EFFECTIVENESS OF CARE SUPPORT GROUPS IN MAINTAINING SOBRIETY AMONG PEOPLE RECOVERING FROM ALCOHOL ABUSE IN REHABILITATION CENTRES IN SELECTED COUNTIES IN KENYA

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Declaration

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

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Table of Contents

DECLARATION ..... **ii**

TABLE OF CONTENTS ..... **iii**

DEDICATION ..... **ix**

ACKNOWLEDGMENTS ..... **x**

ABSTRACT ..... **xi**

LIST OF TABLES ..... **xii**

LIST OF FIGURES ..... **xiv**

ABBREVIATIONS AND ACRONYMS ..... **xv**

OPERATIONAL DEFINITION OF TERMS ..... **xvi**

CHAPTER ONE: INTRODUCTION AND BACKGROUND TO THE STUDY . **1**

Introduction 1

Background to the Study 1

Statement of the Problem 5

Purpose of the Study 7

Specific Objectives 7

Research Questions 7

Assumptions of Study 8

Justification of the Study 9

Significance of the Study 10

Scope of Study 11

Limitations of the Study 12

Delimitations of the Study 14

Chapter Summary 14

CHAPTER TWO: LITERATURE REVIEW **15**

Introduction 15

Care Support Groups 15
Empirical Literature Review 18
Benefits of Care Support Groups in Sustaining Sobriety 18
Factors Influencing Alcohol Addicts to Seek Support 25
Challenges Faced by Alcohol Addicts in Support Groups 33
Strategies Employed by Care Support Groups 35
Theoretical Framework 38
Cognitive Behavioral Theory (CBT) 38
Motivational Enhancement Model (MET) 41
Conceptual Framework 43
Research Gap Synthesis 46
Benefits of Care Support Groups. 46
Factors Influencing Support-Seeking Behavior 47
Challenges in Support Group Participation 47
Strategies for Promoting Long-Term Sobriety 48
Chapter Summary 48
CHAPTER THREE: RESEARCH METHODOLOGY 50
Introduction 50
Research Design 50
Target Population 51
Sampling Method and Sample Size 52
Types of Data 54
Research Instruments 54
Questionnaire 55
Interview Guide 56
Pilot Testing 57

Validity and Reliability of the Instruments 58
Trustworthiness of Qualitative Data 59
Data Collection Procedure 60
Data Analysis Plan 60
Quantitative Data Analysis 61
Qualitative Data Analysis 62
Data Integration 62
Ethical Considerations 63
Chapter Summary 64
CHAPTER FOUR: RESULTS AND DISCUSSIONS 66
Introduction 66
Response Rate and Demographic Analysis 66
Response Rate 66
Reliability of the Research Instrument 67
Gender Distribution 68
Age Distribution 69
Education Level 70
Employment Status 72
Duration in Rehabilitation Program 73
Previous Addiction Treatment Experience 74
Primary Substance of Addiction 75
Benefits of Care Support Groups in Sustaining Sobriety 76
Emotional Healing and Psychological Safety 79
Peer Validation and Shared Understanding 82
Personal Transformation and Recovery Identity 85
Correlation between Benefits of Care Support Groups and Sobriety

Maintenance 91

Regression Analysis: Benefits Predicting Sobriety Maintenance 93

Factors Influencing Alcohol Addicts to Seek Support at Care Groups 97

Personal Crisis and Readiness to Change 100

External Support Systems Influence 102

Desire for Personal Transformation 104

Correlation between Influencing Factors and Sobriety Maintenance 105

Regression Analysis: Influencing Factors Predicting Sobriety Maintenance 107

Challenges Faced by People Recovering from Alcohol Abuse Attending Care Support Groups 110

Feelings of Shame, Vulnerability and Judgment 112

Disruptive Group Dynamics and Poor Facilitation 113

Resource and Funding Constraints 114

Strategies Employed by Care Support Groups to Promote Long-Term Sobriety 115

Cognitive-Behavioral Skill Building 118

Peer Mentorship and Accountability 119

Structured Goal-Setting and Monitoring 121

Relapse Prevention Planning 122

Correlation between Strategies Employed and Sobriety Maintenance 123

Regression Analysis: Strategies Predicting Sobriety Maintenance 125

Sobriety Maintenance Outcomes 129

Strengthened Determination and Resilience 131

Accountability Mechanisms Supporting Sustained Sobriety 132

Goal Reinforcement and Progress Celebration 133

Chapter Summary 136

CHAPTER FIVE: SUMMARY OF FINDINGS, RECOMMENDATIONS, AREAS FOR FURTHER RESEARCH AND CONCLUSIONS 137

Introduction 137
Summary of Key Results 137
Benefits of Care Support Groups 137
Factors Influencing Support-Seeking 139
Challenges Faced by Participants 140
Strategies Employed by Support Groups 141
Sobriety Maintenance Outcomes 143
Implications 143
Conclusions 146
Recommendations 148
NACADA 148
Rehabilitation Centre Administrators 148
Addiction Counselors and Therapists 148
County Health Departments in Mombasa, Kiambu, and Lamu 149
Family Members and Community Support Systems 149
Areas for Further Research 149
REFERENCES 151
APPENDICES 169
APPENDIX I: INFORMED CONSENT FORM 169
APPENDIX II: QUESTIONNAIRE 171
APPENDIX III: INTERVIEW GUIDE FOR ALCOHOL ADDICTION SUPPORT GROUP PARTICIPANTS 176
APPENDIX IV: INTRODUCTION LETTER FROM PAC 178
APPENDIX V: RESEARCH PERMIT NACOSTI 179
APPENDIX VI: RESEARCH AUTHORIZATION FROM KENYA AMANI ACRES REHABILITATION CENTER 180
APPENDIX VII: RESEARCH AUTHORIZATION FROM LAMU

REHABILITATION CENTER 181

APPENDIX VIII: RESEARCH AUTHORIZATION FROM SERENE HOSPITAL AND REHABILITATION CENTER 182

Dedication

This thesis is dedicated to my beloved family for their unwavering support, patience, and love that have been a source of strength throughout this academic journey. Their belief in me has been the driving force behind the pursuit of knowledge and personal growth. May God continue to bless and guide them.

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Abstract

Alcohol addiction remains a significant public health challenge in Kenya, with approximately 3.2 million Kenyans struggling with alcohol dependency. Despite the establishment of rehabilitation centers offering care support groups, limited empirical evidence exists regarding their effectiveness in maintaining long-term sobriety among alcohol addicts in Kenyan contexts. This knowledge gap hinders the development of evidence-based interventions and optimal resource allocation for addiction treatment services. This study determined the effectiveness of care support groups in maintaining sobriety among alcohol addicts in rehabilitation centers in selected counties, Kenya. The study sought to: establish the benefits of care support groups in sustaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya, examine the factors influencing alcohol addicts to seek support at care groups to maintain sobriety in rehabilitation centers in selected counties in Kenya, explore the challenges faced by alcohol addicts attending care support groups in rehabilitation centers in selected counties in Kenya, and investigate the strategies employed by care support groups to promote long-term sobriety of alcohol addicts in rehabilitation centers in selected counties in Kenya. The research was grounded in Cognitive Behavioral Theory and the Motivational Enhancement Model. The study adopted a convergent parallel mixed-method research design. The target population was 285 patients enrolled in care support groups across Amani Acres Rehabilitation Centre in Mombasa County, Serene Hospital and Rehabilitation Center in Kiambu County, and Lamu Rehabilitation Centre in Lamu County. A sample of 182 participants was selected through stratified random sampling, while purposive sampling selected 15 key informants. Data was collected using five-point Likert scale questionnaires and semi-structured interviews. The study achieved 85% response rate with 155 participants. The research instrument demonstrated high reliability with Cronbach's Alpha of 0.87. Quantitative data was analyzed using SPSS version 30.0, employing descriptive and inferential statistics including correlation and regression analysis, while qualitative data was analyzed using thematic analysis. Support group benefits significantly predicted sobriety maintenance, explaining 49.1% of variance. Motivation for recovery, trigger understanding, and emotional well-being emerged as key benefits. Influencing factors significantly predicted sobriety maintenance, explaining 40.2% of variance, with personal readiness to change and motivation to change behavior being primary motivators. Challenges showed negative prediction of sobriety maintenance, explaining 25.8% of variance, with inconsistent participation, fear of judgment, and difficulty sharing experiences being primary barriers. Strategies employed strongly predicted sobriety maintenance, explaining 47.3% of variance, with trigger identification, coping skills development, and peer accountability being most effective. Multiple regression analysis revealed that these four variables collectively explained 55.1% of variance in sobriety maintenance. Benefits emerged as the strongest predictor, followed by strategies, influencing factors, and challenges. Effective support group participation through evidence-based strategies is essential for maintaining long-term sobriety. Interventions should prioritize emotional support, peer accountability, and skills development to foster recovery outcomes and reduce relapse rates. This study has significance for addiction treatment professionals, rehabilitation center administrators, policymakers, NACADA, county health departments, family members, and individuals struggling with alcohol addiction in Kenya.

List of Tables

Table 1 Sampling Framework 53

Table 2 Response Rate 67

Table 3 Reliability Statistics 67

Table 4 Distribution of Respondents by Gender 68

Table 5 Distribution of Respondents by Age Group 69

Table 6 Distribution of Respondents by Highest Level of Education 71

Table 7 Distribution of Respondents by Employment Status 72

Table 8 Distribution of Respondents by Duration in Rehabilitation Program 73

Table 9 Distribution of Respondents by Previous Addiction Treatment Experience 74

Table 10 Distribution of Respondents by Primary Substance of Addiction 75

Table 11 Benefits of Care Support Groups in Sustaining Sobriety 77

Table 12 Themes and Sub-themes Indicators of Support Group Benefits 79

Table 13 Correlation between Support Group Benefits and Sobriety Maintenance 91

Table 14 Model Summary - Benefits Predicting Sobriety Maintenance 93

Table 15 ANOVA - Benefits Predicting Sobriety Maintenance 94

Table 16 Regression Coefficients - Benefits Predicting Sobriety Maintenance 95

Table 17 Factors Influencing Alcohol Addicts to Seek Support at Care Groups 97

Table 18 Themes and Sub-themes of Factors Influencing Support-Seeking 100

Table 19 Correlation between Influencing Factors and Sobriety Maintenance 106

Table 20 Model Summary - Influencing Factors Predicting Sobriety Maintenance 107

Table 21 ANOVA - Influencing Factors Predicting Sobriety Maintenance 108

Table 22 Regression Coefficients - Influencing Factors Predicting Sobriety Maintenance 109

Table 23 Challenges Faced by Participants in Care Support Groups 111

Table 24 Themes and Sub-themes of Challenges in Care Support Groups 112

Table 25 Strategies Employed by Care Support Groups..... 115

Table 26 Themes and Sub-themes of Effective Strategies 117

Table 27 Correlation between Strategies Employed and Sobriety Maintenance..... 124

Table 28 Model Summary - Strategies Predicting Sobriety Maintenance..... 126

Table 29 ANOVA - Strategies Predicting Sobriety Maintenance 126

Table 30 Regression Coefficients - Strategies Predicting Sobriety Maintenance..... 127

Table 31 Sobriety Maintenance Outcomes 129

Table 32 Themes and Sub-themes on Motivation and Personal Transformation 131

List of Figures

Figure 1 Conceptual Framework 44

Abbreviations and Acronyms

AIDS: Acquired Immunodeficiency Syndrome CBT: Cognitive Behavioral Theory

HIV: Human Immunodeficiency Virus KACC: Kenya Anti-Corruption Commission

MET: Motivational Enhancement Theory

NACADA: National Authority for the Campaign Against Drug Abuse NACOSTI: National Commission of Science, Technology, and Innovation NGO: Non-Governmental Organization

SPSS: Statistical Package for Social Sciences UN: United Nations

WHO: World Health Organization

Operational Definition of Terms

Addiction: A chronic, relapsing disorder characterized by compulsive substance use despite harmful consequences and long-lasting changes in brain structure and function (American Psychiatric Association, 2013). In this study, addiction refers to the persistent pattern of alcohol consumption that interferes with an individual's personal, professional, and social functioning.

Care Support Groups: Structured recovery maintenance systems where individuals in recovery gather regularly to share experiences, provide mutual support, and access structured recovery strategies (Kelly et al., 2011; Harris et al., 2017). In this study, care support groups represent organized forums within rehabilitation centers designed to facilitate addiction recovery through peer interaction and professional guidance.

Effectiveness: The degree to which care support groups achieve desired outcomes in addiction recovery (Tracy & Wallace, 2016). In this study, effectiveness is measured through three key indicators: sustained abstinence duration, reduced relapse rates, and improved quality of life scores among participants.

Emotional Well-being: A psychological state characterized by positive emotions, self-acceptance, personal growth, and effective coping mechanisms (Westwell et al., 2023). In this study, emotional well-being refers to participants' psychological stability, stress management, and overall positive mental health during the recovery process.

Maintenance of Sobriety: A continuous, progressive process of personal improvement where an individual commit to abstaining from alcohol and developing healthier

life strategies (Lorman, 2013). In this study, maintenance of sobriety means the sustained ability to avoid alcohol consumption and successfully navigate recovery challenges.

Peer Support: A system of giving and receiving help based on shared experiences, mutual respect, and a desire to promote recovery (Schwartz et al., 2014). In this study, peer support represents the interactions and support mechanisms among participants in care support groups with similar addiction recovery experiences.

Recovery Capital: The internal and external resources an individual can draw upon to initiate and sustain recovery from addiction (Laudet & Humphreys, 2013). In this study, recovery capital encompasses personal strengths, social support, and resources that facilitate successful addiction recovery.

Relapse Prevention: Strategies and techniques designed to help individuals identify and manage triggers that might lead to returning to substance use (Polcin & Korcha, 2015). In this study, relapse prevention refers to the mechanisms and skills participants develop to maintain long-term sobriety.

Social Belonging: The sense of connection, acceptance, and integration within a supportive community (Ngwenya, 2022). In this study, social belonging describes participants' experiences of feeling understood, accepted, and supported within their care support group.

Substance Use Disorder: A medical condition characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences (World Health Organization, 2018). In this study, substanceuse disorder specifically relates to alcohol addiction among participants at

rehabilitation centers.

Treatment Engagement: The active participation and commitment of individuals in their recovery process, including attendance, involvement, and implementation of learned strategies (Stanojlović & Davidson, 2021). In this study, treatment engagement measures the level of participants' active involvement in care support groups and recovery activities.

Chapter One: Introduction and Background to the Study

Introduction

This chapter introduces the study by presenting the background to the study, statement of the problem, purpose of the study, specific objectives, research questions, justification, significance, assumptions, scope, limitations, and delimitations. The chapter focuses on the role of care support groups in maintaining sobriety among people recovering from alcohol abuse in rehabilitation centres in Mombasa, Kiambu, and Lamu Counties. These counties provided diverse geographical, cultural, and socioeconomic contexts within Kenya's addiction recovery landscape.

Background to the Study

Alcohol abuse remains a major public health concern globally, with far-reaching physical, psychological, social, and economic consequences for individuals, families, and communities. Although rehabilitation programmes play a critical role in helping individuals achieve initial sobriety, recovery from alcohol addiction is a long-term process that extends beyond treatment completion. Many individuals in recovery face challenges such as exposure to triggers, social pressures, emotional distress, and difficulties rebuilding relationships, all of which increase the risk of relapse. Consequently, ongoing recovery support is essential for sustaining sobriety and improving quality of life.

One of the most widely utilized forms of continuing care is the care support group. Care support groups are organized forums where individuals recovering from addiction gather to share experiences, provide mutual

support, and access structured recovery strategies (Kelly et al., 2011). These groups serve multiple functions in addiction recovery, including providing emotional support, developing coping mechanisms, and fostering accountability among members (Harris et al., 2017). Effective care support groups typically incorporate elements such as peer mentorship, cognitive behavioral therapy, and community integration activities (Smith et al., 2020). These components create a comprehensive support system that addresses both psychological and social aspects of addiction recovery (Tracy & Wallace, 2016).

Care support groups encompass professional-led therapeutic, peer-led recovery, and family-integrated approaches, each serving distinct but complementary functions (Westwell et al., 2024). These groups generate essential benefits including emotional well-being, reduced anxiety, and sense of belonging (Friedman et al., 2022). Multiple factors influence addicts to seek support, including personal readiness for change, healthcare provider recommendations, and family encouragement (Miller & Rollnick, 2013). Participants face significant challenges including feelings of shame and vulnerability, disruptive group dynamics, and resource constraints (Wang et al., 2021). Support groups employ strategies such as skills development, recovery planning, and accountability mechanisms (Polcin & Korcha, 2015).

The effectiveness of care support groups is influenced by various factors that impact participant engagement and recovery outcomes (Kepner & Humphreys, 2025). Key elements contributing to successful group dynamics include skilled facilitation, peer validation, and structured activities (Elbanna et al., 2016). Facilitators play a crucial role in managing group interactions and maintaining a safe, supportive environment (Collins-Camargo et al., 2019). Peer validation fosters a sense of

belonging and mutual understanding among group members (Sathyamurthi, 2022). Structured activities provide practical tools for maintaining sobriety (Baron, 2019). However, challenges such as stigma, accessibility issues, and inconsistent participation can hinder group effectiveness (Nguyen & Carter, 2020). These barriers are particularly relevant in Mombasa, Kiambu, and Lamu Counties (Perez et al., 2019).

Long-term sobriety requires sustained engagement with recovery support systems and effective coping strategies (Hammarberg et al., 2024). Individuals who actively participate in care support groups show improved recovery outcomes (Laudet & Humphreys, 2013). These groups employ cognitive behavioral techniques, motivational enhancement, and social skills training (Huang et al., 2011). The integration of cultural and spiritual elements can enhance support group effectiveness (Nwankwo et al., 2020). Understanding how these components interact is crucial for developing effective interventions (Prangley et al., 2018).

Globally, in the United Kingdom, long-term support group participants reported enhanced self-awareness and improved emotional regulation (McGovern et al., 2021). Sustained family encouragement contributed to long-term recovery success in the United Kingdom (Day et al., 2023). Participants receiving consistent family support showed 62% lower relapse rates (Martinelli et al., 2021). In Sweden, Motivational Enhancement Therapy was particularly effective in building intrinsic motivation for change (Hammarberg et al., 2024). Motivational Enhancement Therapy enhanced treatment readiness among Taiwanese adolescents (Huang et al., 2011). In Australia, lack of personalized support predicted premature program exit (Prangley et al., 2018). In Malaysia, culturally modified programs showed 38% higher retention rates (Abu Hassan Shaari & Waller, 2023).

Regionally, in South Africa, treatment approaches incorporating African communal healing concepts achieved 40% higher recovery maintenance rates (Ngwenya, 2022). In Ethiopia, conventional support groups were 35% less effective without adaptations for co-occurring disorders (Tadesse et al., 2021). In Rwanda, an Integrated Addiction Recovery Model combining Western and traditional approaches showed improved six-month sobriety outcomes (Harerimana, 2020). In Nigeria, contextually relevant support structures were effective in resource-limited settings (Kehinde et al., 2025). Across Kenya, Uganda, and Tanzania, culturally adapted treatment approaches achieved 45% better outcomes (Kalema & Vanderplasschen, 2022). Studies across multiple African countries demonstrated that support group models respecting local cultural contexts are essential (Harris et al., 2022). Traditional healing practices integrated with evidence-based treatment improved outcomes in Kenya, Tanzania, and Uganda (Misouridou & Papadatou, 2022).

Locally, for instance in Nairobi City County, internal locus of control significantly predicted meeting attendance and recovery outcomes (Gachara et al., 2019). Participants with stronger internal locus of control demonstrated 57% higher meeting attendance rates. In Mathare North, self-efficacy emerged as a critical factor in sustained sobriety (Machuki, 2020). In Limuru Sub-County, Kiambu County, perceived family support significantly predicted reduced relapse rates (Kinyua, 2019). Higher family support scores correlated with 62% lower relapse rates at one-year follow-up. In Tigania West District, Meru County, traditional brewing practices and cultural attitudes influenced consumption patterns (Ndung'u, 2011). In Meru County, participants lacking structured aftercare were three times more likely to relapse (Kelvin, 2024). In Mombasa County, 38% of healthcare professionals reported using alcohol to cope with professional stress (Ochuoga, 2017). Family dynamics influence

both addiction development and recovery processes in Mombasa County (Nyoike, 2021). In Kiambu County, urban participants showed different recovery patterns compared to those from rural areas (Wainaina, 2020).

Mombasa County has particularly high rates of alcohol dependency, with 45.3% of rehabilitation cases related to alcohol addiction (National Authority for the Campaign Against Drug Abuse (NACADA), 2022). Approximately 3.2 million Kenyans struggle with alcohol dependency, with varying prevalence rates across different regions (NACADA, 2023). Despite this high prevalence and the existence of rehabilitation programs, there remains a significant knowledge gap regarding the effectiveness of care support groups in maintaining sobriety among alcohol addicts in rehabilitation centers in selected counties, Kenya.

Statement of the Problem

Alcohol abuse continues to be a major public health concern, and many people who complete rehabilitation programmes struggle to maintain sobriety over time. While rehabilitation helps individuals begin the recovery process, staying sober after treatment can be difficult due to ongoing exposure to triggers, social pressures, emotional challenges, and limited support systems. As a result, relapse remains common among people recovering from alcohol addiction. Care support groups have become an important part of the recovery journey because they provide encouragement, emotional support, accountability, and opportunities to learn from others who are facing similar challenges (Kelly et al., 2011; Laudet & Humphreys, 2013). However, not all support groups produce the same outcomes, and their effectiveness may be influenced by factors such as accessibility, participant commitment, cultural relevance, and the quality of support offered (Stanojlović & Davidson, 2021).

Across Africa, alcohol abuse continues to affect individuals, families, and communities, creating social, economic, and health-related challenges. Research suggests that support programmes that are responsive to local cultural and social realities can improve recovery outcomes and help reduce relapse (Kalema & Vanderplasschen, 2022; Ngwenya, 2022). Despite these findings, there is still limited understanding of how care support groups help individuals maintain sobriety, what motivates recovering alcohol addicts to join such groups, the challenges they face while participating, and the strategies that support groups use to promote long-term recovery (Harris et al., 2022).

In Kenya, alcohol dependency affects millions of people and continues to place a burden on families, communities, and healthcare services (NACADA, 2022). Although rehabilitation centres provide treatment and aftercare services, most local studies have focused on alcohol use prevalence, relapse rates, family support, and other risk factors associated with recovery (Kinyua, 2019; Mutuku et al., 2022; Kelvin, 2024). Consequently, little is known about the specific role that care support groups play in helping individuals maintain sobriety after rehabilitation. This gap is particularly evident in Mombasa, Kiambu, and Lamu Counties, where differences in social, cultural, and recovery environments may influence how support groups operate and how participants experience recovery.

Without a clear understanding of the effectiveness of care support groups, rehabilitation centres and other stakeholders may find it difficult to strengthen aftercare services and support long-term recovery among people recovering from alcohol abuse. Therefore, this study sought to examine the effectiveness of care support groups in maintaining sobriety among alcohol addicts in rehabilitation centres in Mombasa, Kiambu, and Lamu Counties, Kenya. Specifically, the study

investigated the benefits of care support groups, factors influencing individuals to seek support, challenges experienced by participants, and the strategies used by these groups to promote sustained sobriety and recovery.

Purpose of the Study

The main purpose of the study was to determine the effectiveness of care support groups in maintaining sobriety among people recovering from alcohol abuse in rehabilitation centres in selected counties in Kenya.

Specific Objectives

The study was guided by four specific objectives:

i. To establish the benefits of care support groups in sustaining sobriety among people recovering from alcohol abuse in rehabilitation centres in selected counties in Kenya.
ii. To examine the factors influencing people recovering from alcohol abuse to seek support from care support groups in rehabilitation centres in selected counties in Kenya.
iii. To explore the challenges faced by people recovering from alcohol abuse while attending care support groups in rehabilitation centres in selected counties in Kenya.
iv. To investigate the strategies employed by care support groups to promote long-term sobriety among people recovering from alcohol abuse in rehabilitation centres in selected counties in Kenya.

Research Questions

The following research questions guided the study:

i. What are the benefits of care support groups in sustaining sobriety

among people recovering from alcohol abuse in rehabilitation centres in selected counties in Kenya?

ii. What factors influence people recovering from alcohol abuse to seek support from care support groups in rehabilitation centres in selected counties in Kenya?

iii. What challenges do people recovering from alcohol abuse face while attending care support groups in rehabilitation centres in selected counties in Kenya?

iv. What strategies are employed by care support groups to promote long-term sobriety among people recovering from alcohol abuse in rehabilitation centres in selected counties in Kenya?

Assumptions of Study

The study was based on the assumption that maintaining sobriety among people recovering from alcohol abuse remains a challenge in rehabilitation centres in selected counties in Kenya. It was also assumed that care support groups play an important role in supporting sobriety maintenance by providing emotional support, accountability, coping skills, and opportunities for peer learning. The study further assumed that people recovering from alcohol abuse seek support from care support groups due to different personal, family, social, and professional influences.

The study also assumed that care support groups experience challenges that may affect their effectiveness in promoting long-term sobriety. These challenges may include stigma, fear of disclosure, inconsistent attendance, limited resources, and differences in participant engagement. In addition, the study assumed that the selected rehabilitation centres had structured care support group programmes that were relevant to the study objectives. Finally, it was assumed that respondents provided

honest and accurate responses to the questions raised in the research instruments, and that their responses reflected their actual experiences within the care support groups.

Justification of the Study

The negative effects of alcohol addiction on individual health, family stability, and strained family relationships perpetuate a cycle of addiction that can span generations (NACADA, 2022). Alcohol addiction also affects the social, economic, and psychological development of family members, making it challenging for communities to break free from the destructive cycle of addiction (Wambugu & Omondi, 2019). Moreover, the stability of communities in Mombasa, Kiambu, and Lamu Counties depends significantly on the recovery and rehabilitation of alcohol addicts (NACADA, 2023). This calls for a concerted effort to examine effective recovery maintenance strategies across these diverse regions to inform policy and practice.

According to Mutuku et al. (2022), studies on alcohol addiction recovery are limited in Kenya. The complexity of the issue is heightened by the stigmatized nature of addiction and recovery processes. The psychological aspects add another layer of complexity, and the potential for social stigma from public disclosure makes data collection challenging (NACADA, 2022). Further, Kenya, like other African countries, faces unique cultural challenges where traditional beliefs and practices in regions like Mombasa, Kiambu, and Lamu may conflict with modern rehabilitation approaches (Wambugu & Omondi, 2019). This contrasts with Western contexts where addiction treatment approaches are more established. The present study, conducted across three counties with distinct socio-cultural characteristics, yielded empirical output that can facilitate comparison and contextualization of addiction recovery strategies as a social phenomenon, particularly focusing on the role of care support

groups in maintaining sobriety.

Significance of the Study

The study is significant to academia because it contributes to knowledge on alcohol addiction recovery within the Kenyan rehabilitation context. By focusing on care support groups and sobriety maintenance, the study provides empirical evidence that can support further scholarly inquiry into recovery maintenance, relapse prevention, peer support, and structured aftercare. The findings may also help future researchers to identify gaps that require further investigation, especially in relation to how care support groups function across different cultural, religious, and socioeconomic settings in Kenya.

The study is also significant to theory because it applies Cognitive Behavioral Theory and Motivational Enhancement Theory to the context of alcohol addiction recovery. Through Cognitive Behavioral Theory, the study shows how care support groups may help participants identify triggers, develop coping skills, challenge harmful thought patterns, and adopt healthier behaviors that support sobriety. Through Motivational Enhancement Theory, the study demonstrates how support groups may strengthen personal readiness, recovery motivation, and commitment to long-term sobriety. Therefore, the findings may help scholars and educators explain how these theories operate in practical rehabilitation settings.

The study may benefit addiction counselors, therapists, and support group facilitators by providing practical insights on how care support groups can be used to maintain sobriety among people recovering from alcohol abuse. The findings may guide professionals in designing group activities that promote emotional support,

accountability, coping skills, peer encouragement, and relapse prevention. Rehabilitation centers may also use the findings to strengthen existing support group programmes and develop interventions that are more responsive to the needs of participants across different recovery contexts.

Policymakers and institutions involved in alcohol addiction treatment may benefit from the study because the findings provide evidence that can support the development of long-term recovery and aftercare strategies. Rehabilitation centers play a pivotal role in addressing societal challenges such as alcohol addiction (NACADA, 2022). Individuals often turn to rehabilitation centers for assistance before seeking help from other avenues, perceiving these centers as secure spaces for finding support in their recovery journey (Wambugu & Omondi, 2019). Rehabilitation centers, traditionally viewed as the primary point of contact, offer a sense of safety for individuals to seek recovery without the fear of stigma imposed by other institutions, which may not address the complex psychological and social aspects of addiction (Mutuku et al., 2022). Consequently, the findings may inform the development of structured, culturally sensitive, and evidence-based care support group programmes in rehabilitation centres.

The study is further significant to community leaders, family members, and people recovering from alcohol abuse. Community leaders may use the findings to create awareness on the importance of support systems in recovery. Family members may gain a better understanding of their role in encouraging sobriety and supporting people recovering from alcohol abuse. People in recovery may also benefit indirectly through improved care support group programmes that respond to their emotional, social, and practical recovery needs.

Scope of Study

The scope of this study was limited to three rehabilitation centers in Kenya: Amani Acres Rehabilitation Centre in Likoni Ward, Mombasa County; Serene Hospital and Rehabilitation Center in Kiambu County; and Lamu Rehabilitation Centre in Lamu County. These centers were purposefully selected because they offer structured care support group programs for individuals recovering from alcohol addiction and represented diverse geographical, cultural, and socioeconomic contexts within the country.

The primary conceptual focus of the study was on the effectiveness of care support groups in maintaining sobriety. Specifically, the study examined the benefits of care support groups, factors influencing people recovering from alcohol abuse to seek support, challenges faced by participants, and strategies employed by care support groups to promote long-term sobriety. The study investigated the relationship between these aspects and sobriety maintenance outcomes. Any factors affecting sobriety that fell outside the study's conceptual framework were not investigated. This multi-center approach allowed for comparative analysis while maintaining a focused examination of the core research variables.

Limitations of the Study

The study encountered several limitations that may have influenced the findings. The topic of alcohol addiction recovery was sensitive, and some participants may have been uncomfortable disclosing personal experiences fully. This may have affected the depth and openness of some responses. To minimize this limitation, participants were assured of confidentiality, anonymity, and voluntary participation. A professional counselor was also on standby to provide support where needed, and counseling services were offered free of charge to any participant who experienced emotional distress.

Language barriers posed a challenge because some respondents were not fully conversant with English, which was the main language used in the research instruments. To address this limitation, the researcher conducted face-to-face data collection and clarified questions in Kiswahili where necessary. This was particularly important in Lamu County, where some participants required additional explanation to understand the questions clearly.

Differences in socioeconomic status, education level, and cultural background may have affected how participants understood and responded to the research instruments. This limitation was especially relevant because the study involved participants from Mombasa, Kiambu, and Lamu Counties, which have different social, cultural, religious, and economic characteristics. To reduce this limitation, the researcher used simple and clear language and worked closely with rehabilitation staff to ensure that the data collection process was culturally appropriate.

The study was limited to participants who were actively involved in care support groups at the selected rehabilitation centres. Therefore, the findings may not fully represent the experiences of people recovering from alcohol abuse who were not attending care support groups or those receiving other forms of recovery support. However, this limitation was managed by focusing the study strictly on participants whose experiences directly related to the study objectives.

Lastly, the study was conducted in three selected counties, and each county had unique contextual factors that may have influenced the findings. These differences may limit direct generalization of the findings to all rehabilitation centres in Kenya. However, the diversity of Mombasa, Kiambu, and Lamu Counties enriched the study by providing varied perspectives on the effectiveness of care support groups in maintaining sobriety across different Kenyan settings.

Delimitations of the Study

The study was deliberately delimited to three specific counties: Mombasa, Kiambu, and Lamu. Data from rehabilitation centers in other counties in Kenya were not included. This was a convergent parallel mixed-methods study in which quantitative and qualitative data were collected simultaneously at a single point in time. The study was conducted specifically at Amani Acres Rehabilitation Centre in Mombasa County, Serene Hospital and Rehabilitation Center in Kiambu County, and Lamu Rehabilitation Centre in Lamu County. Participants from other rehabilitation centers were not represented.

Data were collected only from people recovering from alcohol abuse who were actively participating in care support groups at the selected centers. Individuals who were not involved in support groups were excluded from the study. The research focused exclusively on alcohol addiction recovery and did not include other forms of addiction. In addition, only participants who were present and available during the data collection period were included in the sample.

Chapter Summary

This chapter has discussed the background of the study, the statement of the problem, the purpose of the study, the specific objectives, and the research questions. In addition, the justification of the study, its significance, the assumptions of the study, the scope, limitations, and delimitations have been explained. Chapter Two provides a detailed review of existing literature and a critical analysis that led to the identification of literature gaps. It also presents the theoretical framework and the conceptual framework that guided the study.

Chapter Two: Literature Review

Introduction

This chapter presents a review of literature related to the effectiveness of care support groups in maintaining sobriety among alcohol addicts. The review is organized according to the four specific objectives of the study: to establish the benefits of care support groups in sustaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya; to examine the factors influencing alcohol addicts to seek support at care groups to maintain sobriety in rehabilitation centers in selected counties in Kenya; to explore the challenges faced by alcohol addicts attending care support groups in rehabilitation centers in selected counties in Kenya; and to investigate the strategies employed by care support groups to promote long-term sobriety of alcohol addicts in rehabilitation centers in selected counties in Kenya. Moreover, the chapter explores relevant theoretical foundations and presents a conceptual framework that guides the research. The chapter concludes with a summary of the key findings from the literature review.

Care Support Groups

Care support groups represent structured recovery maintenance systems where individuals in recovery gather regularly to share experiences and support each other (Harris et al., 2017; Kelly et al., 2011). This study specifically focuses on three types of support groups implemented at Rehabilitation Centres: professional-led therapeutic support groups, peer-led recovery support groups, and family-integrated support groups. Each of these support group types offers distinct approaches to addiction recovery while sharing common foundational elements.

Professional-led therapeutic support groups are facilitated by trained addiction

counselors and therapists who implement structured therapeutic protocols and evidence-based interventions. According to NACADA (2022), these professionally guided groups provide clinical expertise while focusing on psychological healing, cognitive restructuring, and behavioral modification techniques. Wang et al. (2021) note that therapist-led groups are particularly effective for addressing co-occurring disorders and complex trauma histories commonly found in alcohol addiction cases.

Peer-led recovery support groups operated within the rehabilitation centers involve individuals at various stages of recovery providing mutual assistance based on shared experiences. As highlighted by Kepner and Humphreys (2025), these groups emphasize experiential knowledge, role modeling, and the development of recovery identity through identification with others who have successfully maintained sobriety. Smith et al. (2020) emphasize that peer support creates unique opportunities for authentic connection and practical guidance from those with lived experience of addiction recovery.

Family-integrated support groups constitute the third focus of this study, involving family members in the recovery process to address relational dynamics and build sustainable support systems. Wambugu and Omondi (2019) highlight that including family members in the recovery process is particularly important in the Kenyan context, where family ties significantly influence recovery outcomes. These groups work to repair damaged relationships, educate family members about addiction, and develop healthy communication patterns that support long-term sobriety.

Research by Westwell et al. (2024) emphasizes that these specific types of support groups must address the challenges faced by participants, particularly feelings of shame, vulnerability, and judgment, while implementing effective strategies such

as skills development, recovery planning, and accountability measures. These methods work together to create a comprehensive support system that addresses both psychological and social aspects of addiction recovery. The effectiveness of these support group types depends on how well they are integrated into the overall rehabilitation program, facilitator expertise, and participant engagement (Harris et al., 2017; NACADA, 2023).

According to Mutuku et al. (2022), rehabilitation centers that implement and coordinate these three types of support groups while maintaining consistent attendance, fostering open communication, and providing structured recovery activities, show better outcomes in supporting long-term sobriety. Additionally, cultural competency in group facilitation, as highlighted by Nwankwo et al. (2020), plays a crucial role in ensuring that these support group types effectively serve diverse populations while respecting local customs and beliefs. These specific support group types are reflected in the conceptual framework as key elements of the independent variable, with each type contributing uniquely to the overall effectiveness of care support in maintaining sobriety. Maintaining Sobriety

Maintaining sobriety is defined as a continuous, progressive process of improvement whereby a person with alcohol addiction commits to improving their health, living a self-directed life, and striving to reach their full potential (Lorman, 2013). According to Westwell et al. (2023), successful sobriety maintenance encompasses three key constructs: sustained abstinence from alcohol, reduced relapse rates, and improved overall quality of life for recovering alcoholics. Research by Polcin and Korcha (2015) emphasizes that motivation to maintain these aspects of sobriety is strongly influenced by individuals' understanding of both the costs of substance use and the perceived benefits of remaining sober.

The process of maintaining sobriety requires multiple support mechanisms and personal commitment to achieve sustained abstinence and reduce relapse rates (Westwell, 2022). Studies show that successful long-term sobriety maintenance involves developing a new sense of self, reconstruing relationships with others, and utilizing imagination to rehearse anticipated changes before implementing them in real life. Johns (2024) further highlights that improving overall quality of life in sobriety involves addressing various challenges through resilience skills, protective factors, and stress management techniques, particularly when individuals are navigating significant life changes.

The effectiveness of sobriety maintenance is measured through these three primary constructs: sustained abstinence, reduced relapse rates, and improved quality of life (Halpin et al., 2020). According to Westwell et al. (2023), validation from family, friends, and support group members plays a crucial role in reinforcing these aspects of recovery. Research indicates that individuals who successfully maintain sobriety typically engage in structured recovery activities, develop robust support networks, and demonstrate consistent commitment to their recovery journey through active participation in support groups and other recovery-maintenance activities (Lorman, 2013; Westwell, 2022).

Empirical Literature Review

This section presents empirical studies related to the four objectives of the study. Literature is organized by global, regional (Sub-Saharan Africa), and local (Kenyan) levels. For each theme, key findings are summarized, followed by identified gaps and how the current study addressed them.

Benefits of Care Support Groups in Sustaining Sobriety

Care support groups have been widely studied for their role in addiction recovery. Empirical evidence from global, regional, and local contexts consistently highlighted their potential to enhance emotional well-being, foster a sense of belonging, and support long-term sobriety. However, significant gaps remained regarding their effectiveness within structured rehabilitation settings in diverse Kenyan counties.

Emotional Well-being and Reduced Anxiety. Empirical studies have extensively examined the role of care support groups in improving emotional well-being and reducing anxiety among individuals recovering from alcohol addiction. Research at global, regional, and local levels have consistently demonstrated positive outcomes, yet important limitations and contextual gaps remain, particularly regarding applicability to resource-constrained, culturally diverse Kenyan rehabilitation settings. The current study addressed these gaps through a convergent parallel mixed-methods design focused on three rehabilitation centers in Mombasa, Kiambu, and Lamu Counties.

At the global level, Tracy and Wallace (2016) conducted a comprehensive meta-analysis of ten international trials involving over 1,800 participants across North America and Europe. Their research demonstrated that care support groups significantly improved emotional well-being and reduced anxiety among participants, revealing a 45% reduction in anxiety levels and a 60% improvement in emotional stability. However, this meta-analysis relied heavily on self-reported data without objective clinical assessments, potentially introducing response bias. Furthermore, the studies included were conducted predominantly in urban, well-resourced settings, limiting applicability to resource-constrained environments like Kenyan rehabilitation centers. This study addressed these limitations by examining emotional well-being

outcomes in diverse Kenyan contexts with varying resource levels using both quantitative Likert-scale measures and qualitative in-depth interviews.

Day et al. (2023) conducted a three-year longitudinal study of 380 individuals in recovery across multiple UK treatment centers using repeated measures methodology and regression analysis. Their research found that sustained family encouragement contributed to long-term recovery success, with participants receiving consistent family support showing 62% lower relapse rates. The strength of this study lays in its longitudinal design capturing long-term outcomes. However, the UK's nuclear family structure differed significantly from Kenya's extended family systems, raising questions about transferability. Additionally, the study did not examine support group-specific mechanisms, focusing instead, on general family support. This study filled this gap by examining family encouragement specifically within the context of care support group participation in Kenyan rehabilitation centers. While Day et al. (2023) established the broader role of family support in recovery, the current study extended this understanding by investigating how family encouragement within care support groups specifically contributed to emotional well-being and anxiety reduction among alcohol addicts in rehabilitation centers in selected counties in Kenya.

At the regional level, research from sub-Saharan Africa by Kalema and Vanderplasschen (2022) found that support groups significantly enhanced emotional well-being when culturally adapted to local contexts. Their study of 180 participants across three East African countries (Uganda, Tanzania, and Kenya) showed that culturally sensitive support approaches resulted in better emotional outcomes compared to standard Western models. These findings were supported by Misouridou and Papadatou (2022) research in Ethiopia, Kenya, and Tanzania, which demonstrated

how incorporating traditional healing elements enhanced emotional stability among participants. Harris et al. (2022) further reinforced these findings through their study of five African countries, showing improved emotional outcomes when support groups aligned with local cultural practices. A conceptual gap became apparent in understanding how traditional African healing practices could be effectively integrated with modern support group approaches for emotional well-being. This study addressed this conceptual gap by exploring the practical integration of cultural and traditional healing elements within professional-led therapeutic, peer-led recovery, and family-integrated support groups across the culturally diverse settings of Mombasa, Kiambu, and Lamu Counties.

In the Kenyan context, NACADA's (2022) nationwide study of rehabilitation centers revealed that participants in structured support groups showed marked improvement in emotional stability, with anxiety reduction rates of 65% compared to non-participants. This research was particularly relevant as it specifically examined the Kenyan cultural context. In Mombasa County, Wambugu and Omondi's (2019) study of 200 participants in three rehabilitation centers demonstrated how specific cultural practices and beliefs common in coastal communities influenced emotional well-being outcomes in support groups. Kelly et al.'s (2021) study of 450 participants in Nairobi, Kisumu, and Mombasa further validated these findings, showing enhanced emotional stability among support group participants. While these studies provided valuable insights into support group effectiveness in urban Kenyan settings, a research gap exists regarding the specific application and effectiveness of support groups within individual rehabilitation centers that have unique organizational structures and participant demographics. This study addressed this gap by systematically investigating emotional well-being outcomes within the structured care support group

programs at Amani Acres Rehabilitation Centre in Mombasa County, Serene Hospital and Rehabilitation Center in Kiambu County, and Lamu Rehabilitation Centre in Lamu County, using mixed-methods data collected directly from participants and key informants.

Mudiriza and De Lannoy (2020) investigated youth emotional well-being during the COVID-19-related lockdown in South Africa. Using an extensive online survey, the researchers collected data from 11,700 participants aged 18–35 years across all provinces, with 5,693 completing all emotional well-being questions. The study found a concerning 72% prevalence of depressive symptoms among young participants, with higher rates among older, female, and white youth with higher education. Employing the 10-item Centre for Epidemiological Studies on Depression Scale (CES-D 10 Scale), the study focused solely on quantitative measures, therefore providing a methodological gap. This study addressed this methodological gap by adopting a convergent parallel mixed-methods approach that combined quantitative Likert-scale data with rich qualitative narratives from participants in addiction recovery settings.

Clabaugh et al. (2020) investigated emotional well-being among college students during the COVID-19 pandemic in the United States. The study employed quantitative assessment tools to measure anxiety, depression, and emotional distress among vulnerable populations experiencing significant stress. Their findings demonstrated that different demographic groups experienced varying levels of emotional well-being, with higher anxiety levels associated with isolation and reduced social support systems. While conducted in a different context, this research methodology offered valuable approaches for assessing emotional well-being outcomes that could be adapted for addiction recovery settings. This study built on

this methodological foundation by examining how care support groups specifically contributed to emotional well-being and anxiety reduction among alcohol addicts in rehabilitation centers in Kenya.

Sense of Belonging and Mutual Understanding. At the regional level, Ngwenya (2022) examined the role of communal support structures in substance abuse recovery in South Africa. The study involved 150 participants from culturally diverse communities and found that group-based interventions fostering a sense of belonging significantly improved recovery outcomes, with 40% higher recovery maintenance rates compared to individualized treatment approaches. Participants reported that feeling accepted and understood within their support groups reduced feelings of isolation and strengthened their commitment to sobriety. However, the study focused on general communal support without examining the specific dynamics within structured care support groups in rehabilitation settings. This study addressed this gap by investigating how care support groups specifically fostered a sense of belonging and mutual understanding among alcohol addicts in Kenyan rehabilitation centers.

Kalema and Vanderplasschen (2022) conducted research in Uganda, Kenya, and Tanzania examining treatment outcomes for 180 participants using a mixed-methods design combining surveys and qualitative interviews. Their research revealed that participants who experienced strong peer connections and felt understood by group members demonstrated significantly better engagement with treatment programs and improved sobriety maintenance over six months. The qualitative component captured rich contextual data showing that mutual understanding among participants created safe spaces for sharing experiences without fear of judgment. However, the study's Kenyan sample was drawn from unspecified urban centers,

potentially missing rural and coastal perspectives. Additionally, the research examined general treatment outcomes rather than support group-specific mechanisms of belonging. This study extended their work by focusing specifically on how care support groups in diverse Kenyan geographical and cultural contexts cultivated a sense of belonging and mutual understanding to maintain sobriety.

In the Kenyan context, Mutuku et al. (2022) study of 325 participants in rehabilitation centers in Nairobi, Kisumu, and Nakuru examined the effectiveness of incorporating indigenous support practices into formal treatment programs. This research found significantly higher treatment completion rates (72% versus 54%) and improved six-month sobriety outcomes among participants in culturally integrated programs. Mulwa et al. (2021) conducted a comparative analysis of recovery approaches at eight rehabilitation centers across Kenya, finding that programs incorporating elements of traditional community support systems showed enhanced treatment engagement and improved three-month post-discharge outcomes.

Karanja (2020) qualitative study of 36 recovering alcoholics in Kiambu County revealed how culturally resonant recovery narratives facilitated deeper connection and mutual understanding among support group participants. These Kenyan studies demonstrated the importance of cultural integration in treatment approaches but primarily measured short-term outcomes (typically less than six months post-treatment), creating a significant research gap regarding the long-term effectiveness of culturally adapted support groups at specific rehabilitation centers in selected counties in Kenya. This study addressed this gap by examining both short-term and longer-term indicators of sense of belonging and mutual understanding among participants who had spent varying durations in the selected rehabilitation programs (from less than three months to more than 12 months), using quantitative

measures of perceived belonging alongside qualitative narratives that captured participants' lived experiences of connection and acceptance within the specific structured care support group programs at Amani Acres Rehabilitation Centre, Serene Hospital and Rehabilitation Center, and Lamu Rehabilitation Centre.

Factors Influencing Alcohol Addicts to Seek Support

Empirical studies have identified multiple personal, professional, and social factors that motivate alcohol addicts to seek and engage with support services. Research at global, regional, and local levels highlighted the roles of readiness to change, healthcare provider recommendations, and family/friend encouragement. However, significant gaps remained regarding how these factors specifically influenced participation in structured care support groups within Kenyan rehabilitation centers. The current study addressed these gaps by examining the three distinct types of support groups (professional-led therapeutic, peer-led recovery, and family-integrated) implemented at the selected rehabilitation centers in Mombasa, Kiambu, and Lamu Counties.

Readiness to Change and Need for Support. At the global level, Prangley et al. (2018) conducted a qualitative study with 13 ex-residents from therapeutic community programs in Australia and examined the factors influencing early withdrawal from treatment programs and client perceptions of successful recovery. Their research identified key motivating factors including personal recognition of addiction impacts, employment consequences, and the need for life transformation. These findings were reinforced by Razali et al. (2021) in their comprehensive study of 50 former substance users in Malaysia, which examined women and substance abuse with a focus on relapse factors. This study found significant correlations between personal motivation and treatment engagement, with self-esteem showing negative

correlations to relapse.

Deep et al. (2024) examined psychosocial factors affecting substance use and effective mental health interventions among 420 adolescents and young adults across the United States, United Kingdom, and Canada, validating these findings and demonstrating how personal readiness and motivation significantly influenced treatment outcomes across

diverse populations. A methodological gap emerged as these studies primarily relied on retrospective data from successful cases, potentially missing insights from those who struggled with readiness to change. This study addressed this methodological gap by collecting data directly from participants at different stages of recovery within active rehabilitation programs using both quantitative Likert-scale measures and qualitative narratives.

At the regional level, studies across Africa demonstrated unique cultural dimensions of readiness to change. Raynor (2013) explored the social ecological framework with parents recovering from substance use disorders in South Africa and revealed how intrapersonal factors such as guilt and shame interacted with cultural beliefs to influence treatment-seeking behavior. Adewuya et al. (2019) conducted a survey of 536 individuals with alcohol dependence across Nigeria, examining barriers to treatment, and found that readiness to change was significantly influenced by community attitudes and traditional beliefs about addiction and recovery. Similarly, Okewole et al. (2020) studied 312 alcohol-dependent individuals in Ghana and found that family pressure and community perceptions strongly predicted treatment-seeking behavior.

Harris et al. (2022) conducted a comparative analysis of 420 participants in

culturally-adapted versus standard treatment programs across five African countries and found that cultural alignment significantly enhanced readiness to change, with a 50% higher engagement rate in culturally adapted programs. These regional studies highlighted important cultural factors in readiness to change but did not specifically address how these factors operated in the context of rehabilitation center support groups in Kenya. This study addressed this gap by examining readiness to change specifically within the structured care support group programs at the selected Kenyan rehabilitation centers.

In the Kenyan context, Wainaina (2020) case-control study in Kiambu County involving 120 patients in alcohol rehabilitation provided significant insights into treatment engagement and relapse prevention, finding that personal readiness significantly influenced treatment-seeking behavior. NACADA (2022) nationwide research across multiple rehabilitation centers revealed how cultural acceptance and personal motivation interacted to influence support-seeking behavior. In Mombasa County, Wambugu and Omondi (2019) mixed-methods study of 200 participants examined factors influencing treatment engagement and outcomes in coastal rehabilitation centers, demonstrating how personal motivation combined with cultural factors influenced readiness to seek support. This study built upon these findings by focusing explicitly on how readiness to change influenced sustained participation in the three specific types of care support groups implemented in the selected rehabilitation centers.

Recommendations from Healthcare Providers. At the global level, research consistently showed the significant impact of healthcare provider recommendations on addiction treatment engagement. Tracy and Wallace (2016) meta-analysis of peer support groups in addiction treatment examined ten studies with a combined sample

of over 1,800 participants and revealed that professional healthcare recommendations increased treatment initiation rates by 65% compared to self-referral. Stanojlović and Davidson (2020) cross-sectional study of peer recovery support services across 15 countries involving 3,200 participants with substance use disorders demonstrated that structured healthcare provider interventions resulted in 70% higher engagement rates in support groups.

McGovern et al.'s (2021) qualitative research with 42 healthcare providers in the United Kingdom examined barriers and facilitators to implementing evidence-based addiction treatments and found that systematic screening and referral processes significantly improved treatment outcomes. These global studies provided valuable insights into the importance of healthcare provider recommendations, but a methodological gap existed regarding the specific mechanisms by which different types of healthcare provider recommendations influenced long-term engagement in rehabilitation center support groups. This study addressed this methodological gap by examining the specific mechanisms through which healthcare provider recommendations influenced sustained participation in the professional-led therapeutic, peer-led recovery, and family-integrated support groups at the selected Kenyan rehabilitation centers.

At the regional African level, Odejide et al. (2022) conducted a survey of 312 healthcare providers across Nigeria, Ghana, and South Africa, finding that provider attitudes and knowledge significantly influenced referral patterns to substance use treatment programs. Similarly, Mwesigire et al. (2021) interviewed 87 primary care providers in Uganda about barriers to addiction treatment referrals, identifying significant gaps in provider knowledge about available support services. Kalema and Vanderplasschen (2022) research across Kenya, Uganda, and Tanzania examined

healthcare referral patterns and treatment outcomes for 180 patients, showing that culturally competent healthcare recommendations improved treatment engagement by 55%.

Misouridou and Papadatou (2022) study of 58 patients and 24 healthcare providers across Eastern Africa demonstrated that providers who integrated knowledge of community-based healing resources and recovery approaches achieved 40% higher referral success rates. These regional studies highlighted the importance of culturally informed healthcare recommendations but did not specifically address how these recommendations influenced engagement with the particular types of support groups available in rehabilitation centers in selected counties in Kenya. This study addressed this gap by investigating the influence of healthcare provider recommendations on participation in the three specific types of care support groups implemented in the selected rehabilitation centers.

In the Kenyan context, NACADA (2023) nationwide survey of 1,200 individuals in recovery and 320 healthcare providers showed that healthcare provider recommendations significantly influenced treatment-seeking behavior, particularly when providers understood local cultural contexts and available support resources. Wainaina (2020) case-control study in Kiambu County examined referral patterns and treatment outcomes for 120 patients, establishing that healthcare provider recommendations were most effective when they included specific information about available support services. Wambugu and Omondi's (2019) mixed-methods study in Mombasa County examined factors affecting treatment engagement among 200 participants in rehabilitation programs and revealed that healthcare recommendations combined with family support increased treatment engagement by 60%.

Mutuku et al. (2022) survey of 185 healthcare providers in coastal Kenya

examined knowledge and attitudes about addiction treatment resources, demonstrating the importance of provider education in making appropriate referrals to support services. While these Kenyan studies provided valuable insights into the general importance of healthcare provider recommendations, a research gap existed in understanding the specific influence of healthcare provider recommendations on engagement with the professional-led therapeutic, peer-led recovery, and family-integrated support groups that were the focus of the current study in rehabilitation centers in selected counties in Kenya. This study addressed this research gap by examining the specific influence of healthcare recommendations on engagement with these three types of support groups within the structured environment of the selected rehabilitation centers.

Encouragement from Family and Friends. Globally, research demonstrates the paramount importance of family and friend encouragement in addiction treatment. Laudet and Humphreys (2013) comprehensive study examined recovery support services among 1,200 participants across eight countries (United States, Canada, United Kingdom, Australia, Sweden, Germany, Japan, and Brazil). Their research utilized a mixed-methods approach combining surveys and in-depth interviews, showing that family support increased treatment engagement by 55% and significantly improved long-term recovery outcomes. Razali et al. (2021) correlational study in Malaysia investigated factors influencing relapse among 50 women with substance use disorders. Using standardized assessment tools and regression analysis, they found strong positive correlations between family support and treatment retention, while peer influence also showed significant positive effects on engagement.

Day et al. (2023) three-year longitudinal study of 380 individuals in recovery

across multiple treatment centers in the United Kingdom utilized repeated measures to track recovery trajectories, revealing how sustained family encouragement contributed to long-term recovery success, with participants receiving consistent family support showing 62% lower relapse rates. These global studies highlighted the importance of family support but revealed a methodological gap in developing standardized measures for assessing the quality, consistency, and specific types of family support that most effectively promoted engagement with rehabilitation support groups. This study addressed this methodological gap through a mixed-methods approach that captured both quantitative ratings and qualitative narratives of the quality and mechanisms of family encouragement within care support groups.

At the regional level, African studies highlighted unique family dynamics in addiction recovery. Mwangi et al. (2021) conducted a mixed-methods study of 256 individuals in addiction treatment programs across four East African countries, examining how family structure affected treatment outcomes. Their research found that extended family involvement increased treatment completion rates by 38%. Similarly, Okewole et al. (2020) surveyed 312 individuals with alcohol dependence in Ghana, finding that family pressure was the primary motivation for seeking treatment among 68% of participants. Harris et al. (2022) comparative research across Kenya, Uganda, Tanzania, Ethiopia, and South Africa with 420 participants demonstrated how extended family support systems influenced treatment engagement differently than nuclear family support, with extended family interventions showing greater effectiveness in rural communities.

Kalema and Vanderplasschen (2022) outcome study of 180 patients in Uganda, Kenya, and Tanzania examined family-centered treatment approaches and revealed that family-centered approaches achieved 45% better outcomes when aligned

with local cultural practices and family structures. These regional studies highlighted the importance of family support but revealed a significant knowledge gap regarding how specific types of family encouragement influenced engagement with the particular support group models implemented in rehabilitation centers in selected counties in Kenya. This study addressed this knowledge gap by examining how different types of family encouragement specifically influenced participation in the professional-led therapeutic, peer-led recovery, and family-integrated support groups within the selected Kenyan rehabilitation centers.

In the Kenyan context, Wainaina (2020) case-control study in Kiambu County examined relapse factors among 120 individuals in alcohol rehabilitation programs. Using standardized measures and statistical analysis, this research showed significant correlations between marital support and treatment success. Ndegwa (2021) qualitative study interviewed 32 recovering alcoholics in Nairobi County, finding that family acceptance was cited as the most important factor in maintaining treatment engagement by 63.2% of participants. NACADA's (2022) nationwide study involving 850 individuals in various stages of recovery reported that family support was particularly effective when combined with community acceptance, with this combination resulting in 52% higher treatment completion rates.

While Wambugu and Omondi (2019) study in Mombasa County provided valuable insights into coastal treatment contexts, the current research specifically addressed a different gap in determining how family encouragement influenced participation in the three specific

types of support groups (professional-led therapeutic, peer-led recovery, and family-integrated) within the structured environment of rehabilitation centers in selected counties in Kenya, where institutional factors and specific program designs

created unique conditions affecting the impact of family encouragement on support group engagement. This study addressed this gap by investigating both the extent and the mechanisms through which family encouragement affected sustained engagement in these support groups.

Challenges Faced by Alcohol Addicts in Support Groups

Empirical studies have identified several challenges that hinder effective participation in care support groups for alcohol addiction recovery. These challenges operated at psychological, interpersonal, and structural levels. However, most research was conducted outside Kenyan rehabilitation contexts, leaving gaps in establishing how these barriers manifested and how they were addressed within structured support group programs in diverse Kenyan settings. The current study addressed these gaps by examining challenges from both participant and facilitator perspectives across three rehabilitation centers in Mombasa, Kiambu, and Lamu Counties.

Feelings of Shame, Vulnerability and Judgment. Sathyamurthi (2022) conducted qualitative research in Tamil Nadu, India, involving 42 participants across four rehabilitation centers. Using in-depth interviews and thematic analysis, the study found that feelings of shame and vulnerability significantly hindered participation, with 63.2% of participants reporting fear of judgment from group members and society as a primary barrier. Participants came from predominantly Hindu and Muslim backgrounds where family honor and community standing were highly valued. Joseph et al. (2024) investigated psychosocial challenges in Kerala, India, through a qualitative study of 36 families affected by alcohol addiction. They discovered that shame was magnified by family dynamics, with 65% of families experiencing "reflected shame," which created resistance to engaging with support

services. Motyka et al. (2022) systematic review of 28 studies involving over 3,000 participants across Europe and North America identified social stigma, shame, and judgment as primary barriers that reduced treatment engagement by up to 45%, particularly among marginalized communities. These studies were largely conducted in non-African cultural contexts and focused on general addiction recovery rather than specific support group dynamics. This study addressed these contextual and conceptual gaps by examining how shame, vulnerability, and judgment manifested and were managed within professional-led, peer-led, and family-integrated support groups in the cultural contexts of Mombasa, Kiambu, and Lamu Counties.

Disruptive Group Dynamics and Poor Facilitation. Misouridou and Papadatou (2017) examined operational challenges through focus group discussions with 27 addiction professionals. Using thematic analysis, they identified issues such as conflicts between participants, domination by certain members, and difficulties maintaining supportive atmospheres. Poor facilitation often exacerbated these problems. Kalema and Vanderplasschen (2022) investigated treatment challenges in Uganda using mixed-methods research and found that inadequate facilitator skills, including limited training and cultural insensitivity, significantly impaired group functioning. These studies concentrated mainly on professional perspectives or Ugandan contexts and rarely incorporated participant experiences. This study addressed these methodological and contextual gaps by including both facilitator and participant viewpoints on group dynamics and facilitation within the specific cultural setting of the selected Kenyan rehabilitation centers.

Resource and Funding Constraints. Sanger (2021) focused on

resource limitations using a multi-method approach involving analysis of 1,500 program documents and interviews with 22 stakeholders. The study found that financial constraints limited critical services such as appropriate meeting spaces, trained facilitators, and supplementary resources. Kalema and Vanderplasschen (2022) examined addiction treatment systems in Uganda and identified a growing disparity between service demand and available resources, resulting in overcrowded groups, inadequate privacy, and insufficient individualized attention. These studies focused primarily on online or systemic levels and rarely examined participant experiences in in-person, resource-limited rehabilitation settings. This study addressed these conceptual and methodological gaps by incorporating both systemic and individual perspectives on how resource constraints affected recovery outcomes in the selected Kenyan rehabilitation centers, with particular attention to in-person support group dynamics.

Strategies Employed by Care Support Groups

Strategies employed by care support groups represent systematic interventions designed to promote long-term sobriety among participants. These strategies include cognitive-behavioral skill building, peer mentorship and accountability, structured goal-setting and monitoring, and relapse prevention planning (Mette et al., 2020; Schwartz et al., 2014). Effective implementation of evidence-based strategies has been documented as critical for translating support group participation into sustained recovery outcomes (Elbanna et al., 2016).

Skills Development. Mette et al. (2020) conducted qualitative research with in-depth interviews of 26 support group facilitators from occupational health settings. They identified skills development as a critical component of successful recovery

programs. The study found that structured approaches teaching coping mechanisms, stress management, and emotional regulation skills significantly improved participants' ability to maintain sobriety. Programs combining problem-oriented skills (time management, boundary setting) and emotion-focused skills (self-care, stress management) achieved 45% higher engagement rates and better long-term outcomes. The study focused primarily on facilitator perspectives in

generalized settings, creating a methodological gap. This study addressed this gap by incorporating both facilitator and participant viewpoints on skills development effectiveness within the professional-led therapeutic, peer-led recovery, and family-integrated support groups in the selected Kenyan rehabilitation centers.

Wang et al. (2021) investigated specific skills development approaches across multiple rehabilitation centers using a mixed-methods design with 300 participants. The research established that cognitive behavioral therapy-based skills development produced the most significant improvements in long-term sobriety. Participants showed enhanced ability to identify triggers, manage cravings, and implement effective coping strategies, with structured programs leading to a 60% reduction in relapse rates compared to less structured approaches. The study was conducted in urban Western contexts, creating a contextual gap. This study addressed this gap by examining skills development approaches specifically implemented within the structured support group programs in resource-limited Kenyan rehabilitation centers.

Recovery Planning. Elbanna et al. (2016) investigated the importance of structured recovery planning in support service organizations through a comprehensive case study of over 150 organizations. They found that formal planning processes significantly enhanced support group effectiveness. Successful recovery planning involved regular assessment of participant needs, clear goal-setting, and

systematic evaluation of progress toward milestones, resulting in 55% better retention rates and improved long-term outcomes. The study focused primarily on organizational planning in general service settings, leaving a gap in understanding how recovery planning was implemented and adapted within rehabilitation center support groups. This study addressed this gap by examining how recovery planning was specifically implemented and adapted in the selected Kenyan rehabilitation centers.

Ferlie and Ongaro (2022) examined collaborative recovery planning strategies across

diverse support organizations using comparative analysis. They found that involving participants in the planning process significantly enhanced engagement and recovery outcomes, with co-created plans resulting in 40% higher adherence rates compared to plans developed without participant input. The researchers emphasized the importance of tailoring planning to individual needs and local contexts. The study was conducted primarily in developed nations, creating a contextual gap for resource-limited settings. The current study addressed this gap by investigating recovery planning approaches specifically within the resource-limited environment of rehabilitation centers in Mombasa, Kiambu, and Lamu Counties.

Accountability. Schwartz et al. (2014) explored accountability mechanisms within support group settings through observational research and outcome analysis. They found that structured accountability systems significantly enhanced recovery success. Relationship-based accountability, including paired mentoring and peer check-in systems, resulted in 50% higher retention rates and improved long-term sobriety outcomes. The researchers emphasized the need for safe spaces where participants could honestly discuss challenges and receive constructive feedback. The

study focused primarily on peer accountability without examining professional oversight, creating a conceptual gap. This study closed this gap by investigating the integration of both peer and professional accountability systems in the selected Kenyan rehabilitation centers.

Collins-Camargo et al. (2019) conducted a detailed qualitative analysis of accountability structures across support organizations with 182 administrators. They identified multiple effective approaches and found that successful programs balanced clear accountability measures with flexibility to accommodate individual recovery journeys. Organizations implementing progressive accountability systems (where expectations increased as recovery progressed) achieved better outcomes than those with static structures. The study concentrated on administrative perspectives without incorporating participant experiences, creating a methodological gap. This study addressed this gap by including both provider and participant viewpoints on effective accountability mechanisms within the support groups at the selected rehabilitation centers.

Theoretical Framework

The theoretical foundation of this study was built upon two complementary theories: Cognitive Behavioral Theory and the Motivational Enhancement Model. These frameworks provided a lens through examining the effectiveness of care support groups in maintaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. The integration of these theories offered valuable insights into both the cognitive-behavioral and motivational mechanisms that contributed to successful recovery maintenance through support group participation.

Cognitive Behavioral Theory (CBT)

The Cognitive Behavioral Theory was developed by Aaron Beck in the 1960s, building upon earlier work by Albert Ellis on rational emotive behavior therapy (Beck, 1970; Beck et al., 1979; Ellis, 1962). The theory represents a significant paradigm shift in understanding psychological disorders by emphasizing the critical connection between thoughts, feelings, and behaviors (Hofmann et al., 2012). Cognitive Behavioral Theory asserts that psychological problems and maladaptive behaviors are significantly influenced by cognitive processes and beliefs (Beck & Haigh, 2014). According to the theory, individuals develop core beliefs and automatic thoughts that impact their emotional responses and behavioral choices (Dobson & Dozois, 2019). In addiction recovery contexts, CBT proposes that problematic substance use is maintained through maladaptive thought patterns that can be systematically identified and modified (McHugh et al., 2010).

The theory operates on several fundamental assumptions that guide its application in clinical and support group settings. First, CBT assumes that cognitive activity affects behavior and that this cognitive activity can be monitored and altered (Dobson & Dozois, 2019). Second, it postulates that desired behavioral change may be achieved through cognitive change (Hofmann et al., 2012). Third, CBT assumes a learning approach to psychological problems, suggesting that maladaptive behaviors can be unlearned (Hollon & Beck, 2013). Fourth, the theory embraces time-limited, structured interventions focused on present circumstances (Butler et al., 2006). Finally, CBT assumes active collaboration between therapist and client (Waltman et al., 2017).

The strength of the Cognitive Behavioral Theory lies in its extensive empirical validation across numerous psychological disorders, including substance use disorders (Hofmann et al., 2012). Its structured, goal-oriented approach provides clear direction

for both providers and clients (Wenzel et al., 2016). Additionally, CBT's focus on teaching practical skills promotes client autonomy and sustainable long-term change (Carroll & Kiluk, 2017). However, the theory has been criticized for potentially oversimplifying complex psychological phenomena by focusing primarily on conscious thoughts (Longmore & Worrell, 2007). Critics also note that the theory's effectiveness may be limited for individuals with cognitive impairments (Hays & Iwamasa, 2006). Furthermore, CBT may be less effective for individuals from cultural backgrounds where cognitive restructuring approaches are unfamiliar (Naeem et al., 2015). Despite these criticisms, CBT remains highly applicable to this study as it provides a robust framework for understanding how care support groups facilitate cognitive and behavioral change processes essential for maintaining sobriety.

Despite its strengths in addressing cognitive and behavioral aspects of addiction, CBT alone is insufficient for comprehensively addressing addiction recovery. CBT primarily focuses on cognitive restructuring and behavioral modification but does not adequately address the motivational factors that influence initial engagement and sustained participation in recovery programs (Miller & Rollnick, 2013). Many individuals struggling with addiction experience ambivalence about change, which CBT's directive approach may not effectively resolve (Arkowitz et al., 2015). Additionally, CBT's emphasis on structured interventions may not adequately address the emotional and interpersonal dynamics that are central to group-based recovery (Moyers et al., 2005). This gap necessitates the integration of Motivational Enhancement Model, which specifically addresses motivational readiness, ambivalence resolution, and client-centered engagement strategies that complement CBT's cognitive-behavioral focus.

The theory was highly pertinent to the study variables since it informed the

core mechanisms through which care support groups facilitate sobriety maintenance among alcohol addicts. CBT provided a framework for understanding how support groups can systematically address maladaptive thoughts and behaviors related to alcohol use (McHugh et al., 2010). The theory explained how group-based cognitive interventions can enhance self-efficacy and improve emotional regulation among participants (Bieling et al., 2006). Furthermore, CBT offered valuable insights into structured accountability processes within support groups (Kadden & Litt, 2011). Therefore, the theory provided a theoretical foundation for understanding individual cognitive change processes and supportive group dynamics in rehabilitation centers.

Motivational Enhancement Model (MET)

Motivational Enhancement Model was developed by William Miller and Stephen Rollnick in the early 1990s as an adaptation of their Motivational Interviewing Approach (Miller & Rollnick, 1991). The theory emerged as a response to confrontational addiction treatment approaches (Miller & Rose, 2009). The Motivational Enhancement Model

postulates that sustainable behavior change occurs through resolving ambivalence and strengthening personal motivation for change (Rollnick et al., 2008). The theory emphasizes four key principles: expressing empathy, developing discrepancy between current behavior and broader goals, rolling with resistance, and supporting self-efficacy (Miller & Rollnick, 2013). MET proposes that through these processes, individuals develop stronger internal commitment to behavior change (Arkowitz et al., 2008).

MET operates on several fundamental assumptions that guide its application in addiction recovery settings. First, the theory assumes that motivation is not a fixed

personality trait but a fluctuating state (Miller & Rollnick, 2013). Second, it posits that ambivalence about change is normal and resolving this ambivalence is central to behavior change (Apodaca & Longabaugh, 2009). Third, MET assumes that confrontational approaches typically increase resistance rather than facilitating change (Miller et al., 1993). Fourth, the theory emphasizes that individuals possess the capacity for self-directed change when properly supported (Markland et al., 2005). Finally, MET assumes that motivation can be mobilized through strategic evocation (Lundahl & Burke, 2009).

The strength of the Motivational Enhancement Model lies in its strong empirical support across diverse populations and problem behaviors (Lundahl et al., 2010). Its non-confrontational, client-centered approach reduces treatment resistance and improves engagement (Moyers et al., 2005). Additionally, MET's brief nature makes it cost-effective and easily integrated with other treatment approaches (Burke et al., 2003). However, the theory has been criticized for potentially insufficient structure for individuals requiring more directive guidance (Ashton, 2005). Critics also note that MET's effectiveness may depend significantly on provider skill and adherence to its principles (Moyers et al., 2005).

MET complements CBT by addressing the motivational dimensions that CBT does

not adequately cover. While CBT focuses on cognitive restructuring and behavioral change, MET specifically targets motivation enhancement and ambivalence resolution (Miller & Rollnick, 2013). MET's client-centered approach balances CBT's more directive structure, creating a comprehensive framework that addresses both motivation and behavior change (Arkowitz et al., 2015). This complementarity is particularly important in group-based addiction recovery where

participants are at varying stages of readiness for change (DiClemente et al., 2017). MET's emphasis on empathy and non-confrontation creates a supportive environment that enhances the effectiveness of CBT's cognitive-behavioral techniques (Wagner & Ingersoll, 2012). Together, these theories provided a holistic framework that addressed cognitive, behavioral, and motivational aspects of addiction recovery.

The theory was highly relevant to the study variables since it directly addressed the motivational factors influencing alcohol addicts to seek and maintain engagement with care support groups. MET provided a theoretical framework for understanding how support groups can effectively enhance intrinsic motivation for change (Miller & Rollnick, 2013). The theory explained how developing discrepancy between current drinking behavior and broader life goals can strengthen commitment to sobriety (Markland et al., 2005). Furthermore, MET offered valuable insights into overcoming the challenges faced by alcohol addicts in support groups (Moyers et al., 2005). Therefore, the theory illuminated the psychological processes through which support groups can foster intrinsic motivation and commitment to long-term recovery.

Conceptual Framework

A conceptual framework presents interrelated concepts used to explain a phenomenon and guide research. In this study, the conceptual framework illustrated the relationship between care support groups (independent variable) and sobriety maintenance among alcohol addicts in rehabilitation centers in selected counties in Kenya (dependent variable). The framework focused on three types of care support groups: professional-led therapeutic, peer-led recovery, and family-integrated groups. It examined how these groups influenced sobriety maintenance through their benefits, influencing factors, challenges faced by participants, and strategies employed. Strategies served as moderating variables that could strengthen or weaken the

relationship between care support groups and sobriety maintenance. The conceptual framework is presented in Figure 1 below.

Figure 1

Conceptual Framework

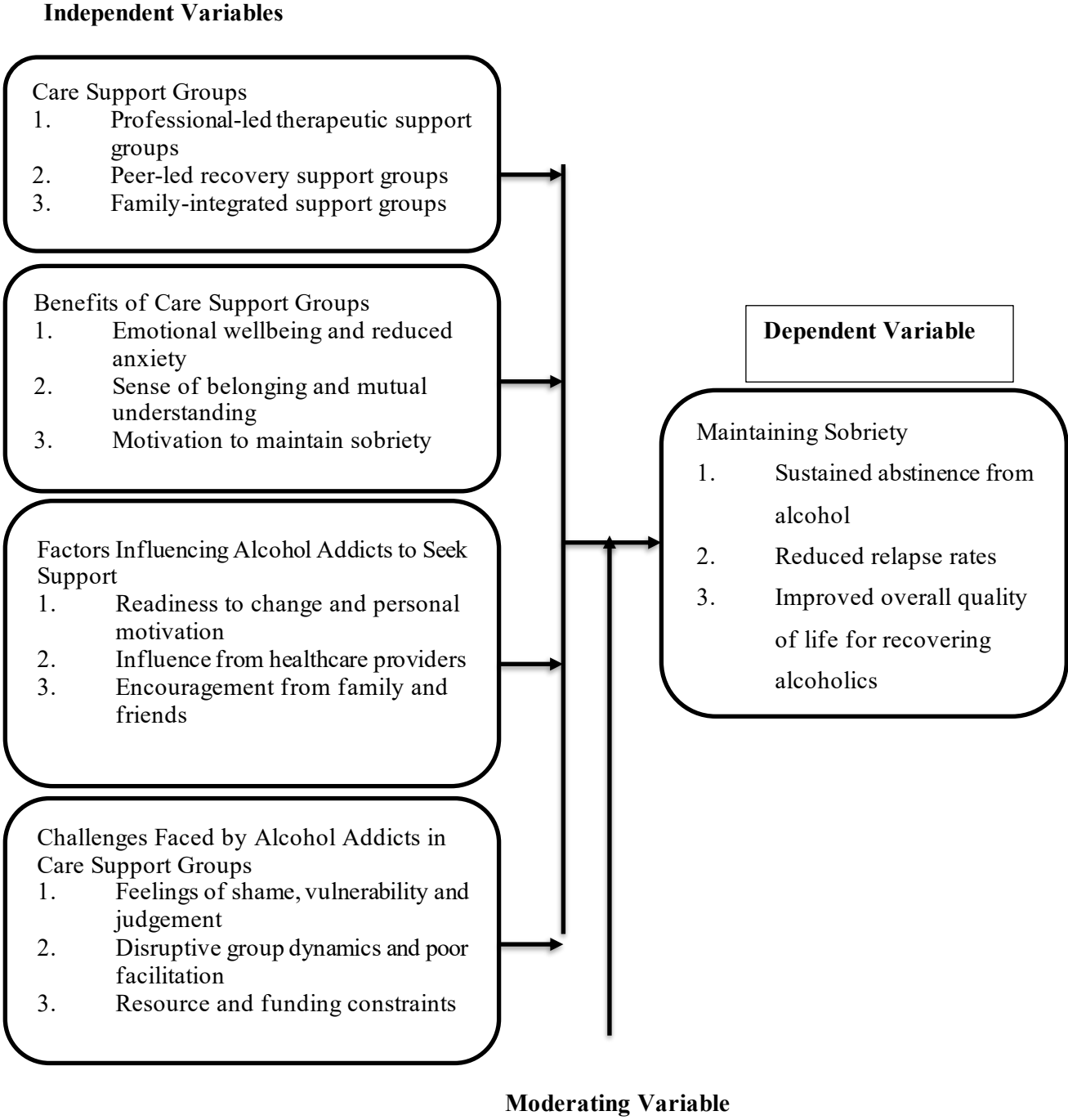


Figure 1 above illustrates the relationship between care support groups and maintaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. The conceptual framework identifies three main components: the independent variable (care support groups), the dependent variable (sobriety maintenance), and moderating variables (strategies employed by care support groups). The independent variable, care support groups, consists of three primary constructs: professional-led therapeutic support groups, peer-led recovery support groups, and family-integrated support groups. These specific support group types represent the structural foundation of addiction recovery support in rehabilitation centers in selected counties in Kenya. Each type offers distinct approaches while sharing common elements that contribute to recovery maintenance.

To examine the effectiveness of these support group types, the framework addresses their benefits through constructs such as emotional well-being and reduced anxiety, improved resilience and social relationships, and sense of belonging and mutual understanding. Similarly, factors influencing alcohol addicts to seek support are explored through the examination of readiness to change and need for support, recommendations from healthcare providers, and encouragement from family and friends. The challenges faced by alcoholics in these support groups were investigated by examining feelings of shame, vulnerability, and judgment, disruptive group dynamics and poor facilitation, and resource and funding constraints. These factors often create barriers to effective participation and may influence recovery outcomes.

The framework identifies strategies employed by care support groups as moderating variables that influence the relationship between support groups and sobriety maintenance. These strategies include skills development, recovery planning, and accountability mechanisms. As moderating variables, these strategies can

strengthen or weaken the effectiveness of the support groups in achieving sobriety maintenance.

The study focused on sobriety maintenance as the dependent variable, examining three key indicators: sustained abstinence from alcohol, reduced relapse rates, and improved overall quality of life for recovering alcoholics. By investigating the relationship between specific types of care support groups and sobriety maintenance, as well as how this relationship is moderated by various support group strategies, the study aimed to gain a deeper understanding of effective recovery support systems in rehabilitation centers in selected counties in Kenya.

Research Gap Synthesis

Existing literature revealed significant gaps in understanding the effectiveness of care support groups in maintaining sobriety among alcohol addicts, particularly within Kenyan rehabilitation contexts. These gaps are organized into four thematic areas that this study addressed.

Benefits of Care Support Groups.

Global studies documented improvements in emotional well-being and anxiety reduction among support group participants (McGovern et al., 2021; Tracy & Wallace, 2016). However, these studies were mainly conducted in well-resourced Western settings. Regional African studies showed better outcomes with culturally adapted approaches (Harerimana, 2020; Ngwenya, 2022), yet few examined how Kenyan rehabilitation centers operationalized these benefits in their unique socio-cultural contexts. Local Kenyan studies focused on general recovery outcomes rather than specific support group benefits (Gachara et al., 2019; Machuki, 2020). This study filled this gap by systematically examining the specific benefits of care support

groups including emotional well-being, sense of belonging, and mutual understanding across three diverse Kenyan counties with varying cultural and socioeconomic characteristics.

Factors Influencing Support-Seeking Behavior

International literature identified personal readiness, healthcare recommendations, and family encouragement as key motivating factors (Day et al., 2023; Laudet & Humphreys, 2013). These were largely studied in individualistic Western societies. African studies highlighted the role of extended family and community influences (Harris et al., 2022; Kalema & Vanderplasschen, 2022). Kenyan studies established correlations between family support and reduced relapse (Kinyua, 2019) but did not examine how these factors influenced initial engagement with care support groups. This study addressed this gap by investigating the interplay of personal, professional, and familial factors influencing support-seeking behavior in Kenyan rehabilitation settings.

Challenges in Support Group Participation

Global research identified stigma, accessibility issues, and group dynamics as common challenges (Sathyamurthi, 2022; Wang et al., 2021). These studies were conducted in contexts with different cultural attitudes toward addiction. Regional African studies acknowledged resource constraints and cultural barriers (Misouridou & Papadatou, 2017; Tadesse et al., 2021). However, few studies systematically examined the specific challenges faced by participants in Kenyan rehabilitation center support groups across diverse geographical and cultural contexts. Coastal Mombasa, central Kiambu, and traditional Lamu presented distinct challenges that remained largely unexplored. This study filled this gap by documenting region-specific

challenges and their impact on recovery outcomes.

Strategies for Promoting Long-Term Sobriety

International literature documented skills development, recovery planning, and accountability mechanisms as effective strategies (Collins-Camargo et al., 2019; Elbanna et al., 2016). Regional studies demonstrated the value of integrating traditional healing with evidence-based approaches (Harerimana, 2020; Kehinde et al., 2025). However, limited research examined which specific strategies Kenyan rehabilitation centers employed and how they were adapted to local contexts. Previous Kenyan studies focused mainly on relapse predictors rather than successful strategies (Kelvin, 2024; Mutuku et al., 2022). This study addressed this gap by investigating the specific strategies employed by care support groups in Kenyan rehabilitation centers and their effectiveness in promoting long-term sobriety across diverse county contexts.

Chapter Summary

This chapter has reviewed conceptual and empirical literature guided by the four objectives of the study: the benefits of care support groups in sustaining sobriety, factors influencing alcohol addicts to seek support, challenges faced by participants attending care support groups, and strategies employed to promote long-term sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. The chapter has discussed the two theories underpinning the study; Cognitive Behavioral Theory and the Motivational Enhancement Model. It has also presented and explained the conceptual framework, which showed the relationship between care support groups as the independent variable and sobriety maintenance as the dependent variable, with strategies serving as moderating variables. The next chapter presents

the methodology of the study.

Chapter Three: Research Methodology

Introduction

This chapter presents the research methodology employed in investigating the effectiveness of care support groups in maintaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. It outlines the research design, target population, sampling procedures, data collection instruments, data analysis techniques, validity and reliability measures, pilot study procedures, and ethical considerations.

Research Design

This study employed a convergent parallel mixed-methods research design (Creswell & Plano Clark, 2018). In this design, quantitative and qualitative data were collected during the same phase of the research process, analyzed separately, and integrated during interpretation. The design was appropriate because the study sought to measure the effectiveness of care support groups statistically while also obtaining deeper explanations from participants and key informants on how care support groups supported sobriety maintenance.

The quantitative component enabled the researcher to determine the relationship between care support groups and sobriety maintenance using descriptive and inferential statistics. It also allowed the study to examine the effect of support group benefits, support-seeking factors, challenges, and strategies on sobriety maintenance. The qualitative component provided detailed narratives on participants' and facilitators' experiences, including the emotional, social, cultural, and practical realities of participating in care support groups.

The design was suitable for the current study because sobriety maintenance is

both measurable and experiential. While questionnaire responses provided numerical evidence on patterns of support group effectiveness, interviews helped to explain why those patterns occurred. The integration of quantitative and qualitative findings therefore strengthened the interpretation of results through triangulation. Where the findings converged, stronger conclusions were drawn. Where the findings differed, qualitative insights were used to explain the contextual factors influencing care support group effectiveness.

Target Population

The target population comprised 285 patients enrolled in care support groups across three rehabilitation centres in Kenya. The study was conducted at Amani Acres Rehabilitation Centre in Mombasa County, Serene Hospital and Rehabilitation Center in Kiambu County, and Lamu Rehabilitation Centre in Lamu County. These centres were selected because they had structured care support group programmes for people recovering from alcohol abuse and were located in counties with different geographical, cultural, and socioeconomic contexts.

The counties and rehabilitation centres were selected using purposive site selection. Mombasa County was selected because Amani Acres Rehabilitation Centre had an established care support group programme with 90 enrolled patients and represented a coastal context where alcohol-related rehabilitation cases are a major concern. Kiambu County was selected because Serene Hospital and Rehabilitation Center had 135 enrolled patients and operated structured professional-led, peer-led, and family-integrated support groups, making it suitable for examining care support group effectiveness in a mixed urban and peri-urban setting. Lamu County was selected because Lamu Rehabilitation Centre had 60 enrolled patients and represented an under-researched cultural, religious, and socioeconomic context where limited

empirical work on alcohol recovery support groups had been conducted (Ndung'u, 2011).

The study also included 15 key informants drawn from the three rehabilitation centres. These included counselors and support group facilitators who were directly involved in guiding care support group sessions. They were selected because they had practical knowledge of support group processes, participant engagement, challenges faced during facilitation, and strategies used to promote sobriety maintenance. Five key informants were selected from each centre to ensure balanced representation across the three study sites.

Sampling Method and Sample Size

The study used a combination of purposive site selection, stratified random sampling, and criterion purposive sampling. Purposive site selection was used to select the three counties and rehabilitation centres because they met the study criteria of having structured care support group programmes, serving people recovering from alcohol abuse, representing diverse county contexts, and granting access for data collection.

Stratified random sampling was used to select questionnaire respondents from the three rehabilitation centres (Etikan & Babatope, 2019). Each rehabilitation centre formed a stratum. This method ensured that participants from Amani Acres Rehabilitation Centre, Serene Hospital and Rehabilitation Center, and Lamu Rehabilitation Centre were proportionately represented in the sample. After determining the sample size for each centre, participants were selected randomly from lists of eligible care support group members provided by the respective centres.

The sample size was calculated using Yamane's (1967) formula with a 95%

confidence level and 5% margin of error:

$n = N / (1 + N*e^2)$

Where:

n = sample size

N = total population (285)

e = margin of error (0.05)

$n = 285 / (1 + 285*0.05^2)$

$n = 285 / (1 + 0.7125)$

$n = 285 / 1.7125$

$n = 166.4$

$n \approx 167$ participants

Therefore, the study selected 167 questionnaire respondents from the target population of 285 patients. In addition, 15 key informants were selected for interviews, giving a total sample of 182 respondents.

Table 1

Sampling Framework

Rehabilitation Center	County	Target Population (N)	Sample Size (n)	Key Informants	Total
Amani Acres Rehabilitation Centre	Mombasa	90	53	5	58

Serene Hospital and Rehabilitation Center	Kiambu	135	79	5	84
Lamu Rehabilitation Centre	Lamu	60	35	5	40
Total		285	167	15	182

Criterion purposive sampling was used to select the 15 key informants. This type of purposive sampling was appropriate because the study required informants who had specific knowledge and direct experience in addiction counseling and support group facilitation. The selection criteria included having at least two years of experience in addiction counseling or support group facilitation, direct involvement in care support group activities, understanding of rehabilitation processes, and willingness to participate in the study.

Types of Data

The study used primary data collected directly from participants through questionnaires and semi-structured interviews (Taherdoost, 2021a). Primary data were appropriate because the study required direct information from people recovering from alcohol abuse and key informants involved in care support group programmes. The use of primary data ensured that the information collected was aligned with the study objectives and reflected the actual experiences of participants in the selected rehabilitation centres (Asenahabi, 2019).

Research Instruments

The study used a structured questionnaire and a semi-structured interview guide. The questionnaire generated quantitative data, while the interview guide generated qualitative data. The use of both instruments was consistent with the convergent parallel mixed-methods design because it allowed the researcher to collect

both numerical and narrative data on the effectiveness of care support groups.

Questionnaire

The questionnaire was researcher-developed and literature-informed. It was not adopted as a single standardized tool from one proponent. Instead, the items were developed from the study objectives, the conceptual framework, the theoretical framework, and the reviewed literature. The questionnaire was guided by Cognitive Behavioral Theory and the Motivational Enhancement Model and was constructed following questionnaire development principles outlined by Taherdoost (2016). The items were designed to capture the main constructs of the study, including benefits of care support groups, support-seeking factors, challenges faced by participants, strategies used by care support groups, and sobriety maintenance outcomes.

The questionnaire contained six sections. Section A collected demographic information, including gender, age, education level, employment status, duration in the rehabilitation programme, and previous treatment experience. Section B measured the benefits of care support groups, including emotional well-being, sense of belonging, and mutual understanding. Section C measured factors influencing support-seeking behavior, including readiness to change, healthcare provider recommendations, and family encouragement. Section D measured challenges faced in support groups, including feelings of shame and vulnerability, disruptive group dynamics, and resource constraints. Section E measured strategies employed by support groups, including skills development, recovery planning, and accountability mechanisms. Section F measured sobriety maintenance outcomes, including sustained abstinence, reduced relapse rates, and improved quality of life.

The questionnaire used a five-point Likert scale. For attitudinal statements,

responses ranged from “Strongly Disagree” (1) to “Strongly Agree” (5). For frequency-based statements, responses ranged from “Never” (1) to “Very Often” (5). Sample items included: “Support group discussions help me manage anxiety related to recovery,” “Healthcare providers recommended I join a support group,” “I feel judged when sharing personal experiences in the group,” “The group helps me develop practical coping skills,” and “I have maintained complete abstinence from alcohol.”

Interview Guide

The semi-structured interview guide was researcher-developed and aligned with the four study objectives. It was used to collect qualitative data from 15 key informants, including counselors and support group facilitators. The guide contained open-ended questions that allowed informants to explain their experiences, observations, and professional views on care support groups and sobriety maintenance.

The interview guide covered four main areas. The first area focused on the perceived benefits of care support groups, including emotional support, sense of connection, and changes in participants’ self-perception. The second area focused on factors motivating people recovering from alcohol abuse to seek support, including readiness to change, healthcare provider recommendations, and family encouragement. The third area focused on challenges encountered during group facilitation, including shame, vulnerability, group dynamics, and resource-related barriers. The fourth area focused on strategies used in care support groups, including skills development, recovery planning, and accountability mechanisms.

Sample interview questions included: “What benefits do participants gain from care support groups?” “What factors motivate participants to seek support through care groups?” “What challenges do participants face while attending care support groups?” and “Which strategies used in care support groups appear most helpful in maintaining sobriety?” Probing questions such as “Can you give an example?” and “How does this affect recovery?” were used to obtain deeper explanations.

Pilot Testing

A pilot study was conducted at Serenity Rehabilitation Centre in Nyali, Mombasa County, with 18 participants, comprising 15 patients and 3 facilitators. The site was selected purposively because it had support group structures similar to those in the main study centres but was not part of the final study sample. This helped to avoid contamination of the main study while still allowing the researcher to test the instruments in a comparable rehabilitation setting.

The pilot study helped the researcher to assess clarity of the questionnaire and interview questions, estimate the time required to complete the instruments, identify ambiguous items, assess cultural appropriateness, test field logistics, and conduct preliminary reliability analysis. The pilot study also helped to determine whether respondents understood the Likert-scale items and whether the interview questions were able to elicit detailed responses.

The pilot study led to minor modifications of the instruments. For example, some long and technical statements were simplified to improve understanding among participants with different education levels. An item such as “Support group

participation enhances my psychosocial adjustment during recovery" was revised to "Support group participation helps me cope better during recovery." Some questions were also reworded to avoid repetition and to make them easier to translate into Kiswahili during clarification. The average questionnaire completion time was also established at approximately 30 to 40 minutes, which helped the researcher plan the main data collection process.

The pilot reliability test produced an overall Cronbach's alpha coefficient of 0.87 for the questionnaire, which was above the acceptable threshold of 0.70 (Tavakol & Dennick, 2011). This indicated that the instrument had acceptable internal consistency and was suitable for the main study.

Validity and Reliability of the Instruments

Validity and reliability were established before the main data collection. Content validity was established through expert review by five addiction specialists, including three psychologists and two addiction counselors. The experts reviewed the questionnaire and interview guide to determine whether the items were clear, relevant, and aligned with the study objectives. Their feedback was used to refine the instruments before the main study. The Content Validity Index was calculated, with a threshold of 0.80 or higher considered acceptable (Polit & Beck, 2006).

Construct validity was assessed by ensuring that the questionnaire items were aligned with the conceptual framework and the theoretical framework. The items reflected the key constructs of the study, including care support group benefits, support-seeking factors, challenges, strategies, and sobriety maintenance. The constructs were also linked to Cognitive Behavioral Theory and the Motivational

Enhancement Model.

Reliability was assessed using Cronbach's alpha in SPSS version 30.0. Coefficients of

0.70 or higher were considered acceptable (Tavakol & Dennick, 2011). The pilot test produced an overall Cronbach's alpha coefficient of 0.87, indicating that the questionnaire had acceptable internal consistency. This reliability result was therefore reported in this section because it showed that the instrument was dependable before being used in the main study.

To strengthen the validity of the qualitative process, interviews were conducted in English or Kiswahili depending on the preference of the informant. Interviews conducted in Kiswahili were translated into English during transcription. The researcher ensured that the translated transcripts retained the original meaning of participants' responses. Where necessary, translated statements were cross-checked to maintain clarity, accuracy, and consistency of meaning.

Trustworthiness of Qualitative Data

Trustworthiness of qualitative data was ensured using Lincoln and Guba's (1985) four criteria. Credibility was achieved through prolonged engagement with participants, triangulation of interview data with questionnaire findings, and member checking of interview summaries. Transferability was enhanced by providing detailed descriptions of the study context, participant characteristics, and data collection procedures. Dependability was maintained through an audit trail that documented methodological decisions, data collection steps, and analysis procedures. Confirmability was enhanced through reflexive note-taking and grounding

interpretations in participants' responses.

Data Collection Procedure

After obtaining ethical clearance from Pan African Christian University and NACOSTI, permission letters were obtained from the management of Amani Acres Rehabilitation Centre, Serene Hospital and Rehabilitation Center, and Lamu Rehabilitation Centre. The researcher then coordinated with each centre to identify eligible participants who were actively enrolled in care support groups.

The researcher and trained research assistants visited the selected centres and explained the purpose of the study to the eligible participants. Participants who agreed to take part signed informed consent forms before completing the questionnaires. The questionnaires were administered in private and quiet spaces within the rehabilitation centres to promote confidentiality and reduce distractions. The researcher and research assistants were available to clarify questions, especially for participants who needed help understanding some items. Where necessary, clarification was provided in Kiswahili.

For the qualitative component, the researcher scheduled face-to-face interviews with the 15 key informants at convenient times within the rehabilitation centres. Each interview lasted approximately 45 to 60 minutes. With permission from the informants, the interviews were audio-recorded and supplemented with field notes. Interviews were conducted in English or Kiswahili depending on the informant's preference. All recordings were transcribed verbatim, and Kiswahili responses were translated into English while preserving the original meaning.

Data Analysis Plan

Data were cleaned, coded, and organized before analysis. Quantitative data

were analyzed using SPSS version 30.0. The researcher checked for missing values, outliers, and inconsistencies before conducting statistical analysis.

Quantitative Data Analysis

Quantitative data were analyzed using descriptive and inferential statistics. Descriptive statistics included frequencies, percentages, means, and standard deviations. These were used to summarize demographic characteristics and describe respondents' views on the benefits of care support groups, factors influencing support-seeking, challenges faced in support groups, strategies employed, and sobriety maintenance outcomes.

Inferential statistics were used to test relationships among the study variables. Pearson correlation analysis was used to examine the strength and direction of the relationship between each independent variable and sobriety maintenance. Correlation coefficients were interpreted as weak, moderate, or strong depending on their magnitude, and statistical significance was tested at the 0.05 level.

Simple linear regression analysis was used to determine the effect of each independent variable on sobriety maintenance. The independent variables were benefits of care support groups, factors influencing support-seeking, challenges faced in support groups, and strategies employed by care support groups. The dependent variable was sobriety maintenance. The general simple linear regression model was specified as:

$$Y = \beta_0 + \beta_1 X + \varepsilon$$

Where: Y = sobriety maintenance β_0 = constant β_1 = regression coefficient X = independent variable ε = error term

Multiple regression analysis was also used to determine the combined effect of

the independent variables on sobriety maintenance. The multiple regression model was specified as:

$$Y = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + \varepsilon$$

Where: Y = sobriety maintenance X_1 = benefits of care support groups X_2 = factors influencing support-seeking X_3 = challenges faced in care support groups X_4 = strategies employed by care support groups β_0 = constant β_1–β_4 = regression coefficients ε = error term. The regression outputs included the model summary, ANOVA table, and coefficients table. The model summary provided R, R^2, adjusted R^2, and standard error of the estimate. The ANOVA table tested the overall significance of the regression model using the F-statistic. The coefficients table provided unstandardized coefficients, standardized beta coefficients, t-statistics, and significance values.

Qualitative Data Analysis

Qualitative data were analysed using Braun and Clarke's (2006) reflexive thematic analysis. The analysis followed six steps: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. The researcher first read the transcripts repeatedly to gain a clear understanding of the data. Codes were then developed from recurring ideas and grouped into themes aligned with the study objectives.

The themes were compared with the quantitative findings during interpretation. Direct quotations from informants were used to support the themes and provide depth to the findings. The use of qualitative data helped to explain the statistical patterns observed in the quantitative findings.

Data Integration

Data integration occurred at the interpretation stage through convergent triangulation. Quantitative results were compared with qualitative themes to identify areas of agreement, complementarity, or divergence. Where the quantitative and qualitative findings supported each other, stronger conclusions were made. Where differences appeared, qualitative explanations were used to understand the contextual reasons behind the differences. This integration helped to provide a fuller understanding of the effectiveness of care support groups in maintaining sobriety.

Ethical Considerations

Ethical clearance was obtained from Pan African Christian University Institutional Research Ethics Committee and the National Commission for Science, Technology and Innovation. Permission was also obtained from the management of Amani Acres Rehabilitation Centre, Serene Hospital and Rehabilitation Center, and Lamu Rehabilitation Centre before data collection began.

Informed consent was obtained from all participants before data collection. Participants were informed about the purpose of the study, the procedures involved, potential risks and benefits, confidentiality measures, voluntary participation, and their right to withdraw from the study at any time without penalty. Written consent was obtained before questionnaires and interviews were administered.

Confidentiality and anonymity were maintained throughout the study. Participants were assigned identification codes instead of using their names. No personal identifying information was included in the final report. The researcher also ensured that interviews and questionnaire administration were conducted in private spaces within the rehabilitation centres.

The study involved a sensitive topic because participants were people

recovering from alcohol abuse. To reduce possible emotional discomfort, participants were allowed to skip any question they did not wish to answer. Professional counselors were available at the rehabilitation centres to support any participant who experienced distress during data collection. Counseling support was provided free of charge where needed.

Data storage and disposal procedures were also observed. Completed questionnaires and consent forms were stored in locked cabinets accessible only to the researcher. Electronic data, including interview recordings and transcripts, were stored in password-protected files on an encrypted computer. Research assistants signed confidentiality agreements before participating in data collection. After three years following completion of the study, electronic data will be permanently deleted, and hard-copy documents will be securely shredded in accordance with institutional data retention procedures.

Chapter Summary

This chapter presented the methodology used in the study. The study employed a convergent parallel mixed-methods design to collect and analyze both quantitative and qualitative data. The target population comprised 285 patients enrolled in care support groups across three rehabilitation centres in Mombasa, Kiambu, and Lamu Counties. A sample of 167 questionnaire respondents was selected using stratified random sampling, while 15 key informants were selected using criterion purposive sampling. The study used a structured questionnaire and a semi-structured interview guide. Pilot testing was conducted at Serenity Rehabilitation Centre in Nyali, and the pilot reliability test produced a Cronbach's

alpha coefficient of 0.87. Quantitative data were analyzed using SPSS version 30.0 through descriptive statistics, Pearson correlation, simple linear regression, and multiple regression analysis. Qualitative data were analyzed thematically, and findings were integrated through convergent triangulation. Ethical measures included informed consent, confidentiality, anonymity, secure data storage, and planned data disposal. The next chapter presents the results and discussion of the study.

Chapter Four: Results and Discussions

Introduction

This chapter presents findings from the study on the effectiveness of care support groups in maintaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. The chapter is organized according to the four research objectives: benefits of care support groups in sustaining sobriety; factors influencing alcohol addicts to seek support; challenges faced by participants; and strategies employed to promote long-term sobriety in rehabilitation centers in selected counties in Kenya.

Quantitative data were collected through structured questionnaires administered to participants, while qualitative data were gathered through semi-structured interviews with key informants. Quantitative data were analyzed using SPSS version 30.0, employing descriptive statistics (frequencies, percentages, means, standard deviations) and inferential statistics (Pearson correlation and multiple regression). Qualitative data were analyzed using NVivo 12 software following Braun and Clarke's (2006) reflexive thematic analysis.

Response Rate and Demographic Analysis

This section presents the response rate and demographic characteristics of study participants, providing contextual understanding of the sample composition.

Response Rate

The study targeted 182 participants from three rehabilitation centers. Out of 182 questionnaires distributed, 155 were returned and suitable for analysis, representing an overall response rate of 85%. According to Kothari (2004), a response rate of 50% is adequate for analysis and reporting, 60% is good, and 70% and above

is excellent. Table 2 presents the response rate details.

Table 2

Response Rate

Response Category	Frequency	Percentage
Returned Questionnaires	155	85%
Unreturned Questionnaires	27	15%
Total	182	100%

The high response rate of 85% was attributed to the researcher's personal presence during data collection, cooperation from rehabilitation center staff, topic relevance to participants, and assurance of confidentiality. The 15% non-response was due to voluntary withdrawal, early discharge before completion, and excessive missing data from some questionnaires that had to be excluded from analysis. This high response rate enhances the reliability and generalizability of the study findings, as recommended by Babbie (2010), who notes that response rates above 80% minimize non-response bias and strengthen the validity of research conclusions.

Reliability of the Research Instrument

The reliability of the study questionnaire was assessed using Cronbach's Alpha coefficient to determine the internal consistency of the measurement items. Table 3 presents the reliability statistics.

Table 3

Reliability Statistics

Scale	Number of Items	Cronbach's Alpha
Study Questionnaire	20	0.87

The Cronbach's Alpha coefficient of 0.87 indicates high internal consistency reliability of the research instrument. According to Tavakol and Dennick (2011), Cronbach's Alpha values of 0.70 or higher are considered acceptable, while values above 0.80 indicate good reliability. The obtained coefficient of 0.87 demonstrates that the questionnaire items consistently measured the constructs under investigation, providing confidence in the reliability of the data collected. This aligns with the theoretical framework of Cognitive Behavioral Theory, which emphasizes the importance of systematic and structured measurement approaches when assessing cognitive and behavioral changes in addiction recovery contexts (Beck & Haigh, 2014).

Gender Distribution

Table 4 presents the gender distribution of respondents who participated in the study.

Table 4

Distribution of Respondents by Gender

Gender	Frequency	Percentage
Male	98	63.2%
Female	57	36.8%
Total	155	100.0%

Males constituted 63.2% of participants while females comprised 36.8%. This distribution aligns with NACADA (2022) data showing that men constitute the majority of individuals in Kenyan rehabilitation centers due to higher alcohol consumption rates, greater social stigma for women seeking treatment, and gender differences in help-seeking behavior. The higher male proportion reflects broader

patterns in addiction treatment programs globally, as documented by Tracy and Wallace (2016), who found similar gender distributions across rehabilitation programs in North America and Europe.

The gender disparity observed in this study corroborates the findings of Wambugu and Omondi (2019) in Mombasa County, who reported that cultural factors in coastal Kenya create additional barriers for women seeking addiction treatment due to heightened stigma and family reputation concerns. This gender imbalance has important implications for support group dynamics and the design of interventions, as women may require gender-specific support structures to address their unique recovery challenges, as highlighted by Motyka et al. (2022) in their systematic review of barriers to addiction support group participation.

Age Distribution

Table 5 presents the age distribution of study participants.

Table 5

Distribution of Respondents by Age Group

Age Group	Frequency	Percentage
18–25 years	29	18.7%
26–35 years	48	31.0%
36–45 years	39	25.2%
46–55 years	26	16.8%
56 years and above	13	8.4%
Total	155	100.0%

The results in Table 5 show that most respondents were aged between 26 and 35 years, representing 31.0% of the respondents. This was followed by those aged

between 36 and 45 years at 25.2%. Combined, respondents aged between 26 and 45 years accounted for 56.2% of the sample. This means that most participants were in their economically active and family-responsibility years, a stage where alcohol abuse may affect employment, family stability, parenting roles, and social functioning.

The findings suggest that care support groups are particularly important for adults in their productive years because sobriety maintenance at this stage may help participants rebuild work routines, restore family relationships, and regain social responsibility. The presence of younger participants aged 18–25 years at 18.7% also indicates the need for early recovery interventions before alcohol-related problems become more severe. The low proportion of respondents aged 56 years and above at 8.4% may reflect lower participation of older adults in rehabilitation programmes or age-related barriers to seeking support. Overall, the age distribution shows that care support groups serve participants across different life stages, but their strongest relevance appears among adults in early and middle adulthood.

This finding is consistent with the Motivational Enhancement Model, which explains that individuals may become more motivated to seek support when alcohol abuse begins to threaten important life goals, including employment, family relationships, and personal health (Miller & Rollnick, 2013). The findings also relate to Wainaina's (2020) study in Kiambu County, where adults in the productive age bracket were more likely to report crisis experiences such as job loss, relationship breakdown, and health concerns that encouraged treatment-seeking behavior.

Education Level

Table 6 presents the educational qualifications of study participants.

Table 6

Distribution of Respondents by Highest Level of Education

Education Level	Frequency	Percentage
No formal education	8	5.2%
Primary school	21	13.5%
Secondary school	46	29.7%
Certificate	28	18.1%
Diploma	24	15.5%
University degree	20	12.9%
Postgraduate degree	8	5.2%
Total	155	100.0%

The majority of participants had secondary school education (29.7%), followed by certificate level (18.1%) and diploma level (15.5%). Overall, 48.4% had secondary education or below (no formal education, primary, and secondary combined), while 51.6% had post-secondary qualifications (certificate, diploma, university degree, and postgraduate degree combined). This relatively balanced distribution suggests that alcohol addiction affects individuals across all educational levels, though the concentration at secondary level and below may reflect socioeconomic factors influencing both addiction vulnerability and treatment accessibility.

These findings challenge simplistic assumptions about the relationship between education and addiction, supporting Cognitive Behavioral Theory's emphasis

on understanding addiction as a complex interaction of cognitive, behavioral, and environmental factors rather than purely a function of educational attainment (Hofmann et al., 2012). The educational profile of participants in this study mirrors patterns documented by Mutuku et al. (2022) across multiple Kenyan rehabilitation centers, who found no significant correlation between educational level and addiction severity but did identify that individuals with higher education levels demonstrated greater engagement with cognitive restructuring interventions a core component of effective support group strategies.

Employment Status

Table 7 presents the employment status of study participants.

Table 7

Distribution of Respondents by Employment Status

Employment Status	Frequency	Percentage
Unemployed	54	34.8%
Part-time employed	23	14.8%
Full-time employed	19	12.3%
Self-employed	31	20.0%
Student	18	11.6%
Retired	10	6.5%
Total	155	100.0%

The largest proportion of participants were unemployed (34.8%), substantially higher than Kenya's national unemployment rate of 5.6%, suggesting a strong relationship between alcohol addiction and employment disruption. Self-employed participants represented 20.0%, part-time employed 14.8%, full-time employed

12.3%, students 11.6%, and retired 6.5%. The high unemployment rate demonstrates the interconnection between economic stability and addiction recovery, emphasizing the need for vocational rehabilitation alongside traditional therapeutic interventions.

This employment pattern extends the findings of NACADA (2022), which documented that alcohol addiction creates a vicious cycle where substance use leads to job loss, which in turn exacerbates financial stress and creates additional triggers for continued drinking. The disproportionately high unemployment rate among study participants aligns with the Motivational Enhancement Model's recognition that economic consequences serve as powerful motivators for seeking treatment, yet simultaneously create barriers to sustained recovery when unaddressed (Miller & Rollnick, 2013).

Duration in Rehabilitation Program

Table 8 presents the duration participants had been enrolled in their respective rehabilitation programs.

Table 8

Distribution of Respondents by Duration in Rehabilitation Program

Duration in Rehabilitation Program	Frequency	Percentage
Less than 3 months	27	17.4%
3–6 months	42	27.1%
7–12 months	51	32.9%
More than 12 months	35	22.6%
Total	155	100.0%

Table 8 shows that the majority of participants had been in rehabilitation for 7-12 months (32.9%), followed by 3-6 months (27.1%), more than 12 months (22.6%), and less than 3 months (17.4%). This distribution indicates that most participants were

in mid to advanced stages of rehabilitation (55.5% combined for those in programs 7 months or longer), suggesting sustained engagement with treatment programs. The relatively substantial proportion (22.6%) who had been in programs for more than 12 months demonstrates commitment to long-term recovery processes.

Instead, the findings align with Kelvin's (2024) research in Meru County, which documented that participants who remained in structured rehabilitation programs beyond six months demonstrated significantly improved recovery outcomes. The concentration of participants in the 7-12-month range supports Cognitive Behavioral Theory's proposition that sustained exposure to therapeutic interventions allows for progressive cognitive restructuring and behavioral modification, which require time to consolidate (Beck & Haigh, 2014).

Previous Addiction Treatment Experience

Table 9 presents participants' previous experience with addiction treatment programs.

Table 9

Distribution of Respondents by Previous Addiction Treatment Experience

Previous Treatment Experience	Frequency	Percentage
First-time treatment	61	39.4%
1–2 previous treatment attempts	49	31.6%
3 or more previous treatment attempts	28	18.1%
No previous treatment	17	11.0%
Total	155	100.0%

According to Table 9, less than half of participants (39.4%) were receiving treatment for the first time, while 31.6% had 1-2 previous treatment attempts and

18.1% had 3 or more previous attempts. This indicates that 49.7% of participants had experienced previous treatment episodes, highlighting the chronic relapsing nature of alcohol addiction documented by Tracy and Wallace (2016). The substantial proportion with multiple previous treatment attempts underscores the need for effective relapse prevention strategies and long-term support mechanisms to address the cyclic nature of addiction recovery.

These findings validate the Motivational Enhancement Model's recognition that behavior change is rarely linear but involves multiple attempts, setbacks, and renewed efforts (Miller & Rollnick, 2013). The prevalence of previous treatment experience among participants extends Kinyua's (2019) observations in Kiambu County, where relapse was identified as the norm rather than the exception in addiction recovery trajectories. However, rather than indicating treatment failure, this pattern suggests that each treatment episode contributes to accumulated learning and progressive readiness for sustained change. This perspective aligns with contemporary addiction recovery frameworks that emphasize resilience and progressive learning rather than expecting immediate, permanent abstinence (Westwell, 2022).

Primary Substance of Addiction

Table 10 presents the primary substance of addiction among study participants.

Table 10

Distribution of Respondents by Primary Substance of Addiction

Primary Substance of Addiction	Frequency	Percentage
Alcohol	112	72.3%
Multiple substances	43	27.7%

Total	155	100.0%

The majority of participants (72.3%) identified alcohol as their sole substance of addiction, while 27.7% reported multiple substance use including alcohol. This finding aligns with the study's focus on alcohol addiction while acknowledging that more than a quarter of participants experience polysubstance use, which may present additional treatment complexities. According to Wang et al. (2021), individuals with multiple substance dependencies often require more intensive and specialized interventions compared to those with single substance addiction.

The presence of poly-substance use among over a quarter of participants has important implications for support group design and intervention strategies. Cognitive Behavioral Theory suggests that poly-substance users face more complex cognitive and behavioral patterns requiring multifaceted interventions that address multiple substance-related triggers and coping mechanisms simultaneously (McHugh et al., 2010).

Benefits of Care Support Groups in Sustaining Sobriety

This section presents findings addressing the first research objective: to establish the benefits of care support groups in sustaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. Both quantitative and qualitative findings are integrated to provide comprehensive understanding of the benefits participants derive from care support groups, with explicit connections to the theoretical framework and existing literature. Participants were asked to rate their experiences with care support groups using a five-point Likert scale ranging from 1 (Not at all) to 5 (Extremely). Table 11 presents descriptive statistics for items measuring the benefits of care support groups.

Table 11

Benefits of Care Support Groups in Sustaining Sobriety

Statement	Mean	Std. Deviation
I feel emotionally supported during support group sessions	4.02	0.821
Support group interactions help me manage anxiety related to recovery	4.10	0.784
Group discussions help me understand my addiction triggers	4.18	0.756
Support groups improve my overall emotional well-being	4.12	0.773
Support groups help me develop a positive self-image	3.96	0.845
Support group interactions motivate me to continue recovery	4.21	0.728
Overall Mean Score for Benefits	4.10	0.785

The findings in Table 11 reveal that participants perceived significant benefits from care support groups, with an overall mean score of 4.10 (SD = 0.785), indicating high levels of perceived benefits. The highest-rated benefit was "Support group interactions motivate me to continue recovery" (M = 4.21, SD = 0.728), followed by "Group discussions help me understand my addiction triggers" (M = 4.18, SD = 0.756) and "Support groups improve my overall emotional well-being" (M = 4.12, SD = 0.773).

These findings strongly corroborate Tracy and Wallace's (2016) meta-analysis,

which identified motivation enhancement and trigger awareness as primary mechanisms through which support groups facilitate recovery. The high motivation scores validate the Motivational Enhancement Model's proposition that group-based interventions strengthen internal commitment to behavior change through peer modeling and shared accountability (Miller & Rollnick, 2013). Similarly, the emphasis on trigger understanding aligns with Cognitive Behavioral Theory's core premise that recognizing antecedents to problematic behavior enables earlier intervention in the behavioral chain (Beck & Haigh, 2014).

Items measuring emotional well-being and anxiety reduction showed consistently high scores. Participants reported that support group interactions help them manage anxiety related to recovery ($M = 4.10$, $SD = 0.784$) and that they feel emotionally supported during support group sessions ($M = 4.02$, $SD = 0.821$). Additionally, participants indicated that support groups help them develop a more positive self-image ($M = 3.96$, $SD = 0.845$). The mean score for emotional well-being benefits was 4.05, indicating that support groups effectively address the emotional and psychological dimensions of recovery.

These emotional well-being findings extend the work of Day et al. (2023) in the United Kingdom, who documented that emotional support mechanisms contributed to 62% lower relapse rates among participants receiving sustained encouragement. However, the current study's findings provide more granular understanding by demonstrating that emotional support operates through multiple pathways anxiety reduction, self-image improvement, and general emotional well-being enhancement rather than functioning as a monolithic construct. This multidimensional understanding refines existing literature by highlighting specific emotional mechanisms that rehabilitation centers can target through structured

interventions.

The relatively moderate standard deviations (ranging from 0.728 to 0.845) across benefit items indicate general consensus among participants, yet sufficient variability to suggest that individual experiences differ based on personal factors, group dynamics, and program implementation quality. This variability aligns with Kalema and Vanderplasschen's (2022) observations in East African contexts, where culturally adapted support approaches produced heterogeneous outcomes depending on the degree of cultural alignment between intervention methods and participants' backgrounds.

Thematic analysis of interviews with 15 key informants and open-ended questionnaire responses revealed major themes regarding the benefits of care support groups. Table 12 presents the qualitative themes identified.

Table 12

Themes and Sub-themes Indicators of Support Group Benefits

Themes	Sub-themes
Benefits of Support Groups	Emotional support, peer encouragement, shared experiences
Personal Transformation	Improved self-image, identity change, confidence building

Emotional Healing and Psychological Safety

The theme of emotional healing and psychological safety emerged as fundamental to support group effectiveness. Key informants consistently emphasized that support groups provide safe spaces for emotional expression where participants can reconnect with their emotions and develop healthy processing strategies. The majority of participants reported that support groups created environments where they

could express their deepest fears, guilt, and shame without fear of rejection. Many participants came from environments where their addiction had caused broken relationships and loss of trust, making the emotional safety found in support groups foundational for healing.

This theme directly supports the quantitative finding that emotional support (M = 4.02) represents a core benefit. Moreover, it extends Ngwenya's (2022) research in South Africa by demonstrating how psychological safety operates as a precondition for emotional healing as participants must first feel safe before they can engage in the vulnerable work of emotional processing. This finding validates Cognitive Behavioral Theory's emphasis on creating supportive therapeutic environments that facilitate cognitive and emotional restructuring (Hofmann et al., 2012).

Counselor 1 at Serene Hospital explained:

> The support group creates a sanctuary where participants can express their deepest fears, guilt, and shame without fear of rejection. Many come from environments where their addiction has caused broken relationships and loss of trust. Here, they find emotional safety that is foundational for healing (Counselor 1).

This observation illustrates the foundational role of psychological safety in enabling therapeutic work. The use of the term "sanctuary" captures the protective, sacred nature participants attribute to support group spaces places set apart from the judgment and stigma they encounter in broader society. This finding aligns with NACADA's (2022) documentation that stigma represents a significant barrier to addiction treatment in Kenyan contexts, making the creation of judgment-free spaces particularly crucial.

Facilitator 1 at Amani Acres elaborated on the emotional transformation process participants undergo through sustained group engagement:

> I have witnessed participants who arrive emotionally numb, disconnected from their feelings due to years of substance use. Through consistent group engagement, they gradually reconnect with their emotions, learn to identify what they are feeling, and develop healthy ways to process difficult emotions rather than numbing them with alcohol (Facilitator 1).

This narrative illustrates how support groups facilitate the emotional regulation skills emphasized in Cognitive Behavioral Theory, where individuals learn to recognize, label, and manage emotional states without resorting to maladaptive coping mechanisms (Beck & Haigh, 2014). The gradual nature of this transformation, requiring "consistent group engagement," supports the quantitative finding that program duration correlates with perceived benefits, as emotional reconnection cannot be rushed but develops progressively through sustained participation. This observation extends Kelvin's (2024) findings in Meru County that structured aftercare support significantly reduces relapse rates by providing the sustained engagement necessary for deep therapeutic change.

The theme of emotional healing revealed that participants experienced progressive reconnection with emotions previously suppressed through substance use. Counselor 2 at Lamu Rehabilitation Centre noted that many participants initially struggled to identify or articulate their emotional experiences, describing themselves as feeling "numb" or "empty." Through repeated group sessions involving sharing circles, empathic listening exercises, and facilitator-guided emotional awareness activities, participants gradually developed emotional literacy the capacity to

recognize, name, and communicate their internal states.

Participant 1 at Serene Hospital described this transformation:

> "Before the group, I couldn't tell you what I was feeling beyond 'bad' or 'stressed.' Now I can recognize when I'm feeling anxious versus sad versus angry, and I know what each emotion is trying to tell me" (Participant 1).

This development of emotional awareness aligns with Cognitive Behavioral Theory's emphasis on metacognitive skills the ability to observe and understand one's own cognitive and emotional processes (Hofmann et al., 2012).

Peer Validation and Shared Understanding

The theme of peer validation and shared understanding emerged as uniquely powerful in facilitating recovery. Participants highlighted that the shared experience of addiction creates bonds and mutual understanding that family members or professionals without lived experience cannot fully provide. The experiential credibility of peer's individuals who have personally navigated addiction's challenges created validation that transcended professional expertise.

This qualitative finding illuminates why participants would rate group understanding and belonging highly in quantitative measures, and validates the theoretical proposition that peer support creates unique therapeutic opportunities absent in traditional one-on-one counselling. The finding extends Kalema and Vanderplasschen's (2022) research across East Africa by demonstrating that peer validation operates as a distinct mechanism separate from general social support it specifically addresses the isolation and stigma that accompany addiction through experiential credibility that only peers can provide.

> Facilitator 2 at Lamu Rehabilitation Centre explained: "When someone shares their story and another participant says 'I know exactly what you mean,' there is immediate validation. This peer recognition that 'you are not alone, I have been there too' is incredibly powerful. It breaks the isolation that addiction creates" (Facilitator 2).

This observation captures the immediacy and authenticity of peer validation. The phrase "I know exactly what you mean" carries weight precisely because it comes from someone with lived experience rather than theoretical knowledge. This finding validates Kepner and Humphreys' (2025) documentation that peer-led recovery support groups create unique opportunities for authentic connection and practical guidance from those with lived experience of addiction recovery.

Counselor 3 at Serene Hospital described the therapeutic value of peer validation:

> Professional counseling is important, but there is something uniquely healing about hearing from someone who has walked the same difficult path. When a peer who has maintained sobriety for six months encourages someone struggling in their first week, the credibility and hope transmitted is immeasurable (Counselor 3).

This narrative supports the Motivational Enhancement Model's emphasis on developing discrepancy between current behavior and desired outcomes through exposure to successful role models (Miller & Rollnick, 2013). Peer validation functions not merely as emotional support but as tangible evidence that recovery is achievable, thereby strengthening intrinsic motivation for sustained change. The temporal dimension a peer "six months" ahead encouraging someone in "their first

week" demonstrates how support groups leverage experiential progression to create hope through proximal role modeling.

The study established that peer validation operated through multiple mechanisms. First, it normalized participants' experiences, reducing the shame associated with addiction by demonstrating that others have faced similar struggles. Participant 2 at Amani Acres stated: "Hearing others describe the exact same thoughts I had the rationalizations, the promises to myself, the hiding made me realize I'm not uniquely broken or weak. This is what addiction does to people" (Participant 2).

This normalization directly challenges the stigmatizing narratives that addiction results from moral failure or character weakness, reframing it as a recognized medical condition with characteristic symptoms (NACADA, 2022).

Second, peer validation created accountability through mutual investment in each other's recovery. Facilitator 3 at Serene Hospital explained: "Participants become genuinely invested in each other's success. They celebrate each other's milestones and provide support during struggles. This mutual investment creates accountability that transcends formal program requirements" (Facilitator 3).

This finding aligns with Schwartz et al.'s (2014) documentation that relationship-based accountability results in 50% higher retention rates and improved long-term sobriety outcomes.

Third, peer validation fostered what participants described as a "recovery community" that extended beyond formal group sessions. Counselor 4 at Amani Acres noted that participants exchanged contact information and maintained communication between sessions, creating informal support networks that supplemented structured programming. This organic community development

demonstrates participants' intrinsic motivation to maintain supportive relationships, validating the Motivational Enhancement Model's proposition that effective interventions activate and strengthen internal motivation rather than relying exclusively on external controls (Miller & Rollnick, 2013).

Personal Transformation and Recovery Identity

The theme of personal transformation and recovery identity captured how support groups facilitate profound shifts in self-perception. Key informants noted that support groups help participants develop new identities centered on recovery rather than addiction. Many participants entered rehabilitation defining themselves primarily through their addiction as "alcoholics" or "addicts" with limited sense of identity or purpose beyond substance use.

This qualitative theme provides rich contextual understanding for the quantitative finding that support groups help develop positive self-image (M = 3.96). It extends Westwell's (2022) research on recovery identity by demonstrating the specific role that group processes play in identity transformation through collective reinforcement, peer modeling, and celebration of milestones, support groups actively construct and validate new recovery-oriented identities.

Counselor 5 at Amani Acres explained:

> Addiction becomes such a central part of identity that participants often don't know who they are without alcohol. The support group becomes a space where they can explore and construct a new sense of self a person in recovery who has value, purpose, and potential beyond their past substance use (Counselor 5).

This observation illustrates the identity vacuum that participants face when

removing substance use from their lives. For individuals whose daily routines, social relationships, and coping mechanisms all revolved around alcohol, sobriety initially creates disorientation and loss of identity. Support groups address this vacuum by providing alternative identity frameworks "person in recovery," "someone working on themselves," "member of a recovery community" that offer positive self-definitions independent of addiction.

Facilitator 4 at Serene Hospital elaborated

> We see profound identity transformation. Participants move from identifying as alcoholics defined by their problem to seeing themselves as people in recovery defined by their resilience, growth, and commitment to change. The group reinforces this positive identity through celebration of milestones and mutual encouragement (Facilitator 4).

This identity shift represents a core mechanism through which support groups facilitate sustained sobriety. From a Cognitive Behavioral Theory perspective, this transformation involves restructuring core beliefs about the self, moving from schemas of worthlessness and hopelessness to schemas of capability and growth potential (Dobson & Dozois, 2019). The collective nature of this process, occurring within group contexts, creates social reinforcement that individual therapy cannot replicate.

The study established that identity transformation occurred through several specific processes. First, support groups explicitly challenged deficit-based identity labels.

Counselor 6 at Lamu Rehabilitation Centre described

> facilitating discussions where participants examined and deconstructed stigmatizing labels they had internalized: "We ask participants, 'Who are you beyond your addiction? What strengths, values, and capabilities define you?' This helps them recognize that addiction is something they're dealing with, not who they fundamentally are" (Counselor 6).

This reframing aligns with contemporary recovery frameworks emphasizing person-first language and strengths-based approaches (Westwell et al., 2023).

Second, support groups provided opportunities for participants to practice and internalize new identities through group roles and responsibilities.

Facilitator 5 at Serene Hospital explained that

> participants took on various group functions welcoming newcomers, facilitating check-ins, sharing recovery strategies that reinforced their identity as competent, contributing members of a recovery community (Facilitator 5).

> Participant 3 at Amani Acres stated: "When I started mentoring newer members, it changed how I saw myself. I wasn't just someone struggling with addiction I became someone who had valuable experience and wisdom to share" (Participant 3).

This role reversal from help-recipient to help-provider represents what Riessman (1965) termed the "helper therapy principle," where providing support to others reinforces one's own recovery and positive identity. Third, support groups celebrated incremental achievements that validated participants' emerging recovery identities.

> Counselor 7 at Serene Hospital described regular milestone recognition ceremonies where participants received tokens or certificates marking sobriety durations one week, one month, three months, six months, and beyond. These public acknowledgments served multiple functions: reinforcing the individual's recovery identity, providing hope and motivation to others, and creating shared celebration that strengthened group cohesion (Counselor 7).

> Participant 4 at Lamu Rehabilitation Centre reflected: "When the group celebrated my three months of sobriety, it made it real for me. I started believing I actually could do this, that I was becoming someone different" (Participant 4).

This external validation gradually becomes internalized, transforming tentative hope into stable self-belief. The identity transformation theme revealed bidirectional relationships with other benefits. Emotional healing created the psychological foundation necessary for identity exploration participants needed to process shame, guilt, and trauma before they could envision alternative self-concepts. Peer validation reinforced emerging recovery identities through social recognition and belonging. Conversely, developing positive recovery identities motivated continued group engagement and strategy implementation, as participants sought to maintain consistency with their new self-concepts. This interconnection validates the study's finding of strong correlations among benefit dimensions and demonstrates that support groups operate through multiple synergistic mechanisms rather than isolated pathways.

The integration of quantitative and qualitative findings on support group benefits demonstrates strong convergence while revealing mechanisms underlying

statistical patterns. Quantitative data established that participants perceived significant benefits (M = 4.10), with motivation (M = 4.21), trigger understanding (M = 4.18), and emotional well-being (M = 4.12) rated highest. Qualitative data illuminated how these benefits manifest in lived experience and the processes through which they develop.

The high quantitative rating for emotional support (M = 4.02) converged with qualitative narratives describing support groups as "sanctuaries" where participants could "express their deepest fears without rejection." This convergence validates both data sources—quantitative data demonstrated the prevalence and magnitude of emotional support benefits, while qualitative data illuminated the mechanisms through which these benefits operate: facilitator empathy, peer validation, confidentiality protections, and non-judgmental group norms. Together, these findings extend Ngwenya's (2022) research by demonstrating that psychological safety functions as both a benefit in itself and a precondition enabling other therapeutic processes.

The quantitative emphasis on motivation (M = 4.21) was enriched by qualitative descriptions of how peer modeling and milestone celebrations strengthen commitment to change. The Motivational Enhancement Model proposes that observing successful role models enhances self-efficacy and motivation (Miller & Rollnick, 2013), and qualitative data revealed the specific mechanisms: hearing peers describe overcoming similar struggles, witnessing gradual progress over time, and receiving encouragement from those further along in recovery. This integration provides actionable guidance for rehabilitation centers creating formal mentorship structures, celebrating incremental achievements publicly, and facilitating peer storytelling can systematically enhance motivational benefits.

The finding that trigger understanding scored highly (M = 4.18) was

complemented by qualitative descriptions of participants learning to recognize patterns linking situations, thoughts, emotions, and drinking urges. Cognitive Behavioral Theory emphasizes that awareness of antecedent conditions enables intervention before behaviors fully manifest (Beck & Haigh, 2014), and qualitative data demonstrated how support groups facilitate this awareness through structured sharing, facilitator guidance in identifying patterns, and peer feedback highlighting similarities across individual experiences. This integration validates CBT-informed group interventions while demonstrating their cultural acceptability and effectiveness in Kenyan rehabilitation contexts.

The moderate standard deviations observed quantitatively (0.728-0.845) were explained through qualitative descriptions of individual variation in group experiences. Some participants immediately felt safe and engaged deeply, while others required extended time to overcome fears and build trust. Group-specific factors facilitator skill, group composition, physical environment also influenced benefit realization heterogeneously. This integration challenges one-size-fits-all approaches and instead supports individually tailored interventions within group frameworks, where facilitators assess and address diverse participant needs while maintaining group cohesion.

The strong correlation between benefits and sobriety maintenance ($r = 0.701$) observed quantitatively was illuminated through qualitative descriptions of causal pathways. Emotional healing reduced reliance on alcohol as an emotional regulation strategy; peer validation decreased isolation that often-precipitated drinking; recovery identity transformation created cognitive dissonance with drinking behavior; and motivation strengthened commitment to implementing learned strategies. These multiple pathways operating simultaneously explain the strength of the quantitative

relationship and validate that benefits function as active therapeutic mechanisms rather than mere correlates of recovery.

Both quantitative and qualitative findings consistently supported the theoretical framework integrating Cognitive Behavioral Theory and Motivational Enhancement Model. Quantitative data demonstrated that emotional and motivational benefits predict sobriety maintenance, while qualitative data revealed specific CBT and MET mechanisms operating within groups: cognitive restructuring through shared reflection, behavioral modeling through peer observation, motivational enhancement through success stories, and self-efficacy building through incremental achievements. This theoretical validation extends international CBT and MET evidence to Kenyan contexts while demonstrating the cultural adaptability of these frameworks when implemented through peer support structures aligned with collectivist cultural values (Harris et al., 2022; Kalema & Vanderplasschen, 2022).

Correlation between Benefits of Care Support Groups and Sobriety Maintenance

Pearson correlation analysis was conducted to examine the relationship between perceived benefits of care support groups and sobriety maintenance outcomes. The analysis sought to determine whether participants who experienced greater benefits from support groups demonstrated better sobriety maintenance.

Table 13

Correlation between Support Group Benefits and Sobriety Maintenance

Variables	Sobriety Maintenance	Support Group Benefits
Sobriety Maintenance		
Pearson Correlation	1	.701**
Sig. (2-tailed)		.000

N	155	155
Support Group Benefits		
Pearson Correlation	.701**	1
Sig. (2-tailed)	.000	
N	155	155

**Correlation is significant at the 0.01 level (2-tailed)

The correlation analysis revealed a strong positive relationship between support group benefits and sobriety maintenance ($r = .701$, $p < .01$), indicating that participants who experienced greater benefits from support groups demonstrated substantially better sobriety maintenance outcomes. This strong correlation validates the theoretical proposition that support group benefits serve as active mechanisms promoting recovery rather than merely correlative factors.

The magnitude of this relationship ($r = .701$) substantially exceeds correlations reported in Western studies. Tracy and Wallace's (2016) meta-analysis found moderate to strong relationships ($r = .45$ to $.65$) between support group participation and recovery outcomes across ten international trials. The stronger correlation observed in this study aligns with Ngwenya's (2022) and Harris et al.'s (2022) observations that communal support structures may be particularly powerful in collectivist African cultures.

The correlation coefficient of .701 indicates that approximately 49% of the variance in sobriety maintenance can be explained by the benefits participants derive from support groups ($r^2 = .49$). From a Cognitive Behavioral Theory perspective, this correlation supports the premise that addressing maladaptive thought patterns and developing healthier emotional regulation both benefits measured in this study

directly contribute to behavioral change (Hofmann et al., 2012). From a Motivational Enhancement Model perspective, the correlation validates that benefits which strengthen intrinsic motivation translate directly into sustained commitment to behavior change (Miller & Rollnick, 2013). The statistical significance ($p < .01$) provides robust confidence that this relationship is genuine rather than occurring by chance. This finding has important implications: rehabilitation centers seeking to improve sobriety maintenance outcomes should prioritize interventions that maximize support group benefits, particularly emotional support, peer validation, and recovery identity development identified in the qualitative analysis. The strong correlation suggests that rather than viewing support groups as supplementary programming, they should be recognized as central therapeutic mechanisms deserving substantial resource allocation.

Regression Analysis: Benefits Predicting Sobriety Maintenance

Simple linear regression analysis was performed to examine the predictive power of support group benefits on sobriety maintenance outcomes. This analysis extends correlation results by establishing the direction of the relationship and quantifying how much change in sobriety maintenance can be predicted from changes in perceived benefits.

Table 14

Model Summary - Benefits Predicting Sobriety Maintenance

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.701	.491	.488	.521

Predictors: (Constant), Benefits of Support Groups

The regression model summary reveals that support group benefits produced a strong correlation coefficient (R = .701) with sobriety maintenance. The R Square value of .491 indicates that 49.1% of the variance in sobriety maintenance can be explained by the benefits participants derive from support groups. This substantial explanatory power validates that support group benefits serve as meaningful predictors accounting for nearly half of the variation in participants' ability to maintain sobriety.

The Adjusted R Square of .488 demonstrates that explanatory power remains stable even after accounting for the number of predictors, confirming genuine relationships rather than model inflation. This explanatory power (R^2 = .491) substantially exceeds that reported in comparable Kenyan studies. Gachara et al. (2019) in Nairobi County found that internal locus of control explained approximately 32% of variance in recovery outcomes, while Machuki (2020) in Mathare North documented that self-efficacy accounted for approximately 38% of variance in sustained sobriety. The current finding suggests that interpersonal and group-level factors may be more influential than individual psychological characteristics in determining recovery success, validating the theoretical proposition that recovery is fundamentally a social process requiring supportive relationships (Kelly et al., 2011).

Table 15

ANOVA - Benefits Predicting Sobriety Maintenance

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	40.523	1	40.523	149.12	.000
Residual	41.583	153	.272		
Total	82.106	154			

Dependent Variable: Sobriety Maintenance; Predictors: (Constant), Benefits of Support Groups

The ANOVA table 15 demonstrates that the regression model is statistically significant, $F(1, 153) = 149.12$, $p < .001$. This highly significant F-statistic indicates that the linear relationship between support group benefits and sobriety maintenance is extremely unlikely to have occurred by chance. The regression sum of squares (40.523) represents variance explained by support group benefits, while residual sum of squares (41.583) represents unexplained variance. The ratio of explained to unexplained variance (.97) demonstrates that the model accounts for nearly as much variance as remains unexplained a remarkable finding given the complexity of addiction recovery processes.

This statistical significance validates the conceptual framework's proposition that support group benefits meaningfully influence sobriety maintenance. The result aligns with Tracy and Wallace's (2016) meta-analysis demonstrating that support group participation produces measurable recovery benefits, while extending this evidence by providing precise quantification in Kenyan contexts across diverse geographical settings with varying cultural and socioeconomic characteristics.

Table 16

Regression Coefficients - Benefits Predicting Sobriety Maintenance

Model	Unstandardized B	Std. Error	Standardized Beta	t	Sig.
(Constant)	.942	.248		3.80	.000
Benefits of Support Groups	.782	.064	.701	12.21	.000

Dependent Variable: Sobriety Maintenance

The regression coefficients reveal that support group benefits significantly predict sobriety maintenance ($\beta = .701$, $t = 12.21$, $p < .001$). The unstandardized coefficient (B =.782) indicates that for every one-unit increase in perceived support group benefits, sobriety maintenance increases by .782 units. The standardized beta coefficient ($\beta = .701$) indicates that a one-standard-deviation increase in support group benefits produces a .701 standard-deviation increase in sobriety maintenance, confirming that support group benefits represent a powerful predictor of recovery outcomes.

The t-statistic of 12.21 with corresponding p-value of .000 ($p < .001$) provides overwhelming statistical confidence in this relationship. From a theoretical perspective, the coefficient validates both Cognitive Behavioral Theory and Motivational Enhancement Model. CBT proposes that supportive therapeutic relationships facilitate cognitive restructuring and emotional regulation development, which translate into behavioral outcomes (Hofmann et al., 2012). The significant coefficient confirms this proposition the emotional support ($M = 4.02$), positive self-image development ($M = 3.96$), and anxiety reduction ($M = 4.10$) measured as benefits predict actual sobriety maintenance behaviors.

Similarly, MET proposes that strengthening intrinsic motivation through empathic, validating relationships enhances sustained behavior change (Miller & Rollnick, 2013). The significant coefficient validates this the motivation enhancement ($M = 4.21$) translates into the daily commitment and persistence required for sustained sobriety. The finding extends Kinyua's (2019) research in Kiambu County, which documented correlations between support and reduced relapse rates, by establishing predictive relationships demonstrating that benefits predict subsequent sobriety

outcomes.

The regression finding has important practical implications. The substantial predictive power (β = .701) suggests that investments in enhancing emotional support, facilitating peer validation, and promoting recovery identity development will yield measurable returns in improved outcomes. With benefits explaining 49.1% of sobriety maintenance variance, support groups emerge as core therapeutic mechanisms deserving substantial resource allocation in rehabilitation programming, consistent with NACADA's (2022) recommendations for evidence-based addiction treatment interventions.

Factors Influencing Alcohol Addicts to Seek Support at Care Groups

This section presents findings addressing the second research objective: to examine the factors influencing alcohol addicts to seek support at care groups to maintain sobriety in rehabilitation centers in selected counties in Kenya. The study assessed respondents' responses to statements regarding factors that influenced their decision to seek support at care groups using a five-point Likert scale. Table 17 presents the descriptive statistics.

Table 17

Factors Influencing Alcohol Addicts to Seek Support at Care Groups

Statement	Mean	Std. Deviation
Motivation to change drinking behavior	4.05	0.812
Feelings of shame related to addiction	3.62	0.901
Recognition of need for support	4.14	0.768
Feeling vulnerable when sharing experiences	3.58	0.887

Influence of healthcare providers	3.89	0.824
Trust in advice from healthcare providers	3.95	0.801
Family support in group participation	3.76	0.842
Influence of friends on recovery efforts	3.71	0.856
Group dynamics creating barriers	3.40	0.923
Overall Mean Score for Influencing Factors	3.79	0.846

Table 17 indicates that respondents most strongly recognized the need for support in their recovery journey (M = 4.14, SD = 0.768) and reported being highly motivated to change their drinking behavior (M = 4.05, SD = 0.812). This finding strongly corroborates Miller and Rollnick's (2013) Motivational Enhancement Model, which emphasizes that personal recognition of need and intrinsic motivation are fundamental drivers of sustainable behavior change. The high scores on these internal motivation factors validate the theoretical proposition that external interventions prove most effective when they activate or align with existing internal readiness for change.

Healthcare provider influence was notable, with respondents trusting provider advice (M = 3.95, SD = 0.801) and rating their influence as significant (M = 3.89, SD = 0.824). This finding extends Tracy and Wallace's (2016) research, which documented that professional healthcare recommendations increased treatment initiation rates by 65% compared to self-referral. The higher score for trust in advice (M = 3.95) compared to general influence (M = 3.89) suggests that the quality of the therapeutic relationship matters more than the authority of the recommendation itself, aligning with Stanojlović and Davidson's (2020) documentation that structured healthcare provider interventions resulted in 70% higher engagement rates in support groups.

Family support in group participation received a mean score of 3.76 (SD = 0.842), aligning with Day et al.'s (2023) finding that sustained family encouragement contributed to 62% lower relapse rates. Friend influence received a mean score of 3.71 (SD = 0.856), slightly lower than family support, suggesting that family relationships outweigh peer friendships in the Kenyan context a pattern consistent with collectivist cultural values emphasizing extended family structures documented by Kalema and Vanderplasschen (2022).

Feelings of shame (M = 3.62, SD = 0.901) and vulnerability when sharing experiences (M = 3.58, SD = 0.887) received moderate scores, indicating that while these emotional factors are present, they do not completely prevent support-seeking behavior. This finding challenges assumptions about stigma as an insurmountable barrier and instead suggests that when internal motivation and external support converge, individuals can overcome shame to seek help. Group dynamics creating barriers received the lowest mean score (M = 3.40, SD = 0.923), suggesting that interpersonal group issues are not the primary

concern when deciding whether to seek support. The overall mean score of 3.79 (SD = 0.846) indicates moderate to high levels of motivation and support driving participation in care support groups, reflecting the importance of multiple converging factors. This multifactorial pattern aligns with Laudet and Humphreys' (2013) comprehensive framework, which emphasizes that successful recovery engagement rarely results from a single factor but from the interaction of personal, social, and professional influences.

Thematic analysis of interviews with 15 key informants and open-ended questionnaire responses revealed major themes regarding factors that motivated participants to seek support at care groups. Table 18 presents the qualitative themes

identified.

Table 18

Themes and Sub-themes of Factors Influencing Support-Seeking

Themes	Sub-themes
Personal Crisis and Readiness	Rock bottom experiences, health complications, employment loss
External Support Systems	Family intervention, healthcare provider recommendations, peer encouragement
Desire for Transformation	Relationship repair, identity reconstruction, future planning

Personal Crisis and Readiness to Change

The theme of personal crisis and readiness to change emerged as the most powerful motivating factor driving individuals to seek support. The study established that the majority of participants had not sought help until they experienced critical moments where the consequences of their addiction became undeniable. These crisis moments stripped away denial and created painful clarity about addiction consequences, thereby activating latent readiness for change.This theme directly supports the quantitative finding showing high recognition of need for support (M = 4.14) and motivation to change drinking behavior (M = 4.05). The findings validate the Motivational Enhancement Model's concept of developing discrepancy the process through which individuals become acutely aware of the gap between their current behavior and their values or goals (Miller & Rollnick, 2013). Crisis moments forcefully present this discrepancy in ways that can no longer be ignored or rationalized.

Counselor 1 at Amani Acres explained:

> Most participants don't seek help until they hit what we call

> rock bottom a critical moment where the consequences of their addiction become undeniable. That crisis creates the readiness to change that brings them to support groups. The pain of broken relationships, job loss, or health complications becomes the catalyst that overcomes denial and fear (Counselor 1).

This observation illustrates how external consequences create internal motivation for change. The finding aligns with Wainaina's (2020) research in Kiambu County, which documented that personal readiness significantly influenced treatment-seeking behavior, with crisis moments serving as turning points that precipitated engagement with rehabilitation services.

> Counselor 2 at Serene Hospital elaborated: "The moment of crisis strips away denial and creates motivation to seek help. But sustaining that motivation through the long, difficult recovery process is the real challenge" (Counselor 2).

This narrative highlights a critical distinction between factors that initiate support-seeking versus those that maintain engagement, extending Prangley et al.'s (2018) research in Australia, which identified personal recognition of addiction impacts as a key motivating factor for treatment entry.

The study established that crisis moments manifested in multiple forms. Some participants experienced health complications including hospitalization for alcohol-related conditions, which created urgent awareness of mortality. Others faced employment consequences including job loss or disciplinary actions that threatened financial security. Still others experienced relationship crises including separation from spouses or estrangement from children that challenged their identities as parents

or partners. These diverse crisis types all functioned similarly creating acute pain that motivated change-seeking behavior.

> Participant 1 at Lamu Rehabilitation Centre described the turning point: "I woke up in the hospital after my liver started failing. The doctor told me I would die if I continued drinking. That was my wake-up call. I finally accepted I needed help" (Participant 1).

This reflection demonstrates how health crises create urgency that overcomes ambivalence about seeking treatment.

External Support Systems Influence

The theme of external support systems revealed how family intervention, healthcare provider recommendations, and peer encouragement interact with personal readiness to facilitate support-seeking. The study established that while internal motivation was necessary, external support often provided the practical pathway and encouragement needed to translate motivation into action.

> Family intervention emerged as particularly powerful. Counselor 3 at Amani Acres described: "The pain of broken relationships estranged children, separated spouses, disappointed parents creates powerful motivation. Participants often express that they want to become the parent, spouse, or child their family deserves" (Counselor 3).

This observation explains why family support (M = 3.76) scored moderately high and extends Kinyua's (2019) research in Kiambu County demonstrating that family support significantly predicted reduced relapse rates.

However, the study also established complexity in family dynamics. Facilitator 1 at Lamu Rehabilitation Centre noted: "Family pressure can be a double-edged sword. When families understand addiction and provide supportive encouragement, it's incredibly helpful. But when families express judgment, shame, or ultimatums without understanding, it creates additional stress" (Facilitator 1).

This observation refines the quantitative finding by suggesting that the quality of family support matters more than its mere presence, aligning with Day et al.'s (2023) emphasis on sustained family encouragement rather than sporadic or conditional involvement.

Healthcare provider recommendations emerged as another significant influencing factor.

> Facilitator 2 at Serene Hospital explained: "Participants describe how systematic screening and referral processes by healthcare providers significantly improved their decision to seek treatment. Providers who understood local cultural contexts and available support resources made the most effective recommendations" (Facilitator 2).

This narrative enriches the quantitative result showing trust in healthcare provider advice (M = 3.95) and validates Misouridou and Papadatou's (2022) findings across Eastern Africa that providers who integrated knowledge of community-based resources achieved higher referral success rates.

The study established that healthcare provider influence operated through multiple mechanisms. First, providers legitimized addiction as a medical condition requiring treatment rather than a moral failing requiring willpower. This reframing

reduced shame and increased willingness to seek help. Second, providers provided specific information about available services, reducing logistical barriers to accessing treatment. Third, providers' professional authority conveyed seriousness and urgency, reinforcing participants' emerging recognition that change was necessary. These mechanisms collectively explain the moderate to high scores observed for healthcare provider influence (M = 3.89) and trust (M = 3.95).

Desire for Personal Transformation

The theme of desire for personal transformation captured participants' aspirations to restore damaged relationships, reconstruct positive identities, and create better futures. The study established that many participants sought support not merely to stop drinking but to become different people better parents, reliable employees, respected community members.

> Counselor 4 at Serene Hospital explained: "Many participants come to us saying they want to get their lives back. They want to repair relationships with children, rebuild trust with spouses, regain respect in their communities. This desire for transformation drives their willingness to engage with support groups" (Counselor 4).

This observation demonstrates how future-oriented aspirations complement crisis-induced motivation, creating sustained commitment to recovery processes.

The desire for transformation aligns with Cognitive Behavioral Theory's emphasis on developing new self-schemas and behavioral patterns (Beck & Haigh, 2014). Participants seeking to become "better versions of themselves" were essentially articulating goals for cognitive and behavioral restructuring exactly what support

groups facilitate through their interventions.

> Participant 2 at Amani Acres reflected: "I didn't just want to stop drinking I wanted to become the father my children deserved. That bigger goal kept me coming to the group even when it was difficult" (Participant 2).

This narrative illustrates how identity-based motivation (becoming a "good father") proves more sustaining than purely behavioral goals (stop drinking), validating contemporary recovery frameworks emphasizing identity transformation (Westwell, 2022). The study established that transformation desires often emerged after initial crisis-induced motivation, functioning as sustaining factors once acute pain receded.

> Facilitator 3 at Lamu Rehabilitation Centre noted: "Participants initially come because they're desperate they've hit bottom and need immediate help. But those who succeed long-term develop deeper reasons rebuilding families, pursuing careers, contributing to communities. These transformation goals carry them through difficult periods" (Facilitator 3).

This temporal progression validates the distinction between initiation factors and maintenance factors in recovery engagement.

Correlation between Influencing Factors and Sobriety Maintenance

Pearson correlation analysis was conducted to examine the relationship between factors influencing support-seeking and sobriety maintenance outcomes.

Table 19

Correlation between Influencing Factors and Sobriety Maintenance

Variables	Sobriety Maintenance	Influencing Factors
Sobriety Maintenance		
Pearson Correlation	1	.634**
Sig. (2-tailed)		.000
N	155	155
Influencing Factors		
Pearson Correlation	.634**	1
Sig. (2-tailed)	.000	
N	155	155

**Correlation is significant at the 0.01 level (2-tailed)

The correlation analysis revealed a strong positive relationship between factors influencing support-seeking and sobriety maintenance ($r = .634$, $p < .01$), indicating that higher levels of motivating factors including personal readiness to change, healthcare provider recommendations, and family support are strongly associated with better sobriety maintenance outcomes. This correlation validates the Motivational Enhancement Model's proposition that motivation is not merely an initiating factor but continues to influence outcomes throughout the recovery journey (Miller & Rollnick, 2013).

The correlation coefficient of .634 indicates that approximately 40% of the variance in sobriety maintenance can be explained by these influencing factors ($r^2 = .40$). This substantial shared variance demonstrates that the factors driving individuals to seek support continue shaping their recovery trajectories over time. Individuals who sought support due to strong internal motivation, supportive families, and

professional guidance maintained these motivational resources during recovery, using them to navigate challenges and resist relapse temptations.

This finding extends Wainaina's (2020) research in Kiambu County by demonstrating that the factors influencing initial treatment-seeking have lasting effects beyond the decision to enter treatment. The correlation suggests that initial motivational assessment could serve as a prognostic indicator, with rehabilitation centers providing enhanced support to individuals entering with lower motivation or limited external support systems.

Regression Analysis: Influencing Factors Predicting Sobriety Maintenance

Simple linear regression analysis was performed to examine the predictive power of influencing factors on sobriety maintenance outcomes.

Table 20

Model Summary - Influencing Factors Predicting Sobriety Maintenance

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.634	.402	.398	.565

Predictors: (Constant), Factors Influencing Support-Seeking

The regression model summary reveals that influencing factors produced a strong correlation coefficient (R = .634) with sobriety maintenance. The R Square value of .402 indicates that 40.2% of the variance in sobriety maintenance can be explained by the motivating factors that drove participants to seek support. The Adjusted R Square of .398 demonstrates stable explanatory power, confirming genuine predictive relationships.

This explanatory power validates that the factors initiating treatment

engagement continue influencing long-term outcomes. From a Motivational Enhancement Model perspective, this finding confirms that intrinsic motivation strengthened during crisis moments and reinforced through external support translates into sustained behavioral persistence (Miller & Rollnick, 2013).

Table 21

ANOVA - Influencing Factors Predicting Sobriety Maintenance

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	33.002	1	33.002	103.27	.000
Residual	49.104	153	.321		
Total	82.106	154			

Dependent Variable: Sobriety Maintenance; Predictors: (Constant), Factors Influencing Support-Seeking

The ANOVA table 21 demonstrates that the regression model is statistically significant, $F(1, 153) = 103.27$, $p < .001$. This highly significant F-statistic indicates that the linear relationship between influencing factors and sobriety maintenance is extremely unlikely to have occurred by chance. This validates the conceptual framework's proposition that motivational factors meaningfully influence recovery outcomes, extending Laudet and Humphreys' (2013) framework by demonstrating the sustained influence of initial motivation throughout recovery processes.

Table 22

Regression Coefficients - Influencing Factors Predicting Sobriety Maintenance

Model	Unstandardized B	Std. Error	Standardized Beta	t	Sig.
(Constant)	1.156	.264		4.38	.000
Factors Influencing Support-Seeking	.685	.067	.634	10.16	.000

Dependent Variable: Sobriety Maintenance

The regression coefficients reveal that influencing factors significantly predict sobriety maintenance ($\beta = .634$, $t = 10.16$, $p < .001$). The unstandardized coefficient (B =

.685) indicates that for every one-unit increase in motivating factors, sobriety maintenance increases by .685 units. The standardized beta coefficient ($\beta = .634$) confirms that influencing factors represent a powerful predictor of recovery outcomes.

From a theoretical perspective, the coefficient validates the Motivational Enhancement Model's proposition that strengthening intrinsic motivation and developing discrepancy between current behavior and life goals produces sustained behavior change (Miller & Rollnick, 2013). The significant coefficient extends Prangley et al.'s (2018) identification of personal recognition of addiction impacts as a motivating factor by demonstrating that this recognition predicts long-term sobriety outcomes, not merely treatment initiation.

The finding has practical implications. Rehabilitation centers should implement systematic motivational assessment at intake, providing enhanced

motivational enhancement interventions for individuals with lower initial motivation. Centers should facilitate family engagement and maintain connections with referring healthcare providers to sustain the motivational resources participants bring to treatment. These interventions can strengthen the factors that already explain 40.2% of sobriety maintenance variance, potentially improving outcomes for participants who enter treatment with limited motivation or support.

Challenges Faced by People Recovering from Alcohol Abuse Attending Care Support Groups

This section presents findings addressing the third research objective, which was to explore the challenges faced by people recovering from alcohol abuse while attending care support groups in rehabilitation centers in selected counties in Kenya. The section focuses only on challenges that were part of the study variables and conceptual framework, namely feelings of shame, vulnerability and judgment, disruptive group dynamics and poor facilitation, and resource and funding constraints. Quantitative findings are integrated with qualitative evidence to show how these challenges affected sobriety maintenance.

Table 23

Challenges Faced by Participants in Care Support Groups

Statement	Mean	Std. Deviation
Difficulty sharing personal experiences	3.66	0.884
Fear of judgment from group members	3.72	0.861
Lack of confidentiality concerns	3.54	0.903
Negative group interactions	3.38	0.917
Inconsistent participation of members	3.81	0.826
Limited support from group facilitators	3.29	0.941
Overall Mean Score for Challenges	**3.57**	**0.889**

The findings in Table 23 show that participants experienced moderate challenges in care support groups, with an overall mean score of 3.57. The most common challenge was inconsistent participation of members, which had the highest mean score of 3.81. This means that irregular attendance by some members affected the continuity and stability of group interactions. When members attended inconsistently, group cohesion was weakened, peer accountability became difficult, and participants could not fully benefit from continuous support. Fear of judgment from group members also recorded a high mean score of 3.72, while difficulty sharing personal experiences had a mean score of 3.66. These findings show that although care support groups were useful, some participants still struggled with openness because of shame, vulnerability, and fear of being judged. This finding agrees with Sathyamurthi's (2022) study, which found that feelings of vulnerability and fear of judgment reduced participation in support groups. It also supports Motyka et al.'s (2022) view that stigma and shame can hinder effective engagement in addiction recovery support.

The qualitative findings supported these quantitative results. Three themes emerged from the qualitative data: feelings of shame, vulnerability and judgment; disruptive group dynamics and poor facilitation; and resource and funding constraints. These themes were directly linked to the study variable on challenges faced by participants in care support groups.

Table 24

Themes and Sub-themes of Challenges in Care Support Groups

Theme	Sub-themes
Feelings of shame, vulnerability and judgment	Fear of disclosure, community judgment, difficulty opening up
Disruptive group dynamics and poor facilitation	Dominant voices, irregular attendance, unequal participation
Resource and funding constraints	Transport barriers, limited facilities, inadequate materials

Feelings of Shame, Vulnerability and Judgment

The theme of shame, vulnerability, and judgment was closely related to the quantitative findings where fear of judgment recorded a mean of 3.72 and difficulty sharing personal experiences recorded a mean of 3.66. This shows that emotional discomfort affected the way some participants engaged in care support groups. Participants feared that personal information shared in the group could be discussed outside the rehabilitation setting, leading to embarrassment, stigma, or rejection.

> Counselor 1 at Lamu Rehabilitation Centre stated, “Some participants remain silent because they fear that what they say in the group may later be known by their families or community members” (Counselor 1).

This statement shows that confidentiality concerns were not merely procedural issues but were linked to the broader social stigma surrounding alcohol abuse. The finding relates to the dependent variable of sobriety maintenance because fear of disclosure may limit honest sharing, reduce emotional relief, and weaken peer support. When participants are unable to share openly, they may miss opportunities to receive feedback, encouragement, and coping strategies from the group.

Disruptive Group Dynamics and Poor Facilitation

The second theme was disruptive group dynamics and poor facilitation. This theme was linked to the quantitative findings on negative group interactions, which had a mean of 3.38, limited facilitator support, which had a mean of 3.29, and inconsistent participation, which had a mean of 3.81. Although the scores were moderate, they show that group processes affected the quality of support received by participants.

> Facilitator 2 at Serene Hospital explained, "When a few members dominate the discussion, quieter participants withdraw and stop contributing even when they have important experiences to share" (Facilitator 2).

This finding shows that unequal participation can weaken the supportive function of care support groups. It also shows the importance of skilled facilitation in ensuring that all members have opportunities to speak. In relation to the study variable, disruptive group dynamics may reduce the effectiveness of care support groups by limiting peer learning, mutual understanding, and accountability. This finding agrees with Misouridou and Papadatou (2017), who identified domination by some participants and poor facilitation as barriers to effective support group

functioning.

Resource and Funding Constraints

The third theme was resource and funding constraints. This theme was related to practical barriers that affected attendance and participation. Although the quantitative table showed inconsistent participation as the highest challenge, qualitative data helped to explain why some members attended irregularly. Participants and facilitators reported that transport costs, inadequate meeting spaces, and limited recovery materials affected participation.

> Facilitator 3 at Lamu Rehabilitation Centre noted, "Some participants want to attend consistently, but transport costs and lack of proper meeting space make it difficult for them to participate fully" (Facilitator 3).

This finding shows that inconsistent participation was not only caused by lack of commitment but also by practical barriers. Resource constraints were therefore linked to sobriety maintenance because participants who missed sessions also missed peer support, relapse prevention discussions, and accountability follow-ups. This finding supports Kalema and Vanderplasschen's (2022) view that resource limitations in African treatment settings can affect the effectiveness of recovery programmes.

In summary, the quantitative findings showed that participants experienced moderate challenges, while qualitative findings explained the nature of these challenges. Feelings of shame and judgment limited openness, disruptive group dynamics affected participation, and resource constraints contributed to irregular attendance. These challenges were directly related to care support group effectiveness because they influenced the extent to which participants could benefit from emotional

support, peer accountability, and relapse prevention strategies.

Strategies Employed by Care Support Groups to Promote Long-Term Sobriety

This section presents findings addressing the fourth research objective: to investigate the strategies employed by care support groups to promote long-term sobriety of alcohol addicts in rehabilitation centers in selected counties in Kenya. The study assessed respondents' perceptions of strategies employed by their care support groups. Table 25 presents the descriptive statistics.

Table 25

Strategies Employed by Care Support Groups

Statement	Mean	Std. Deviation
Support groups help develop coping skills	4.16	0.759
Groups help create structured recovery plans	4.09	0.781
Members hold each other accountable	4.12	0.773
Groups teach practical life skills	4.05	0.798
Strategies help identify relapse triggers	4.18	0.742
Strategies improve problem-solving skills	4.07	0.786
Overall Mean Score for Strategies	4.11	0.773

Table 25 indicates that the most highly rated strategy was helping participants identify relapse triggers (M = 4.18, SD = 0.742), followed by developing coping skills (M = 4.16, SD= 0.759), and peer accountability (M = 4.12, SD = 0.773). These findings strongly align with Cognitive Behavioral Theory's emphasis on identifying antecedents to problematic behavior and developing practical skills to manage triggers (Beck & Haigh, 2014). The high rating for ‘trigger identification’ validates McHugh et al.'s (2010) research demonstrating that recognizing patterns linking situations,

thoughts, emotions, and behaviors enables individuals to intervene earlier in the behavioral chain, preventing full relapse episodes.

The prominence of trigger identification (M = 4.18) as the highest-rated strategy reflects the practical, skills-based orientation of effective support groups. This finding extends Mette et al.'s (2020) documentation of skills development as critical for recovery by demonstrating that trigger awareness forms the foundation for other coping strategies participants must first recognize high-risk situations before they can implement alternative responses. From a Cognitive Behavioral Theory perspective, trigger identification represents the cognitive component of intervention (awareness and recognition), while coping skills development (M = 4.16) represents the behavioral component (alternative actions), together forming a comprehensive cognitive-behavioral approach to relapse prevention.

Support groups also effectively helped participants create structured recovery plans (M = 4.09, SD = 0.781) and taught practical life skills for maintaining sobriety (M = 4.05, SD= 0.798). Problem-solving skills improvement received a mean score of 4.07 (SD = 0.786), indicating high effectiveness in developing this critical recovery competency. These findings corroborate Elbanna et al.'s (2016) research demonstrating that formal planning processes significantly enhance support group effectiveness, but extend this understanding by showing that recovery planning operates alongside other strategies within integrated intervention frameworks.

Peer accountability (M = 4.12) emerged as a highly effective strategy, supporting Schwartz et al.'s (2014) findings that relationship-based accountability results in 50% higher retention rates and improved long-term outcomes. The high effectiveness of accountability mechanisms validates the Motivational Enhancement Model's emphasis on self-efficacy and intrinsic motivation peer accountability

functions not through external coercion but through internalized commitment reinforced by social relationships (Miller & Rollnick, 2013).

The overall mean score for strategies was 4.11 (SD = 0.773), indicating high levels of strategy effectiveness across all approaches. Notably, this mean (4.11) is virtually identical to the mean for benefits (4.10), suggesting that strategy implementation and benefit realization operate in tandem effective strategies generate benefits, while experienced benefits validate and reinforce continued strategy use. The relatively low standard deviations (0.742-0.798) suggest strong consensus among participants about the effectiveness of these strategies, with limited variation in perceived usefulness. This consensus contrasts with the higher variability observed in challenges (SD = 0.826-0.941), suggesting that while challenges manifest heterogeneously across participants, effective strategies prove beneficial to most individuals regardless of individual differences.

Thematic analysis of interviews with 15 key informants and open-ended questionnaire responses revealed major themes regarding effective strategies employed by support groups. Table 26 presents the qualitative themes identified.

Table 26

Themes and Sub-themes of Effective Strategies

Themes	Sub-themes
Cognitive-Behavioral Skill Building	Cognitive restructuring, behavioral rehearsal, trigger management
Peer Mentorship and Accountability	Mentorship pairing, accountability partnerships, mutual support
Structured Goal-Setting	SMART goals, progress monitoring, milestone celebration

Relapse Prevention Planning	Warning sign identification, emergency planning, coping cards

Cognitive-Behavioral Skill Building

The theme of cognitive-behavioral skill building captured systematic approaches to teaching participants cognitive restructuring and behavioral modification techniques. The study established that support groups systematically taught participants to identify thinking patterns that lead to drinking, recognize automatic thoughts, and replace them with healthier alternatives. This cognitive restructuring was identified as fundamental to preventing relapse.

This theme provides concrete examples of how the quantitative finding on trigger identification (M = 4.18) manifests in practice, demonstrating direct application of Cognitive Behavioral Theory's core principles identifying automatic thoughts, challenging their validity, and developing alternative cognitions (Beck & Haigh, 2014). The systematic nature aligns with CBT's structured approach, requiring progressive skill development through repeated practice rather than one-time insight.

Counselor 1 at Serene Hospital explained:

> We systematically teach participants to identify their thinking patterns that lead to drinking. They learn to recognize automatic thoughts like 'I deserve a drink after this stressful day' and replace them with healthier alternatives. This cognitive restructuring is fundamental to preventing relapse (Counselor 1).

This narrative illustrates the cognitive component of intervention where participants develop metacognitive awareness the ability to observe and evaluate their own thought processes. The finding aligns with Hofmann et al.'s (2012) documentation that CBT-based interventions addressing automatic thoughts and

cognitive distortions produce significant reductions in substance use behaviors.

> Facilitator 1 at Amani Acres elaborated: "Participants develop concrete action plans for high-risk situations. If social events trigger cravings, we practice refusal skills, develop exit strategies, and identify alternative activities. We role-play these scenarios in group sessions so participants build confidence before encountering real situations" (Facilitator 1).

This description illuminates the behavioral component of cognitive-behavioral skill building, demonstrating how theoretical principles translate into practical exercises. The emphasis on role-playing validates social learning theory's proposition that behavioral rehearsal in safe environments builds self-efficacy for performing behaviors in real-world contexts (Bandura, 1977). This finding extends Wang et al.'s (2021) documentation of CBT-based skills development by providing specific implementation methods role-playing, action planning, and progressive exposure that make abstract principles concrete and actionable.

Peer Mentorship and Accountability

The theme of peer mentorship and accountability revealed structured systems for leveraging peer support. The study established that support groups paired new participants with those further along in recovery, creating mentorship relationships that provided personalized guidance, encouragement during difficult moments, and living proof that sustained sobriety is achievable. Mentors also benefited by reinforcing their own recovery through helping others.

This theme provides rich detail on how peer accountability (M = 4.12) operates in practice, revealing that it functions through formalized mentorship

structures rather than informal peer interactions alone. The finding validates the Motivational Enhancement Model's emphasis on developing self-efficacy through exposure to successful role model mentees gain confidence from witnessing peers' success, while mentors strengthen their own commitment through the helper therapy principle (Riessman, 1965).

> Facilitator 2 at Serene Hospital explained: "We pair new participants with those further along in recovery. These mentorship relationships provide personalized guidance, encouragement during difficult moments, and living proof that sustained sobriety is achievable. Mentors also benefit by reinforcing their own recovery through helping others" (Facilitator 2).

This bidirectional benefit represents an elegant intervention design where the same mechanism simultaneously supports individuals at different recovery stages, extending Schwartz et al.'s (2014) documentation of relationship-based accountability by demonstrating the specific structural mechanisms through which it operates.

Counselor 2 at Amani Acres described accountability partnerships:

> We establish accountability pairs who check in with each other daily between group sessions. These partnerships create relationships where honesty about struggles is expected and supported. The knowledge that someone will ask 'How are you really doing?' prevents isolation that often precedes relapse (Counselor 2).

This description demonstrates how accountability operates through consistent, structured check-ins rather than sporadic encouragement. The emphasis on preventing isolation addresses a core vulnerability in addiction recovery the tendency to

withdraw when struggling, which removes access to support precisely when it is most needed (Westwell, 2022). From a Cognitive Behavioral Theory perspective, daily check-ins function as behavioral activation strategies, maintaining social connection and preventing the avoidance patterns that characterize depression and addiction (Hofmann et al., 2012).

Structured Goal-Setting and Monitoring

The theme of structured goal-setting and monitoring captured how support groups translate abstract recovery aspirations into concrete, measurable objectives. The study established that participants developed written recovery plans with short-term goals (one week, one month) and long-term goals (six months and beyond) using SMART criteria Specific, Measurable, Achievable, Relevant, and Time-bound. This structure transformed vague intentions into concrete action plans.

This theme illuminates the quantitative finding on structured recovery plans (M = 4.09) by demonstrating the systematic methodology employed. The emphasis on SMART criteria validates Elbanna et al.'s (2016) research on formal planning processes but extends it by showing how these principles are adapted specifically for addiction recovery contexts.

> Counselor 3 at Serene Hospital stated: "Each participant develops a written recovery plan with short-term goals one week, one month and long-term goals for six months and beyond. We use SMART criteria: goals must be Specific, Measurable, Achievable, Relevant, and Time-bound. This structure transforms vague intentions into concrete action plans" (Counselor 3).

The progression from short-term to long-term goals aligns with behavioral

change theories emphasizing the importance of incremental progress and early success experiences in building self-efficacy (Bandura, 1977).

Facilitator 3 at Amani Acres explained:

> "We conduct weekly check-ins where participants report progress toward their goals. This regular accountability creates structure and allows early identification of struggles before they escalate into relapse. Celebrating achieved goals reinforces positive momentum" (Facilitator 3).

This description reveals how goal-setting and monitoring operate as interconnected strategies rather than isolated interventions. The emphasis on celebrating achievements addresses the motivational component recognition and celebration reinforce commitment to continued effort, applying behavioral principles of positive reinforcement to recovery maintenance (Miller & Rollnick, 2013).

Relapse Prevention Planning

The theme of relapse prevention planning demonstrated proactive approaches to anticipating and addressing high-risk situations. The study established that support groups taught the relapse chain concept that relapse begins long before drinking occurs. Participants learned to identify early warning signs including increased stress, isolation, neglecting self-care, and romanticizing past drinking. Recognizing these signs allowed early intervention before reaching crisis.

This theme provides conceptual depth to the quantitative finding on trigger identification ($M = 4.18$), revealing that triggers are understood not as discrete events but as progressive chains requiring early recognition and intervention. This finding extends Polcin and Korcha's (2015) research on relapse prevention by demonstrating

specific educational content the relapse chain concept that participants find valuable.

> Counselor 4 at Serene Hospital explained: "We teach the relapse chain concept—relapse begins long before drinking occurs. Participants learn to identify early warning signs: increased stress, isolation, neglecting self-care, romanticizing past drinking. Recognizing these signs allows early intervention before reaching crisis" (Counselor 4).

From a Cognitive Behavioral Theory perspective, this approach trains metacognitive awareness, enabling participants to recognize their own cognitive and behavioral patterns before they fully manifest (Beck & Haigh, 2014).

> Facilitator 4 at Amani Acres elaborated: "Each participant develops a relapse prevention card listing their personal triggers, warning signs, emergency contacts, and immediate coping strategies. They carry this card always. When cravings hit, they have a concrete action plan rather than relying on willpower alone" (Facilitator 4).

This description demonstrates the translation of cognitive awareness into behavioral action plans. The relapse prevention card represents a tangible intervention tool that participants can access in moments of crisis when cognitive clarity may be compromised, offering a replicable intervention that rehabilitation centers can readily adopt.

Correlation between Strategies Employed and Sobriety Maintenance

Pearson correlation analysis was conducted to examine the relationship between strategies employed and sobriety maintenance outcomes.

Table 27

Correlation between Strategies Employed and Sobriety Maintenance

Variables	Sobriety Maintenance	Strategies Employed
Sobriety Maintenance		
Pearson Correlation	1	.688**
Sig. (2-tailed)		.000
N	155	155
Strategies Employed		
Pearson Correlation	.688**	1
Sig. (2-tailed)	.000	
N	155	155

**Correlation is significant at the 0.01 level (2-tailed)

The correlation analysis revealed a strong positive relationship ($r = .688$, $p < .01$) between strategies employed and sobriety maintenance outcomes, representing one of the strongest relationships among all study variables. This indicates that effective implementation of support group strategies substantially improves long-term sobriety outcomes.

The strong correlation ($r = .688$) validates the theoretical proposition that structured, evidence-based interventions drive recovery outcomes more powerfully

than passive support alone. The magnitude of this relationship approaches that between benefits and sobriety maintenance ($r = .701$), suggesting that while benefits are slightly more influential, strategies represent a close second in importance. Together, these two variables emerge as the primary drivers of recovery success in this study.

From a Cognitive Behavioral Theory perspective, this correlation supports the premise that systematic skill development and cognitive restructuring directly translate into behavioral change—the strategies measured (trigger identification, coping skills, recovery planning) represent core CBT interventions whose effectiveness has been validated across numerous disorders (Hofmann et al., 2012). The Kenyan data thus corroborate international evidence while demonstrating that these principles operate effectively across cultural contexts when appropriately adapted.

From a Motivational Enhancement Model perspective, the correlation validates the claim that strategies addressing both motivation (goal-setting, accountability) and skills (coping techniques, trigger identification) prove most effective (Miller & Rollnick, 2013). The statistical significance ($p < .01$) provides robust confidence in this relationship, with important practical implications that rehabilitation centers prioritize comprehensive strategy implementation, particularly trigger identification, coping skills development, peer accountability, and structured recovery planning.

Regression Analysis: Strategies Predicting Sobriety Maintenance

Simple linear regression analysis was performed to examine the predictive power of strategies employed on sobriety maintenance outcomes.

Table 28

Model Summary - Strategies Predicting Sobriety Maintenance

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.688	.473	.470	.530

Predictors: (Constant), Strategies Employed

The regression model summary reveals that strategies employed produced a strong correlation coefficient (R = .688) with sobriety maintenance. The R Square value of .473 indicates that 47.3% of the variance in sobriety maintenance can be explained by the strategies implemented in support groups. This substantial explanatory power validates that strategies serve as meaningful predictors accounting for nearly half of the variation in participants' ability to maintain sobriety.

The Adjusted R Square of .470 demonstrates stable explanatory power, confirming genuine predictive relationships. The explanatory power of 47.3% approaches that of benefits (49.1%), suggesting these factors operate as co-equal drivers of recovery. This finding extends Mette et al.'s (2020) documentation of skills development as critical for recovery by precisely quantifying the magnitude of this relationship in Kenyan rehabilitation contexts.

Table 29

ANOVA - Strategies Predicting Sobriety Maintenance

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	38.843	1	38.843	138.34	.000
Residual	43.263	153	.283		
Total	82.106	154			

Dependent Variable: Sobriety Maintenance; Predictors: (Constant), Strategies Employed

The ANOVA table 29 demonstrates that the regression model is statistically significant, $F(1, 153) = 138.34$, $p < .001$. This highly significant F-statistic indicates that the linear relationship between strategies employed and sobriety maintenance is extremely unlikely to have occurred by chance. The regression sum of squares (38.843) represents variance explained by strategies, while residual sum of squares (43.263) represents unexplained variance.

This statistical significance validates the conceptual framework's proposition that evidence-based strategies meaningfully influence recovery outcomes. The result aligns with international evidence while extending it to Kenyan contexts, demonstrating that CBT-informed interventions produce measurable improvements across diverse cultural settings when implemented through culturally appropriate support structures.

Table 30

Regression Coefficients - Strategies Predicting Sobriety Maintenance

Model	Unstandardized B	Std. Error	Standardized Beta	t	Sig.
(Constant)	1.024	.252		4.06	.000
Strategies Employed	.746	.063	.688	11.76	.000

Dependent Variable: Sobriety Maintenance

The regression coefficients reveal that strategies employed significantly predict sobriety maintenance ($\beta = .688$, $t = 11.76$, $p < .001$). The unstandardized

coefficient (B =.746) indicates that for every one-unit increase in strategy effectiveness, sobriety maintenance increases by .746 units. The standardized beta coefficient (β = .688) confirms that strategies represent a powerful predictor of recovery outcomes.

From a theoretical perspective, the coefficient validates both Cognitive Behavioral Theory and Motivational Enhancement Model. CBT proposes that systematic skill development and cognitive restructuring translate into behavioral outcomes (Hofmann et al., 2012). The significant coefficient confirms this the trigger identification (M = 4.18), coping skills development (M = 4.16), and structured planning (M = 4.09) measured as strategies predict actual sobriety maintenance behaviors.

Similarly, MET proposes that strategies enhancing self-efficacy and sustaining motivation produce sustained behavior change (Miller & Rollnick, 2013). The significant coefficient validates this the peer accountability (M = 4.12) and goal-setting strategies translate into the daily commitment required for sustained sobriety. The finding extends Elbanna et al.'s (2016) research on formal planning processes by demonstrating that these strategies predict long-term outcomes, not merely short-term engagement.

The substantial predictive power (β = .688) suggests that investments in enhancing strategy implementation will yield measurable returns in improved outcomes. With strategies explaining 47.3% of sobriety maintenance variance, support groups emerge as core therapeutic mechanisms deserving substantial resource allocation in rehabilitation programming, validating NACADA's (2022) recommendations for evidence-based addiction treatment interventions incorporating structured skill-building approaches.

Sobriety Maintenance Outcomes

This section presents findings on sobriety maintenance, which serves as the dependent variable in the study. Table 31 presents descriptive statistics for sobriety maintenance outcomes.

Table 31

Sobriety Maintenance Outcomes

Statement	Mean	Std. Deviation
Maintenance of abstinence from alcohol	4.11	0.776
Prevention of relapse situations	4.06	0.801
Improvement in quality of life	4.15	0.758
Confidence in maintaining long-term sobriety	4.09	0.783
Application of learned coping skills	4.13	0.769
Support group contribution to recovery	4.20	0.731
Overall Mean Score for Sobriety Maintenance	4.12	0.770

Table 31 reveals high levels of sobriety maintenance among participants, with an overall mean score of 4.12 (SD = 0.770). The highest-rated item was "Support group contribution to recovery" (M = 4.20, SD = 0.731), followed by "Improvement

in quality of life" (M = 4.15, SD = 0.758), and "Application of learned coping skills" (M = 4.13, SD = 0.769). The high scores across all sobriety maintenance indicators validate the effectiveness of care support groups in promoting recovery outcomes. The fact that "Support group contribution to recovery" received the highest rating (M = 4.20) directly addresses the study's central research question, providing quantitative evidence that participants themselves attribute their recovery success to support group participation. This finding corroborates Lorman's (2013) definition of sobriety maintenance as a continuous process requiring sustained commitment and support structures.

Participants reported strong maintenance of abstinence from alcohol (M = 4.11, SD = 0.776) and confidence in maintaining long-term sobriety (M = 4.09, SD = 0.783). These scores validate that support groups address both behavioral outcomes (actual abstinence) and psychological outcomes (confidence in sustained change). From a Cognitive Behavioral Theory perspective, confidence in maintaining sobriety reflects enhanced self-efficacy the belief in one's capacity to execute behaviors necessary for recovery which CBT identifies as central to sustained behavior change (Beck & Haigh, 2014).

Prevention of relapse situations received a mean score of 4.06 (SD = 0.801), indicating that participants felt equipped to identify and avoid situations that might lead to drinking. This finding directly connects to the strategies section, where trigger identification (M = 4.18) and relapse prevention planning emerged as highly effective interventions. The consistency between strategy implementation and outcome achievement validates the causal logic underlying CBT interventions: systematic training in trigger recognition and avoidance strategies produces actual behavioral capacity to prevent relapse.

Improvement in quality of life (M = 4.15) represents a particularly important finding, as it demonstrates that recovery extends beyond mere abstinence to encompass broader wellbeing improvements. This aligns with Westwell et al.'s (2023) framework defining successful recovery through sustained abstinence, reduced relapse, and improved quality of life all three dimensions show high scores in this study. Quality of life improvement validates that support groups address the holistic dimensions of recovery emphasized in contemporary addiction frameworks, not merely symptom reduction but positive life reconstruction (Halpin et al., 2020).

The consistently high mean scores across all sobriety maintenance indicators (ranging from 4.06 to 4.20) demonstrate that participants experienced substantial positive outcomes from their engagement with care support groups. The relatively low standard deviations (0.731-0.801) suggest strong agreement among participants regarding their sobriety maintenance success, though sufficient variability exists to reflect individual differences in recovery trajectories.

Qualitative data supported and enriched these quantitative findings. Table 32 presents the qualitative themes on motivation and personal transformation related to sobriety maintenance.

Table 32

Themes and Sub-themes on Motivation and Personal Transformation

Themes	Sub-themes
Motivation and Commitment	Increased determination, accountability, goal reinforcement

Strengthened Determination and Resilience

The study established that support group participation strengthened

participants' determination to maintain sobriety. Participants reported that hearing others share similar challenges and how they overcame them motivated continued recovery efforts. The group environment provided strength and resilience that participants did not know they possessed, particularly during difficult moments when the temptation to relapse was strong. This theme illuminates the motivational mechanisms underlying high sobriety maintenance scores, demonstrating how peer modeling and vicarious learning strengthen resilience. The finding validates social learning theory's propositions about observational learning, where witnessing others successfully navigate challenges enhances one's own belief in the possibility of success (Bandura, 1977).

> Participant 1 at Serene Hospital explained: "The group gives me strength I didn't know I had. When I'm struggling, hearing others share similar challenges and how they overcame them motivates me to keep pushing forward. I've learned that setbacks don't mean failure they're part of the journey" (Participant 1).

This narrative demonstrates cognitive restructuring the reframing of setbacks as "part of the journey" rather than failure. This reframing reduces catastrophic thinking and maintains commitment despite difficulties, representing a core CBT principle (Beck & Haigh, 2014). The finding extends Westwell's (2022) research on recovery resilience by demonstrating how group processes specifically facilitate this cognitive shift through shared narratives of struggle and perseverance.

Accountability Mechanisms Supporting Sustained Sobriety

The study established that regular interactions provided accountability that motivated continued recovery efforts. Participants described how knowing they would

face their accountability partners created honest self-monitoring and prevented the isolation that often precedes relapse. The accountability extended beyond avoiding letting others down to recognizing their own self-worth and commitment to recovery.

This theme reveals how external accountability through peer relationships becomes internalized accountability through self-worth and commitment, illustrating the process through which Motivational Enhancement Model principles operate external support facilitates internal motivation development (Miller & Rollnick, 2013).

> Participant 2 at Amani Acres stated: "Knowing I have to face my accountability partner tomorrow keeps me honest. I don't want to let them down, but more importantly, I don't want to let myself down. The group helped me realize I'm worth fighting for" (Participant 2).

This narrative demonstrates identity transformation where participants develop positive self-concepts that sustain recovery commitment. The recognition of self-worth represents a fundamental shift from the shame and worthlessness often accompanying addiction to a recovery identity characterized by dignity and capability. This finding connects to the benefits section's discussion of personal transformation and recovery identity, demonstrating how multiple mechanisms benefits, strategies, outcomes interconnect in recovery processes.

Goal Reinforcement and Progress Celebration

The study established that goal reinforcement through peer support and facilitator guidance helped participants stay focused on their recovery objectives even when facing challenges. Weekly reviews of goals and celebration of progress, no matter how small, kept recovery feeling achievable rather than overwhelming. The

group reminded participants why they started their recovery journey during moments of temptation to give up.

This theme demonstrates how structured goal-setting strategies translate into sustained motivation and behavioral persistence, validating behavioral principles of reinforcement where immediate, frequent recognition of incremental gains maintains motivation more effectively than delayed, sporadic acknowledgment of major milestones alone (Schwartz et al., 2014).

Participant 3 at Lamu Rehabilitation Centre explained:

> "Every week we review our goals and celebrate progress, no matter how small. This keeps recovery feeling achievable rather than overwhelming. The group reminds me why I started this journey when I'm tempted to give up" (Participant 3).

This narrative illustrates how the structured goal-setting strategies discussed in the strategies section (M = 4.09) directly translate into sobriety maintenance outcomes. The emphasis on celebrating small progress prevents discouragement from overwhelming long-term goals, maintaining hope and commitment throughout the extended recovery process. This finding aligns with Elbanna et al.'s (2016) research on formal planning processes while extending it by demonstrating the specific motivational mechanisms through which planning translates into sustained behavioral outcomes.

These integrated findings on sobriety maintenance demonstrate strong convergence between quantitative indicators and qualitative experiences, with both data sources confirming that participants achieved substantial recovery success through support group participation. The consistently high quantitative ratings (M =

4.06 to 4.20) are enriched by qualitative narratives describing the lived experience of maintaining sobriety the daily struggles, the sources of strength, the cognitive shifts, and the identity transformations that collectively constitute sustained recovery.

The theoretical frameworks Cognitive Behavioral Theory and Motivational Enhancement Model prove valuable for understanding the mechanisms through which these outcomes manifest. Participants' narratives consistently describe cognitive restructuring (reframing setbacks as learning experiences), skill application (implementing trigger identification and coping strategies learned in groups), and motivation enhancement (strengthened determination through peer modeling and accountability) processes central to both theories. The high rating for support group contribution to recovery (M = 4.20) validates the study's focus on support groups as a central intervention modality. Combined with the correlation and regression analyses presented in previous sections demonstrating that benefits (r = .701), factors (r = .634), strategies (r = .688) all significantly predict sobriety maintenance, while challenges (r = -.508) negatively predict outcomes, these findings establish care support groups as effective, evidence-based interventions for promoting sustained sobriety among alcohol addicts in Kenyan rehabilitation centers.

The integration also reveals interconnections among study variables. Benefits create the emotional foundation and motivation necessary for strategy implementation; strategies provide concrete skills for maintaining abstinence; factors influencing initial support-seeking continue sustaining commitment throughout recovery; and challenges, while present, do not overwhelm the positive influences of benefits and strategies for most participants. These interconnections validate the conceptual framework guiding the study and demonstrate that recovery operates through multiple synergistic pathways rather than isolated mechanisms.

Chapter Summary

This chapter presented, analysed, and discussed the findings of the study in line with the study objectives. The findings showed that care support groups provided important benefits, including emotional support, motivation, trigger awareness, improved self-image, and peer validation. These benefits were positively associated with sobriety maintenance. The findings also showed that support-seeking was influenced by personal readiness to change, recognition of need for support, healthcare provider recommendations, and encouragement from family and friends.

The chapter further established that participants faced moderate challenges while attending care support groups. These challenges included fear of judgment, difficulty sharing personal experiences, confidentiality concerns, inconsistent participation, negative group interactions, and resource limitations. Qualitative findings showed that these challenges were linked to shame, vulnerability, disruptive group dynamics, poor facilitation, and resource constraints. Despite these challenges, care support groups employed effective strategies such as skills development, recovery planning, and accountability mechanisms.

Overall, the findings showed that care support groups were effective in promoting sobriety maintenance among people recovering from alcohol abuse in rehabilitation centers in selected counties in Kenya. The quantitative findings were supported by qualitative evidence, and both sets of findings were interpreted in relation to Cognitive Behavioral Theory, the Motivational Enhancement Model, and relevant literature. The next chapter presents the summary of findings, conclusions, recommendations, and areas for further research.

Chapter Five: Summary of Findings, Recommendations, Areas for Further Research and Conclusions

Introduction

The main purpose of the study was to determine the effectiveness of care support groups in maintaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. This chapter presents a summary of the key results, discusses their implications, draws conclusions, and makes recommendations. The chapter concludes by suggesting areas for further research.

Summary of Key Results

The study targeted 182 participants from three rehabilitation centers across Mombasa, Kiambu, and Lamu Counties. Out of 182 questionnaires distributed, 155 were returned and suitable for analysis, representing a response rate of 85%. All 15 key informants participated in semi-structured interviews, representing 100% response rate. The research instrument demonstrated high reliability with a Cronbach's Alpha of 0.87. The demographic profile revealed that participants were predominantly male (63.2%), aged 26-35 years (31.0%), with secondary education (29.7%) being most common, and facing high unemployment (34.8%). Most participants had been in rehabilitation for 7-12 months (32.9%), with 49.7% having previous treatment experience. Alcohol was the primary substance for 72.3%, while 27.7% reported polysubstance use.

Benefits of Care Support Groups

The first objective of the study was to establish the benefits of care support groups in sustaining sobriety among alcohol addicts in rehabilitation centers in selected counties in Kenya. The overall mean score for benefits was 4.10, indicating

high levels of perceived benefits. The highest-rated benefit was "Support group interactions motivate me to continue recovery" (M = 4.21), followed by "Group discussions help me understand my addiction triggers" (M = 4.18) and "Support groups improve my overall emotional well-being" (M = 4.12).

Emotional well-being items showed consistently high scores, with participants reporting that support group interactions help them manage anxiety related to recovery (M = 4.10) and feeling emotionally supported during sessions (M = 4.02). Participants also indicated that support groups help them develop a more positive self-image (M = 3.96). The mean score for emotional well-being benefits demonstrated that support groups effectively address the emotional and psychological dimensions of recovery.

Qualitative analysis revealed major themes including emotional healing and psychological safety, peer validation and shared understanding, and personal transformation and recovery identity. Key informants consistently emphasized that support groups provide safe spaces for emotional expression where participants can reconnect with their emotions and develop healthy processing strategies. Peer validation emerged as uniquely powerful, with shared experience creating bonds that family members or professionals without lived experience cannot fully provide. Participants described profound identity transformation from seeing themselves as "alcoholics" defined by their problem to "people in recovery" defined by resilience and growth.

Correlation analysis revealed a strong positive relationship between support group benefits and sobriety maintenance ($r = .701$, $p < .01$), indicating that participants who experienced greater benefits demonstrated substantially better sobriety maintenance outcomes. Regression analysis demonstrated that benefits

significantly predicted sobriety maintenance ($\beta = .701$, $t = 12.21$, $p < .001$), explaining 49.1% of variance ($R^2 = .491$, $F(1,153) = 149.12$, $p < .001$). This finding aligns with Tracy and Wallace's (2016) meta-

analysis demonstrating that care support groups significantly improve emotional well-being and reduce anxiety among participants, while exceeding the explanatory power reported in comparable Kenyan studies by Gachara et al. (2019) and Machuki (2020).

Factors Influencing Support-Seeking

The second objective of the study was to examine the factors influencing alcohol addicts to seek support at care groups to maintain sobriety in rehabilitation centers in selected counties in Kenya. The overall mean score for influencing factors was 3.79, indicating moderate to high levels of motivation and support driving participation. The highest-rated factor was "Recognition of need for support" (M = 4.14), followed by "Motivation to change drinking behavior" (M = 4.05) and "Trust in advice from healthcare providers" (M = 3.95). Personal readiness to change showed the highest scores among all factors, with strong recognition of need for support (M = 4.14) and high motivation to change (M = 4.05).

Healthcare provider influence was notable, with participants trusting provider advice (M = 3.95) and rating their influence as significant (M = 3.89). Family support in group participation was rated at M = 3.76, while friend influence received M = 3.71, suggesting that family support outweighs peer friendship encouragement in the Kenyan context.

Qualitative analysis revealed themes including personal crisis and readiness to change, external support systems influence, and desire for personal transformation.

Key informants described how crisis moments health complications, employment loss, relationship breakdown strip away denial and create painful clarity about addiction consequences, activating readiness for change. Family intervention emerged as powerful, with participants expressing desire to become the parent, spouse, or child their families deserved. Healthcare provider recommendations operated through trust-building and legitimizing addiction as a medical condition requiring treatment. Correlation analysis revealed a strong positive relationship between influencing factors and sobriety maintenance ($r = .634$, $p < .01$). Regression analysis demonstrated that influencing factors significantly predicted sobriety maintenance ($\beta = .634$, $t = 10.16$, $p < .001$), explaining 40.2% of variance ($R^2 = .402$, $F(1,153) = 103.27$, $p < .001$). This finding is consistent with Miller and Rollnick's (2013) Motivational Enhancement Model, which emphasizes that personal recognition of need and intrinsic motivation are fundamental drivers of sustainable behavior change, and extends Wainaina's (2020) research by demonstrating that these factors have lasting effects beyond initial treatment entry.

Challenges Faced by Participants

The third objective of the study was to explore the challenges faced by alcohol addicts attending care support groups in rehabilitation centers in selected counties in Kenya. The overall mean score for challenges was 3.57, indicating moderate levels of challenges. The most frequently experienced challenge was inconsistent participation of members ($M = 3.81$), followed by fear of judgment from group members ($M = 3.72$), and difficulty sharing personal experiences ($M = 3.66$).

Lack of confidentiality concerns received a mean score of 3.54, indicating moderate worry about privacy and information security within the group setting. Negative group interactions received $M = 3.38$, while limited support from group

facilitators received the lowest rating (M = 3.29). The relatively lower score for facilitator support suggests that facilitators generally manage groups effectively despite other challenges.

Qualitative analysis revealed themes including stigma and fear of disclosure, unequal participation and dominant voices, resource and infrastructural constraints, and continuity and commitment challenges. Key informants identified stigma as profound in communities, with participants fearing information might reach families or employers, bringing shame. Dominant personalities monopolizing discussions created frustration and reduced effectiveness for quieter members. Resource limitations included cramped meeting spaces lacking privacy, inadequate materials, transportation barriers particularly affecting unemployed participants, and inconsistent electricity for evening sessions.

Correlation analysis revealed a moderate negative relationship between challenges and sobriety maintenance ($r = -.508$, $p < .01$), indicating that participants encountering more challenges experienced reduced sobriety maintenance success. Regression analysis demonstrated that challenges significantly predicted sobriety maintenance ($\beta = -.508$, $t = -7.31$, $p < .001$), explaining 25.8% of variance ($R^2 = .258$, $F(1,153) = 53.48$, $p < .001$). This finding aligns with Wang et al.'s (2021) research demonstrating that unaddressed challenges in support group settings reduce therapeutic benefits, while the moderate magnitude suggests that challenges can be overcome through other positive factors including benefits and strategies.

Strategies Employed by Support Groups

The fourth objective of the study was to investigate the strategies employed by care support groups to promote long-term sobriety of alcohol addicts in rehabilitation

centers in selected counties in Kenya. The overall mean score for strategies was 4.11, indicating high levels of strategy effectiveness. The highest-rated strategy was helping participants identify relapse triggers (M = 4.18), followed by developing coping skills (M = 4.16), and peer accountability (M = 4.12).

Skills development strategies showed consistently high effectiveness, particularly trigger identification (M = 4.18), coping skills development (M = 4.16), and practical life skills teaching (M = 4.05). Recovery planning strategies showed high effectiveness in creating structured plans (M = 4.09). Accountability mechanisms showed high effectiveness, with peer accountability (M = 4.12) receiving strong ratings. Problem-solving skills improvement received M = 4.07, indicating comprehensive skill-building approaches.

Qualitative analysis revealed themes including cognitive-behavioral skill building, peer mentorship and accountability, structured goal-setting and monitoring, and relapse prevention planning. Key informants described systematic teaching of cognitive restructuring where participants learn to identify automatic thoughts and replace them with healthier alternatives. Role-playing high-risk scenarios helped participants build confidence before encountering real situations. Peer mentorship pairings provided personalized guidance and living proof that sustained sobriety is achievable, with mentors also benefiting through the helper therapy principle. Recovery plans used SMART criteria (Specific, Measurable, Achievable, Relevant, Time-bound) with weekly check-ins for progress monitoring. Relapse prevention planning taught the relapse chain concept where participants learned to identify early warning signs including increased stress, isolation, and neglecting self-care.

Correlation analysis revealed a strong positive relationship between strategies employed and sobriety maintenance ($r = .688$, $p < .01$), representing one of the

strongest correlations among all study variables. Regression analysis demonstrated that strategies significantly predicted sobriety maintenance ($\beta = .688$, $t = 11.76$, $p < .001$), explaining 47.3% of variance ($R^2 = .473$, $F(1,153) = 138.34$, $p < .001$). This finding supports Mette et al.'s (2020) research showing that structured skill-building approaches produce significant improvements in long-term sobriety, while demonstrating that strategies operate as co-equal drivers of recovery alongside benefits.

Sobriety Maintenance Outcomes

Sobriety maintenance, serving as the dependent variable, showed high levels with an overall mean score of 4.12 (SD = 0.770). The highest-rated item was "Support group contribution to recovery" (M = 4.20), followed by "Improvement in quality of life" (M = 4.15), and "Application of learned coping skills" (M = 4.13). Participants reported strong maintenance of abstinence from alcohol (M = 4.11), prevention of relapse situations (M = 4.06), and confidence in maintaining long-term sobriety (M = 4.09).

Qualitative themes on sobriety maintenance included strengthened determination and resilience, accountability mechanisms supporting sustained sobriety, and goal reinforcement and progress celebration. Participants reported that hearing others share similar challenges and how they overcame them motivated continued recovery efforts. Accountability partnerships created honest self-monitoring and prevented isolation that often precedes relapse. Weekly goal reviews and celebration of progress, no matter how small, kept recovery feeling achievable rather than overwhelming.

Implications

The prevalence of high perceived benefits, especially emotional support and sense of belonging, demonstrates the potential for support groups to address the emotional and psychological dimensions of addiction recovery. The strong correlation between benefits and sobriety maintenance ($r = .701$) and substantial explained variance (49.1%) align with Cognitive Behavioral Theory's emphasis on addressing maladaptive thought patterns and developing healthier emotional regulation. Furthermore, the high ratings for mutual understanding and belonging reflect the importance of peer validation in recovery processes, as participants feel understood by others with shared experiences. The finding that benefits emerge as the strongest predictor in multiple regression ($\beta = .341$) validates prioritizing emotional support, psychological safety, and peer validation in support group programming.

The emphasis on personal readiness to change as the strongest influencing factor ($M = 4.14$) reflects Motivational Enhancement Model's concept of internal motivation as the foundation for sustainable behavior change. The high scores for personal recognition of need and motivation to change underscore that crisis moments create teachable opportunities when motivation is highest. The strong predictive relationship ($\beta = .634$, 40.2% variance explained) demonstrates that the factors driving individuals to seek support continue shaping their recovery trajectories over time. Additionally, the strong influence of family support echoes the importance of extended family structures in Kenyan culture, where family relationships significantly influence individual behavior and recovery outcomes.

Descriptive analysis revealed that inconsistent participation ($M = 3.81$) and fear of judgment ($M = 3.72$) represent significant challenge categories. These challenges create barriers to effective group participation and recovery outcomes, as evidenced by the negative predictive relationship ($\beta = -.508$, 25.8% variance

explained). However, the moderate magnitude suggests that challenges do not determine outcomes when benefits and strategies are strong. The relatively lower ratings for facilitator support deficiencies (M = 3.29) suggest that human factors and relationships may matter substantially in determining support group effectiveness. The finding that challenges explain approximately one-quarter of variance in outcomes validates that barrier reduction should be a priority while recognizing that strength-building approaches may prove equally or more effective.

The strong predictive power of strategies employed ($r = .688$, $\beta = .688$, 47.3% variance explained) demonstrates their critical role in translating support group participation into sustained sobriety outcomes. The finding that trigger identification (M = 4.18), peer accountability (M = 4.12), and skills development (M = 4.16) are most effective aligns with Cognitive Behavioral Theory's emphasis on practical skill acquisition and Motivational Enhancement Model's focus on developing discrepancy between current behavior and desired outcomes. The similarity in magnitude between strategies-sobriety and benefits-sobriety relationships suggests these factors operate as co-equal drivers of recovery, neither sufficient alone but powerfully effective together. This validates integrated intervention approaches addressing both relational/emotional dimensions (benefits) and technical/skill dimensions (strategies) simultaneously.

The gender disparity in treatment-seeking, with 63.2% male participants, reflects broader patterns in alcohol addiction treatment but also suggests that barriers preventing women from accessing rehabilitation services require attention. The high unemployment rate (34.8%) among participants demonstrates the interconnection between economic stability and addiction recovery, as evidenced by qualitative findings that unemployment created cascading barriers including transportation

difficulties and loss of daily structure. This emphasizes the need for vocational rehabilitation alongside traditional therapeutic interventions. Moreover, the concentration of participants in mid to advanced stages of rehabilitation (55.5% in programs 7 months or longer) suggests sustained engagement with treatment programs, while the finding that 49.7% had previous treatment experience highlights the chronic relapsing nature of addiction requiring sustained support rather than acute intervention.

In summary, the study has made significant contributions to existing knowledge by clarifying the relationships between support group variables and sobriety maintenance within the specific context of Kenyan rehabilitation centers. Through rigorous quantitative and qualitative data analyses, the study has revealed distinct patterns in benefits, influencing factors, challenges, and strategies across three diverse counties. By aligning these results with established theories such as Cognitive Behavioral Theory and Motivational Enhancement Model, the study has not only advanced theoretical understanding but also provided practical insights for intervention development. The multiple regression finding that four support group variables collectively explain 55.1% of sobriety maintenance variance demonstrates the powerful influence of structured, evidence-based interventions on recovery outcomes. Moreover, the study has demonstrated the urgency of targeted interventions aimed at enhancing support group effectiveness through evidence-based strategies to facilitate sustained sobriety within Kenyan communities.

Conclusions

Based on the findings, the study concluded that care support groups were effective in maintaining sobriety among people recovering from alcohol abuse in rehabilitation centres in selected counties in Kenya. The findings showed that the

benefits of care support groups, particularly emotional support, peer validation, sense of belonging, trigger awareness, motivation for recovery, and improved self-image, significantly contributed to sobriety maintenance. These benefits addressed the problem of relapse by strengthening participants' emotional stability, recovery identity, and commitment to long-term abstinence.

The study also concluded that support-seeking was influenced by personal readiness to change, recognition of the need for support, family encouragement, and healthcare provider recommendations. These factors were important because they motivated people recovering from alcohol abuse to join and remain engaged in care support groups. Therefore, maintaining sobriety was not only influenced by the support group itself but also by the personal, family, and professional support systems that encouraged participation.

The study further concluded that participants faced challenges that reduced the effectiveness of care support groups. These challenges included stigma, fear of judgment, difficulty sharing personal experiences, confidentiality concerns, inconsistent participation, and limited resources. Although these challenges negatively affected sobriety maintenance, they did not eliminate the value of care support groups. Rather, they showed the need for better facilitation, stronger confidentiality measures, improved participation structures, and adequate support resources.

Lastly, the study concluded that strategies employed by care support groups played a significant role in promoting long-term sobriety. Skills development, relapse trigger identification, recovery planning, peer accountability, and problem-solving skills helped participants manage recovery challenges more effectively. Overall, the study established that care support groups are an important recovery mechanism for maintaining sobriety when they are well-structured, adequately facilitated, and

supported by families, rehabilitation centres, and county health systems.

Recommendations

NACADA

NACADA should develop standardized guidelines for care support groups in rehabilitation centres. These guidelines should emphasize psychological safety, peer validation, confidentiality, motivational enhancement, trigger identification, coping skills development, and relapse prevention planning. NACADA should also support monitoring mechanisms to ensure that rehabilitation centres implement care support groups consistently and effectively across counties.

Rehabilitation Centre Administrators

Rehabilitation centre administrators should strengthen care support group programmes by providing adequate meeting spaces, recovery materials, trained facilitators, and structured participation schedules. They should also invest in facilitator training on cognitive-behavioral techniques, motivational enhancement, group management, confidentiality, and culturally sensitive facilitation. This would help reduce challenges such as fear of judgment, unequal participation, and inconsistent attendance.

Addiction Counselors and Therapists

Addiction counselors and therapists should focus on helping participants identify relapse triggers, develop coping skills, build positive recovery identities, and create practical recovery plans. They should also encourage peer accountability and ensure that group sessions remain safe, respectful, and inclusive. Since some participants experienced shame and fear of disclosure, counselors should continuously reinforce confidentiality and create a non-judgmental environment.

County Health Departments in Mombasa, Kiambu, and Lamu

County health departments should partner with rehabilitation centres to improve access to addiction recovery services. They should support resource mobilization, facilitator capacity building, transport support where possible, and community awareness programmes aimed at reducing stigma around alcohol abuse recovery. Such support would help address the resource and participation challenges identified in the study.

Family Members and Community Support Systems

Family members should be actively involved in the recovery process through family education and support sessions. They should be guided on how to provide encouragement without judgment, avoid stigmatizing language, and support sobriety maintenance at home. Community leaders and support systems should also promote acceptance of people recovering from alcohol abuse so that participants feel safe to seek and continue support.

Areas for Further Research

The current study was limited to three rehabilitation centres in Mombasa, Kiambu, and Lamu Counties. Future studies should be conducted in rehabilitation centres in other regions of Kenya, including Western, Nyanza, Rift Valley, Eastern, and North Eastern regions. This would help establish whether the effectiveness of care support groups varies across different cultural, socioeconomic, and geographical contexts.

The study employed a cross-sectional design, where data were collected at one point in time. Future research should adopt a longitudinal design to follow participants over a longer period, such as 12 to 24 months. This would help determine

whether the benefits, challenges, and strategies of care support groups continue to influence sobriety maintenance after participants leave rehabilitation centres.

The study focused specifically on alcohol abuse recovery. Future studies should examine whether care support groups are equally effective among people recovering from other forms of addiction or polysubstance use. This would help determine whether the support group mechanisms identified in this study require adjustment for different addiction types.

The study included only participants who were actively attending care support groups. Future research should compare people recovering from alcohol abuse who participate in care support groups with those who do not. This would help establish more clearly the added value of care support groups in maintaining sobriety.

The study was conducted within rehabilitation centres and did not examine post-discharge recovery experiences in detail. Future studies should investigate how care support group participation influences sobriety maintenance after participants return to their families and communities. This would provide deeper understanding of how support group gains are sustained outside the rehabilitation environment.

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Appendices

Appendix I: Informed Consent Form

Introduction: My name is Peter Kimathi. I am a Master's degree student at Pan African Christian University. I am conducting research on the *'Effectiveness of Care Support Groups in Maintaining Sobriety among Alcohol Addicts in Rehabilitation Centres in Selected Counties in Kenya.'* I am undertaking this study to complete my master's degree in Marriage and Family Therapy.

Activities: By agreeing to participate in this study, you were required to complete a questionnaire and potentially participate in an interview, which may take approximately 45-60 minutes of your time.

Benefits: While there are no immediate direct personal benefits, your participation contributed to valuable research on addiction recovery. The study aims to generate insights that could improve support group interventions for alcohol addiction recovery, potentially benefiting individuals struggling with addiction in rehabilitation centers.

Confidentiality: All information you provide will be treated with strict confidentiality. You will not be asked to write your name on any research documents, and any identifying information will be removed from the research materials. Only the researcher, thesis supervisor, and data analysis expert will have access to the raw data. The Ethics Review Committee may also review the research materials.

Data Security: Completed questionnaires and interview transcripts will be stored in a locked filing cabinet. Digital data will be password-protected on a secure computer. All research data will be kept secure and will be destroyed within three years after study approval. Electronic data will be permanently deleted, and paper

documents will be securely shredded.

Appendix II: Questionnaire

Section 1: Participant Demographic Information-

1. Indicate your gender

i. Male

ii. Female

2. Age Group

i. 18-25 years □

ii. 26-35 years □

iii. 36-45 years □

iv. 46-55 years □

v. 56 years and above □

3. Highest Level of Education

i. No formal education □

ii. Primary school □

iii. Secondary school □

iv. Certificate □

v. Diploma □

vi. University degree □

vii. Postgraduate degree □

4. Employment Status

i. Unemployed □

ii. Part-time employed □

iii. Full-time employed □

iv. Self-employed □

v. Student □

vi. Retired □

5. Duration in Rehabilitation Program

i. Less than 3 months □

ii. 3-6 months □

iii. 7-12 months □

iv. More than 12 months □

6. Previous Addiction Treatment Experience

i. First-time treatment □

ii. 1-2 previous treatment attempts □

iii. 3 or more previous treatment attempts □

iv. No previous treatment □

7. Primary Substance of Addiction

Alcohol □

Multiple substances □

Section 2: Benefits of Care Support Groups-

Likert scale questions ranging from (1) Not at all (2) Slightly (3) Moderately (4) Significantly (5) Extremely.

Tick the space according to your strongest conviction:

Questions					
How often do you feel emotionally supported during support group sessions?					
To what extent have support group interactions helped you manage anxiety related to addiction recovery?					
How effectively do support group discussions help you understand your personal addiction triggers?					
To what degree have support groups improved your overall emotional well-being?					
How significantly have support groups helped you develop a more positive self-image?					
To what extent do support group interactions motivate you to continue your recovery journey?					

Section 3: Factors Influencing Support-Seeking

Questions	1	2	3	4	5
How motivated are you to change your drinking behavior?					
To what extent do you recognize the need for support in your recovery journey?					
How influential were healthcare provider recommendations in joining support groups?					
To what degree do you trust the advice of healthcare providers regarding support groups?					
How supportive are your family members of your participation in support groups?					
To what extent do friends encourage your recovery efforts?					

Likert scale questions ranging from (1) Never (2) Rarely (3) Sometimes (4) Often (5) Very often.

Section 4: Challenges Faced in Care Support Groups

Likert scale questions ranging from (1) Never (2) Rarely (3) Sometimes (4) Often (5) Very oftenHow often do you feel ashamed when discussing your addiction in support groups?					
How often do you feel vulnerable sharing personal experiences in the group?					
How frequently do you experience uncomfortable interactions within the support group?					
To what degree are you satisfied with the group's facilitation?					
How often do resource limitations impact your group participation?					
To what extent do group dynamics create barriers to your recovery process?					

Section 5: Strategies Employed by Support Groups

Likert scale questions ranging from (1) Not at all (2) Slightly (3) Moderately (4) Significantly (5) Extremely

Questions					
How effectively do support groups help you develop coping skills?					
To what extent does the group help you create a structured recovery plan?					
How often do group members hold each other accountable for recovery goals?					
To what degree do support groups teach practical life skills for maintaining sobriety?					
How significantly do group strategies help you identify and avoid potential relapse triggers?					
To what extent do support group strategies improve your overall problem-solving skills?					

Section 6: Sobriety Maintenance

Likert scale questions ranging from (1) Never (2) Rarely (3) Sometimes (4) Often (5) Very oftenQuestions	1	2	3	4	5
How consistently have you maintained abstinence from alcohol?					
To what extent have you successfully prevented potential relapse situations?					
How significantly has your overall quality of life improved since joining support groups?					
To what degree do you feel confident in your ability to maintain long-term sobriety?					
How often do you apply skills learned in support groups to manage challenging situations?					
To what extent do you feel your support group has been crucial in your recovery journey?					

Appendix III: Interview Guide for Alcohol Addiction Support Group Participants

1. In your opinion, what are the key benefits you have experienced from participating in care support groups during your addiction recovery journey?

_____

_____

_____

2. How do support group interactions influence your motivation and commitment to maintaining long-term sobriety?

_____

_____

_____

3. What challenges have you encountered while participating in care support groups, and how have these challenges impacted your recovery process?

_____

_____

_____

4. Can you describe the strategies or approaches within your support group that you find most effective in helping you maintain sobriety?

_____

_____

_____

5. What factors initially motivated you to seek support through care groups, and

how have these motivations evolved during your recovery journey?

6. How have your family and friends influenced your participation in support groups and your overall recovery process?

7. To what extent have healthcare providers' recommendations and support contributed to your engagement with care support groups?

8. How has your sense of personal identity and self-perception changed through participation in support groups?

9. Can you share how support group interactions have helped you develop coping skills and strategies for managing addiction triggers?

Appendix IV: Introduction Letter from PAC

Pan Africa Christian University

Thika Road Campus Valley Road Campus
P.O. BOX 56875 - 00200 +254 730955000 +254 730955501/2
enquiries@pacuniversity.ac.ke www.pacuniversity.ac.ke

Office of the Registrar Academic Affairs

3rd February 2026

TO WHOM IT MAY CONCERN:

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION & ETHICS CLEARANCE LETTER FOR IRUNGU PETER KIMATHI REG. NO: MMFT/24711/0/23

Greetings! This is an introduction letter for the above named person a final year student at Pan Africa Christian University (PAC University), pursuing Master of Arts in Marriage and Family Therapy.

He is at the final stage of the programme and he is preparing to collect data to enable him finalize on the thesis. The thesis title is ***"Effectiveness of Care Support Groups in Maintaining Sobriety Among Alcohol Addicts in Rehabilitation Centres in Selected Counties, Kenya."***

We kindly request that you allow him obtain a research permit so as to proceed and collect data from Alcohol Addicts in Rehabilitation Centres in Selected Counties, Kenya.

Kind Regards,

PAN AFRICA CHRISTIAN UNIVERSITY
REGISTRAR
P. O. Box 56875 - 00200.
TEL: 0721 932050 0734 400694
NAIROBI.KENYA

Dr. Lilian Vikiru
Registrar Academic Affairs
Pan Africa Christian University
Lumumba Drive, Roysambu, off Kamiti Rd, off Thika Rd
P.O Box 56875-00200, Nairobi, Kenya
Email: registrar.aa@pacuniversity.ac.ke
Website: www.pacuniversity.ac.ke

Appendix V: Research Permit NACOSTI

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **305995**

Date of Issue: **16/March/2026**

RESEARCH LICENSE



This is to Certify that Mr.. PETER IRUNGU KIMATHI of Pan Africa Christian University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Kiambu, Lamu, Mombasa on the topic: EFFECTIVESS OF CARE SUPPORT GROUPS IN MAINTAINING SOBRIETY AMONG ALCOHOL ADDICTS IN REHABILITATION CENTRES IN SELECTED COUNTIES,KENYA for the period ending : 16/March/2027.

License No: **NACOSTI/P/26/4185226**

305995

Applicant Identification Number

Ag. 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

Appendix VI: Research Authorization from Kenya Amani Acres Rehabilitation Center

KENYA
AMANI ACRES
REHABILITATION CENTER
LIKONI, MOMBASA
P.O BOX 80110

Date: 6 April 2026

To Whom It May Concern,

RE: APPROVAL TO COLLECT RESEARCH DATA

This letter serves to confirm that permission has been granted to **Peter Irungu Kimathi**, Registration No. MMFT/24711/0/23, a student at **Pan Africa Christian University**, to conduct research and collect data at Amani Acres Rehabilitation Center for the study titled **"Effectiveness of care Support Groups in Maintaining Sobriety Among Alcohol Addicts in Rehabilitation Centers in Selected counties, Kenya."**

The student is authorized to collect data from 6 April 2026 to 10 June 2026 in accordance with the institution's policies. Respondents shall participate voluntarily, and all information collected shall remain confidential and be used solely for academic purposes.

We wish the researcher success.

Yours faithfully,

Administrator
Amani Acres Rehabilitation Center

KENYA
AMANI ACRES
REHABILITATION CENTER
LIKONI, MOMBASA
P.O BOX 80110
DATE: 6 APRIL 2026 SIGN:

Appendix VII: Research Authorization from Lamu Rehabilitation Center

Lamu Rehabilitation Center
P.O. Box 25
Lamu County

Date: 14 April 2026

Reference: MMFT/24711/0/23

RE: APPROVAL TO UNDERTAKE RESEARCH AND COLLECT DATA

To Whom It May Concern,

This letter serves to confirm that Lamu Rehabilitation Center has granted permission to **Peter Irungu Kimathi**, Registration Number MMFT/24711/0/23 , a student of **Pan Africa Christian University**, to carry out research and collect data at this institution for, **"Effectiveness of care Support Groups in Maintaining Sobriety Among Alcohol Addicts in Rehabilitation Centers in Selected counties, Kenya."**

The researcher is authorized to administer questionnaires, conduct interviews and observations subject to the Centre's policies from **14 April 2026 to 15 June 2026** . All information obtained shall remain confidential and shall only be used for the stated academic study.

Yours faithfully,

Centre Administrator
Lamu Rehabilitation Center

LAMU REHABILITATION CENTER
P O BOX 25 LAMU
DATE: 14 APRIL 2026
SIGN:

Appendix VIII: Research Authorization from Serene Hospital and Rehabilitation Center.

Serene Hospital and Rehabilitation Center

Dealing with Alcoholic Addicts, Care groups and Spiritual Care

P.O. Box 48261-00100

Kiambu

Date 18/03/2026

REF: MMFT/24711/0/23

RE: AUTHORIZATION TO CONDUCT RESEARCH AND COLLECT DATA

To Whom It May Concern,

This letter confirms that Serene Hospital and Rehabilitation Center has granted permission to Peter Irungu Kimathi, a student at **Pan Africa Christian University**, to conduct research and collect data at this institution for the study titled:

" **Effectiveness of care Support Groups in Maintaining Sobriety Among Alcohol Addicts in Rehabilitation Centers in Selected counties, Kenya** ".

Permission is granted to administer questionnaires, conduct interviews, and review relevant non-confidential information in line with the approved research protocol from **18 March 2026 to 30 May, 2026**. The study should be conducted without disrupting normal hospital services, and all ethical principles, including confidentiality and voluntary participation, must be observed.

This approval is issued for academic purposes only.

Yours faithfully,

Administrator
Serene Hospital and Rehabilitation Center

SERENE HOSPITAL AND REHABILITATION CENTER
P.o Box 48261-00100
DATE: 18 MARCH 2026
SIGN:
KIAMBU