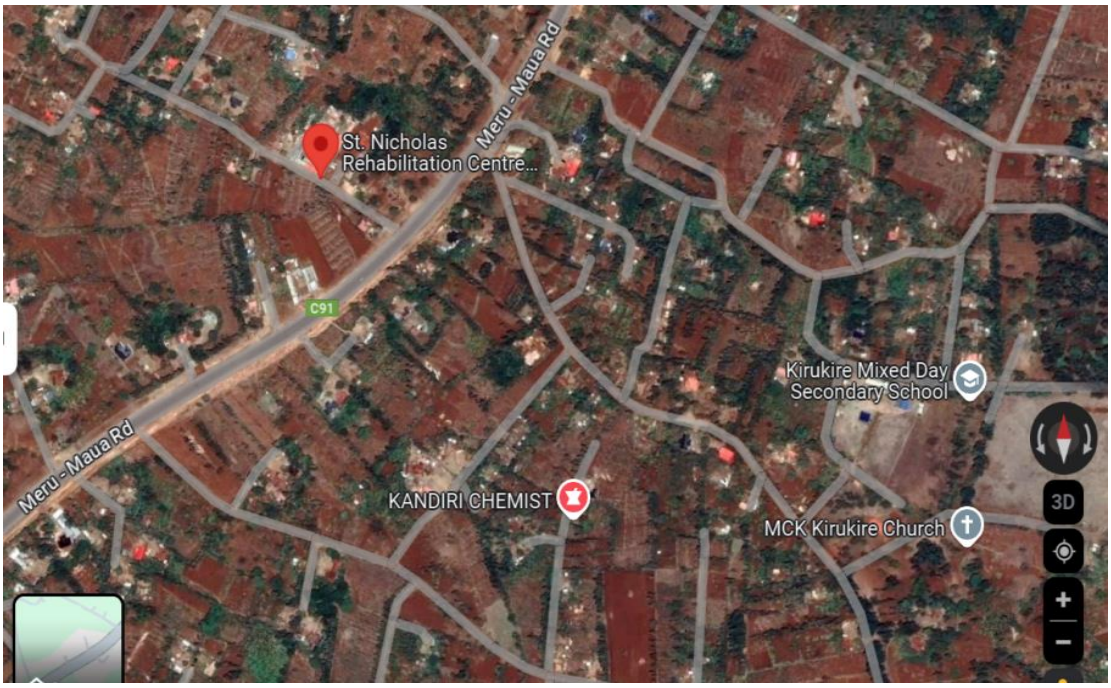

Figure 7: Map of St. Nicholas Rehabilitation Centre in Kianjai

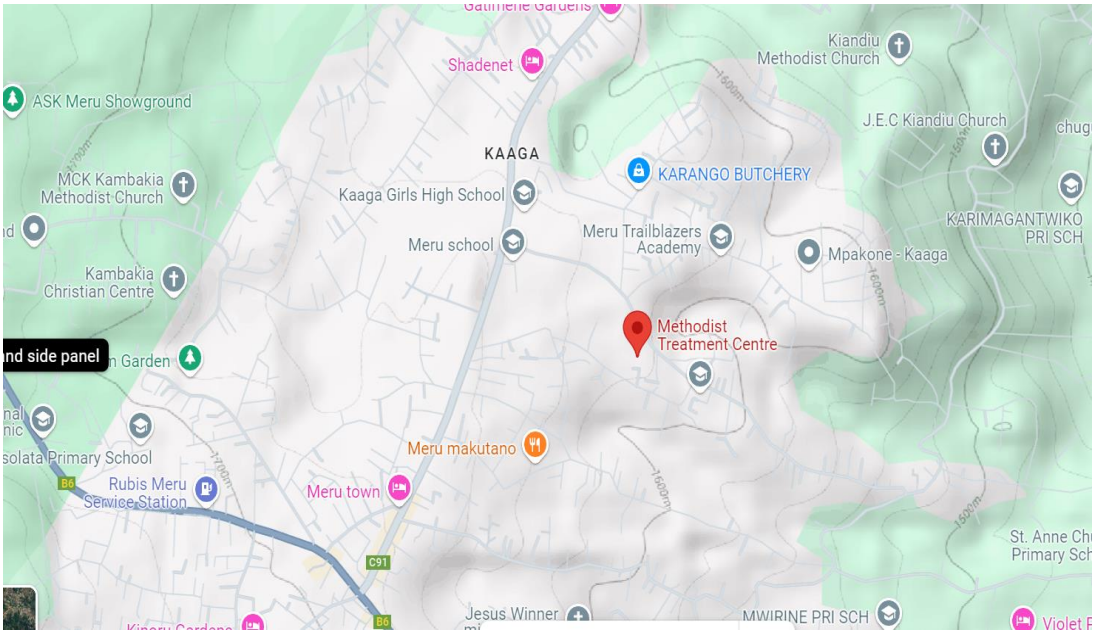

Figure 8: Map of Methodist Treatment Centre in Kaaga

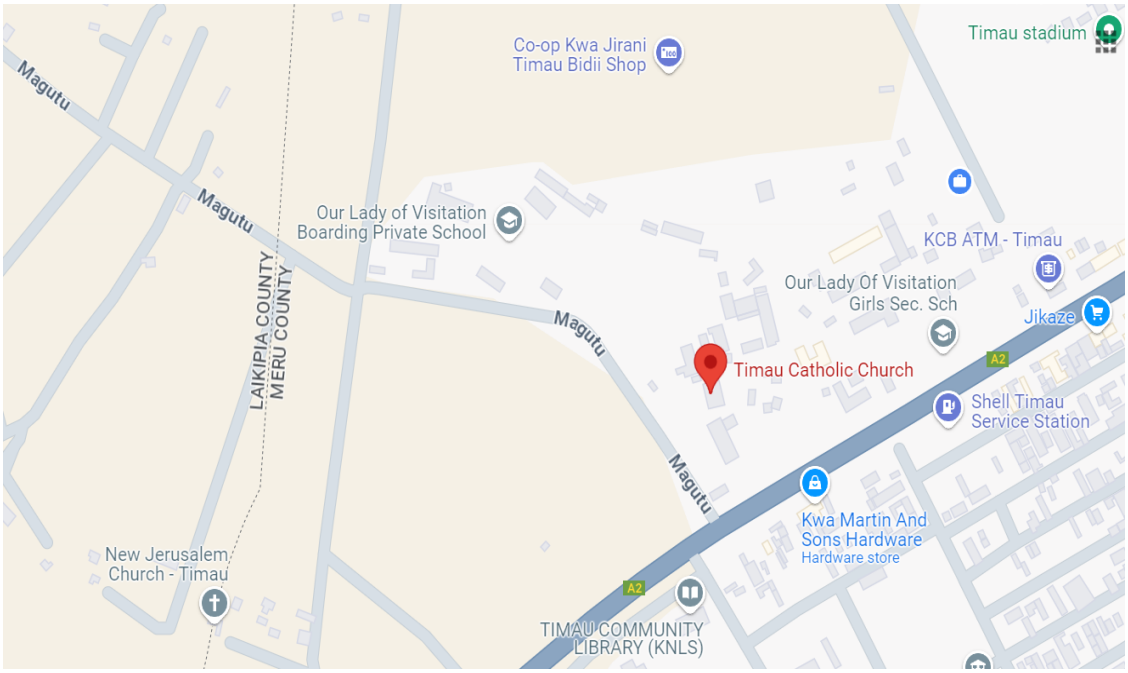

Figure 9: Holy Innocents BPSS Centre Timau

Appendix VIII: Tharaka University Postgraduate Introductory letter

THARAKA UNIVERSITY

P.O BOX 193-60215,
MARIMANTI, KENYA

Telephone: +(254)-0202008549
Website: https://tharaka.ac.ke
Social Media: tharakauni
Email: info@tharaka.ac.ke

OFFICE OF THE DIRECTOR
BOARD OF POSTGRADUATE STUDIES

Ref: TUN/BPGS/PL/08/24 **1st August, 2024**

To Whom it May Concern

Dear Sir/Madam,

RE: MURITHI KELVIN MWEGA ADMISSION NO. AMT23/05691/22

Mr. Murithi Kelvin Mwega is a postgraduate student at Tharaka University undertaking a Master's degree in **Counselling Psychology** The student has completed his coursework and expected to proceed for collection of data having successfully defended his proposal at the faculty level. The title of the study is, '***Psychosocial Factors Contributing to Relapse among Alcoholic Rehabilitees in Selected Rehabilitation Centres in Meru County, Kenya.***' The proposed study will be carried out in **Meru County**.

Any assistance accorded to him will be highly appreciated.

Thank you in advance.

THARAKA UNIVERSITY
DIRECTOR BOARD OF POST GRADUATE STUDIES
01 AUG 2024
P. O. Box 193-60215
MARIMANTI, KENYA

Yours Faithfully,

Dr. Ambrose K. Vengi, Ph.D.
Director
Board of Postgraduate Studies

Appendix IX: Tharaka University Ethics Committee letter

THARAKA UNIVERSITY

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INSTITUTIONAL SCIENTIFIC ETHICS REVIEW COMMITTEE

1st August, 2024

REF: TUNISERC/NSEC/M0020

Dear, Murithi Kelvin Mwega,

RE: Psychosocial Factors Contributing to Relapse among Alcoholic Rehabilitees in Selected Rehabilitation Centres in Meru County, Kenya.

This is to inform you that ***Tharaka University ISERC*** has reviewed and approved your above research proposal. Your application approval number is ***ISERC04023.*** The approval period is **1st August, 2024 – 1st August, 2025.**

This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by ***Tharaka University ISERC.***
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to ***Tharaka University ISERC*** within 72 hours of notification
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to ***Tharaka University ISERC*** within 72 hours
v. Clearance for export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to ***Tharaka University ISERC.***

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://research-portal.nacosti.go.ke and also obtain other clearances needed.

Yours Sincerely,

Dr. Fidelis Ngugi
Chair, ISERC Tharaka University

Appendix X: NACOSTI Research Permit.

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **375036**

Date of Issue: **16/July/2024**

RESEARCH LICENSE

This is to Certify that Mr.. KELVIN MWEGA MURITHI of Tharaka University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Meru on the topic: PSYCHOSOCIAL FACTORS CONTRIBUTING TO RELAPSE AMONG ALCOHOLIC REHABILITEES IN SELECTED REHABILITATION CENTERS IN MERU COUNTY, KENYA for the period ending : 16/July/2025.

License No: **NACOSTI/P/24/37771**

375036

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions