Relationship between Alcohol Dependence and Social Support among Alcoholic Patients at Machakos Level 5 Hospital, Machakos County, Kenya

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ABSTRACT

Alcohol dependence poses a significant challenge to the health and well-being of individuals and communities. This quantitative study investigated the relationship between alcohol dependence and social support among alcoholic patients undergoing treatment at Machakos Level 5 Hospital, Machakos County, Kenya. A correlational research design was used, with a sample of 320 alcohol dependents aged between 18 and 60 years, drawn from a target population of 1,200 patients. The Alcohol Use Disorders Identification Test (AUDIT) and the Multidimensional Scale of Perceived Social Support (MSPSS) were the data collection tools. The theoretical framework was based on the Behavioral Economic Theory of Addiction and Social Support Theory. Data analysis was performed using SPSS version 25, with descriptive statistics including frequencies, percentiles, means, and standard deviations. Inferential statistics included Pearson's correlation and the Chi-square test. The study found that 55.6% of respondents had high levels of alcohol dependence, while 66.3% had high levels of social support. A positive moderate correlation was observed between alcohol dependence and social support (n = 320, r = .402, p = .000), indicating that higher levels of social support were associated with higher levels of alcohol dependence. The study recommended strengthening psychological and social support interventions to enhance recovery efforts among alcoholic patients.

Keywords: Alcohol Dependence, Rehabilitation, Social Support Theory, AUDIT, MSPSS, Correlation Machakos Level 5 Hospital

INTRODUCTION

Alcohol dependence is a widespread social and public health concern that undermines the development of a thriving and equitable society. Global empirical studies have illuminated the prevalence and severity of alcohol dependence among individuals seeking rehabilitation in different healthcare and community settings. Ryder et al. (2009) conducted a study to determine the prevalence of problem alcohol use among current or former heroin users attending primary care for methadone treatment in Ireland. They found a significant prevalence rate of 35% for problem alcohol use within this population. Additionally, 14% of the participants scored 20 or higher on the AUDIT questionnaire, indicating possible alcohol dependence. These findings underscore the dual challenge of co-occurring problem alcohol use and illicit drug use, highlighting the need for further research and targeted interventions to support recovery in this vulnerable population. The high prevalence rates of are mirrored in the United States as evidenced by the research findings in rehabilitation settings by the Recovery Village (2023). The research found a 66% prevalence of heavy drinking among inpatient residents; 54.1% in intensive outpatient and 44.2% among patients in outpatient programs. While both studies showed high alcohol dependence, the US had a higher prevalence in rehabilitation settings compared to Ireland. Regional studies further highlight the issue of level of alcohol dependence in rehabilitation settings with Nalwadda et al. (2018) reporting 39.6% of AUDs among men attending primary care clinics in Uganda. A distinctive feature of this research is its focus on the psychological barriers to treatment, particularly the role of internalized stigma. The study found that 55.0% of participants with positive AUDIT scores refrained from seeking treatment, believing that alcohol use disorders were incurable. Furthermore, 47.5% expressed that alcohol use had severely impacted their lives, while 42.5% experienced shame related to their drinking

behaviors. These findings reveal that social stigma not only affects self-perception but also significantly influences help-seeking behaviors, highlighting a unique challenge in the Ugandan context.

In contrast to findings from previous global and regional studies, Kibera et al. (2017) who conducted a descriptive cross-sectional study to assess the level of alcohol dependence among patients attending the Comprehensive Care Centre at Kenyatta National Hospital in Nairobi found low levels (14%) of alcohol dependence among the respondents. Additionally, the study highlighted a gender factor, where men were found to be more susceptible to alcohol use disorders than women. This focus on gender reveals a potential gap in previous research, suggesting that the understanding of alcohol dependence prevalence could be enriched by considering these differences. Ndetei et al. (2009) found a prevalence of alcohol use disorders at 25.1% among patients admitted to general medical facilities in Kenya, closely aligning with Kibera et al. (2017). Notably, all alcohol users in the study displayed some level of pathological use, ranging from harmful use to dependence. These findings suggests a concerning level of problematic alcohol consumption in medical settings in Kenya, despite the relatively low overall prevalence. Together, global, regional, and local studies highlight the varying prevalence of alcohol dependence across different populations and settings.

The social support theory plays a crucial role in understanding the recovery outcomes for individuals with alcohol dependence. This theory posits that a robust social support system can significantly enhance rehabilitation efforts. It operates on two levels: macro, which encompasses supportive societies, and interpersonal, which focuses on supportive relationships. Two key dimensions of social support are perceived support (the belief that support is available) and received support, which refers to actual assistance provided (Kort-Butler, 2018). Social support can manifest in various forms, including instrumental (practical help), informational (advice), and emotional (sympathy), originating from both primary groups (family and friends) and secondary groups (such as schools and religious organizations). In the context of this study, the social support theory provides a framework for understanding how different types of social support influenced recovery outcomes for alcohol dependents undergoing rehabilitation at Machakos level 5 hospital. Specifically, it helps to identify how the quality and availability of social support directly impact an individual's motivation, rehabilitation adherence, and overall recovery outcomes. Understanding the dynamics offers valuable insights into how enhancing social support systems can facilitate better health outcomes for those struggling with alcohol dependence.

Various studies have emphasized the role of social support in the recovery of individuals with alcohol dependence. Dixit et al. (2015) and Hunter-Reel (2010) both found significant differences in recovery outcomes based on levels of social support. Hunter-Reel (2010) investigated the indirect effect of social support on alcohol use among women with alcohol use disorders participating in two linked randomized controlled trials. The study utilized several measures, including the Important People Interview, the Stages of Change Readiness and Treatment Eagerness Scale, and the Timeline Follow-back interview. It found that individuals with more network support for drinking at the beginning of treatment had lower motivation for abstinence at the end of treatment, which predicted higher drinking frequency over the following six months. The indirect effect of baseline support for drinking on 6-month follow-up drinking frequency was statistically significant, with a Sobel test z-score of 2.49 and a p-value of 0.01. A similar, albeit marginally significant, trend was observed for the relationship between support for not drinking and drinking frequency. Dixit et al. (2015) conducted a study in India examining the extent of social support received by individuals who drink and its impact on treatment outcomes. They used the Social Provision Scale (SPS) and the Social Support Questionnaire (SSQ) to assess the social support provided to male patients with alcohol dependence syndrome. The comparison of social provision scores between the abstinent and relapse groups revealed significant differences. The abstinent group had a median reassurance of worth score of 15, indicating a relatively high level of support, while the relapse group scored a median of 11. The professional and semi-professional groups exhibited a higher median SPS score of 78.0, indicating greater social support in various domains, compared to lower scores in the clerk and semi-skilled groups. These findings suggest that individuals in higher occupational categories tend to receive more extensive social support. Maeng et al. (2022) examined the extent of social support and its impact on excessive alcohol use among middle-aged adults in South Korea using the Perceived Social Supports Scale (PSS). The study found high reliability for social support from family (Cronbach's α = 0.979) and friends (Cronbach's α = 0.967). Although the study did not provide specific figures

for the level of social support, it reported average scores: 94.71 (SD = 18.31) for family support and 86.69 (SD = 15.82) for friends. These scores suggest that participants perceived a relatively high level of social support from both family and friends, with variability in responses indicated by the standard deviations. While the studies are set in different geographical and cultural contexts, they demonstrate a relationship between social support and alcohol dependence as hypothesized in the current study. The collective findings reinforce the current study's focus on social support as a critical factor in the rehabilitation process for alcohol-dependent individuals.

Despite the evidence supporting the importance of social support in treatment outcomes, there is a notable gap in research focusing specifically on the dynamics of social support among alcohol-dependent patients undergoing rehabilitation in Kenya. Existing literature has primarily addressed prevalence rates and substance use patterns, leaving a significant research gap on the role of social support on alcohol dependence among alcoholic patients undergoing rehabilitation at level 5 hospitals in Kenya. This study's central motivation was to fill that gap by investigating the social support experienced by patients at Machakos Level 5 Hospital and its impact on their recovery outcomes, ultimately contributing to a more comprehensive understanding of how social networks can aid in the rehabilitation of individuals facing alcohol dependence. By employing social support theory, the research provided a framework for understanding how different types of support influenced recovery for alcohol dependents undergoing rehabilitation at this facility.

METHODOLOGY

The research adopted a correlational survey design, which was appropriate for examining the relationship between alcohol dependence and social support without manipulating the variables (Fitzpatrick & Wallace, 2006). This design allowed the researcher to identify the strength and direction of the association between these variables. The study took place at the addiction clinic in Machakos Level 5 Hospital, Machakos County, with a target population of 1,200 alcoholic patients undergoing treatment. A stratified sampling technique was used to select participants systematically to ensure that the sample represented the population's characteristics (Cottrell & McKenzie, 2011). The stratification was based on sociodemographic characteristics including age, gender, socioeconomic status, and religion. A random sample was then selected from each stratum to ensure adequate representation of the overall population. The study utilized two standardized tools: the Alcohol Use Disorders Identification Test (AUDIT) and the Multidimensional Scale of Perceived Social Support (MSPSS) to gather data. AUDIT is a validated 10-question survey that includes items related to alcohol consumption, dependence symptoms, and alcohol-related problems (Barrie and Scriven, 2014). MSPSS is a 12-item questionnaire that assesses participants' perceptions of the social support they receive from family, peers, and significant others on a 7-point Likert scale ranging from 1 (very strongly disagree) to 7 (very strongly agree) (Sajatovic & Ramirez, 2012, p. 211). The use of self-reported surveys (AUDIT and MSPSS) introduced a potential limitation, particularly social desirability bias, where participants may provide responses they believe are socially acceptable rather than truthful. Participant's personally identifying information was anonymized to address this limitation. Additionally, participants were informed of their right to withdraw at any time, which aimed to create a more comfortable and honest response environment.

The pre-testing phase was conducted involving 10% of the sample population (32 respondents) to ensure the reliability and validity of these instruments. The pre-testing phase involved distributing AUDIT and MSPSS questionnaires to 29 purposively selected outpatient alcohol dependents undergoing treatment at Machakos County Teaching and Referral Hospital. The collected questionnaires were analyzed using SPSS-25, and Cronbach's alpha was calculated to assess the reliability of the instruments. The pre-test results indicated that the questionnaires were suitable for the full study, allowing the research to proceed without making any significant changes to the instruments.

Data analysis was conducted using the Statistical Package for the Social Sciences (SPSS-25).

Research permits to conduct the study were obtained from the Tangaza University Research Ethics Committee (TUREC), the National Council of Science, Technology, and Innovation (NACOSTI), and the Medical Superintendent of Machakos Level 5 County Referral and Teaching Hospital. Informed consent was obtained, and participants were informed of the study's purpose, procedures, risks, benefits, and their right to withdraw

at any time. Personally identifying data was anonymized and replaced it with unique codes to ensure confidentiality. The research process was conducted with care to avoid causing harm, and no deception was used. Additionally, all academic standards were strictly adhered to, including proper citation and referencing of all sources.

RESULTS

The study aimed to investigate the relationship between social support and alcohol dependence among patients at Machakos Level 5 Hospital in Machakos County, Kenya. The distribution of demographic details was analyzed across five variables: age, gender, religious background, socioeconomic status, education level, and marital status. The social demographic characteristics were summarized and presented accordingly in Table 1.

Social Demographics of the participants

This section delves into the personal backgrounds of participants, exploring their age, gender, religious background, socio-economic status, education level, and marital statuses. The social demographics provide valuable insights into the social context that shapes the experiences of respondents and deepens the understanding of the study's findings.

Table 1: Social Demographic Characteristics of the Respondents

Variables	Frequency	Percentage
Age		
18 – 31	120	37.5
32 – 45	140	43.8
46- 60	60	18.8
	Gender	
Male	180	56.2
Female	140	43.8
	Religious Background	
Christian	240	75
Muslim	40	12.5
No Religious Affiliation	40	12.5
	Socio-Economic Status	
High-Income	120	37.5
Middle-Income	80	25
Low-Income	120	37.5
	Education-Level	
University	160	50
College	40	12.5
Secondary	40	12.5
Primary	80	25

	Marital Status	
Married	160	50
Single	40	12.5
Divorced	40	12.5
Other	80	25

Table 1 summarizes the socio-demographic details of the respondents. Among them, 120 (37.5%) were aged 18-31 years, 140 (43.8%) were aged 32-45 years, and 60 (18.8%) were aged 46-60 years. The sample included 180 males (56.2%) and 140 females (43.8%). Christians comprised 240 respondents (75%), while Muslims and those with no religious affiliation each accounted for 40 (12.5%). In terms of socio-economic status, 120 respondents (37.5%) were high-income, 120 (37.5%) were low-income, and 80 (25%) were middle-income. Finally, 160 respondents (50%) were married, 40 (12.5%) were single, 40 (12.5%) were divorced, and 80 (25%) fell into the 'other' category, which comprised of individuals who preferred not to disclose their marital status.

Levels of Alcohol Dependence

This study determines the level of alcohol dependence among alcoholic patients undergoing treatment at Machakos Level 5 Hospital, Machakos County. Table 2 summarizes the levels of alcohol dependence.

Table 2: Levels of Alcohol Dependence among Alcoholic Patients Undergoing Treatment at Machakos Level 5 Hospital

Descriptions	Range	Frequency	Percentage
Low level of Alcohol Dependence	0-10	62	19.4
Moderate level of Alcohol Dependence	11-20	80	25
High level of Alcohol Dependence	21-40	178	55.6
TOTAL		320	100

According to Table 2, the distribution of alcohol dependence levels among respondents showed that 62 individuals (19.4%) had a low level of alcohol dependence (0-10), 80 individuals (25%) had a moderate level (11-20), and 178 respondents (55.6%) had a high level (21-40). In total, 320 participants were included in the analysis.

The Relationship between the Levels of Alcohol Dependence and Demographic Characteristics

After determining the levels of alcohol use, this study examined the relationship between respondents' demographic characteristics and their alcohol use levels using the Chi-square test. The findings are summarized in Table 3.

Table 3: Relationship between Levels of alcohol dependence and demographic characteristics of respondents

		Alcohol Dependence			Chi-Square test		
Variables	Total	Low-level	Moderate-level	High-level	X^2	df	Sig
Age							
18 - 31	120 (37.5)	28 (8.8)	36 (11.3)	71(23.1)	6.918	4	0.14

32 - 45	140 (43.8)	26 (8.1)	40 (12.5)	60 (20.0)			
46- 60	60 (18.)	8 (2.5)	4 (1.3)	40 (12.5)			
Gender							
Male	180 (56.2)	54 (16.9)	74 (23.1)	172(53.8)	3.708	2	0.157
Female	140 (43.8)	8 (2.5)	6 (1.9)	6 (1.9)			
Religious Background							
Christian	240 (75)	46 (14.4)	72 (22.5)	152 (47.5	3.468	2	0.177
Muslim	40 (12.5)	16 (5.0)	8 (2.5)	26 (8.1)			
No Religious Affiliation	40 (12.5)	26 (8.1)	28 (8.8)	8 (2.5)			
Socio-Economic Status							
High-Income	120 (37.5)	46(14.4)	72 (22.5)	152 (47.5)	3.468	2	0.177
Middle-Income	80 (25)	16 (5.0)	8 (2.5)	26 (8.1)			
Low-Income	120 (37.5)	26 (8.1)	28 (8.8)	8 (2.5)			
Education Level							
University	160 (50)	4 (1.3)	2 (0.6)	14 (4.4)	3.633	6	0.726
College	40 (12.5)	0 (0.0)	0 (0.0)	2 (0.6)			
Secondary	40 (12.5)	0 (0.0)	4 (1.3)	6 (1.8)			
Primary	80 (25)	58 (18.1)	74 (23.1)	156(48.8)			
Marital Status							
Married	160 (50)	4 (1.3)	2 (0.6)	14 (4.4)	3.633	6	0.726
Single	40 (12.5)	0 (0.0)	0 (0.0)	2 (0.6)			
Divorced	40 (12.5)	0 (0.0)	4 (1.3)	6 (1.8)			
Other	80 (25)	58 (18.1)	74 (23.1)	156 (48.8)			

Table 3 illustrates that the analysis of the relationship between sociodemographic characteristics and levels of alcohol dependence at Machakos Level 5 Hospital indicated no statistically significant associations across all variables. For age, the Chi-Square value was 6.918 with a p-value of 0.14, exceeding the 0.05 threshold, which suggests no significant association with alcohol dependence levels. Gender analysis yielded a Chi Square value of 3.708 and a p-value of 0.157, again indicating no significant association. Regarding religious background, the Chi-Square value was 3.468 with a p-value of 0.177, suggesting a lack of significant association. Similarly,

socio-economic status also showed no significant association, with a Chi-Square value of 3.468 and a p-value of 0.177. Education level presented a Chi-Square value of 3.633 and a p-value of 0.726, indicating no significant association with alcohol dependence. Finally, marital status analysis yielded a Chi Square value of 3.633 and a p-value of 0.726, reaffirming the absence of a significant association. Overall, these findings suggest that age, gender, religious background, socio-economic status, education level, and marital status do not significantly influence alcohol dependence levels in the studied population. This suggests that there may be other confounding variables affecting alcohol dependence levels that were not identified in the study, hence the need for further research. In addition, the sample sizes across demographic categories are uneven, with some groups having many more participants than others. The heterogeneity in sample sizes across these categories can limit the generalizability of findings and the ability to draw meaningful conclusions from the data.

Levels of Social Support

This study the level of social support provided to alcoholic patients undergoing treatment at Machakos Level 5 Hospital, Machakos County. Table 4 presents the results.

Table 4: Level of Social Support among Respondents

Descriptions	Range	Frequency	Percentage
Low level of Social Support	10 - 25	4	1.3
Moderate Social Support	26-37	104	32.4
High level of Social Support	38-50	212	66.3
TOTAL		320	100

Table 4 illustrates that 4 respondents (1.3%) reported receiving low social support (scores 1025), while 104 respondents (32.4%) had moderate support (scores 26-37). 212 respondents (66.3%) had high social support (scores 38-50). These results indicate that most patients experienced high levels of social support during treatment.

The Relationship between the Levels of Social Support and Demographic Characteristics After having determined the levels of social support, the study examined the relationship between the levels of social support and the demographic characteristics of respondents. Chi-square test was used for this purpose. The results are summarized in Table 5.

Table 5: Relationship between Levels of Social Support and demographic characteristics of respondents

Variables	Total	Social Support			Chi-Square test		
		Low-level	Moderate-level	High-level	X^2	df	Sig
Age							
18 - 31	120 (37.5)	46 (14.4)	72 (22.5)	152 (47.5)	3.468	4	0.177
32 - 45	140 (43.8)	16 (5.0)	8 (2.5)	26 (8.1)			
46- 60	60 (18.8)	26 (8.1)	28 (8.8)	8 (2.5)			
Gender							
Male	180 (56.2)	54 (16.9)	74 (23.1)	172(53.8)	3.708	2	0.157
Female	140 (43.8)	8 (2.5)	6 (1.9)	6 (1.9)			

Religious Background						
Christian	240 (75)	28 (8.8)	36 (11.3)	71(23.1)	6.918	2	0.14
Muslim	40 (12.5)	26 (8.1)	40 (12.5)	60 (20.0)			
No Religious Affiliation	40 (12.5)	8 (2.5)	4(1.)	40 (12.5)			
Socio-Economic Status							
High-Income	120 (37.5)	46(14.4)	72 (22.5)	152 (47.5)	3.468	2	0.177
Middle-Income	80 (25)	16 (5.0)	8 (2.5)	26 (8.1)			
Low-Income	120 (37.5)	26 (8.1)	28 (8.8)	8 (2.5)			
Education Level							
University	160 (50)	4 (1.3)	2 (0.6)	14 (4.4)	3.633	6	0.726
College	40 (12.5)	0 (0.0)	0 (0.0)	2 (0.6)			
Secondary	40 (12.5)	0 (0.0)	4 (1.3)	6 (1.8)			
Primary	80 (25)	58 (18.1)	74 (23.1)	156 (48.8)			
Marital Status							
Married	160 (50)	4 (1.3)	2 (0.6)	14 (4.4)	3.633	6	0.726
Single	40 (12.5)	0 (0.0)	0 (0.0)	2 (0.6)			
Divorced	40 (12.5)	0 (0.0)	4 (1.3)	6 (1.8)			
Other	80 (25)	58 (18.1)	74 (23.1)	156 (48.8)			

Table 5 presents the distribution of sociodemographic characteristics (age, gender, religious background, socio-economic status, education level, and marital status) about levels of social support (low-level, moderate-level, and high-level) among respondents. The Chi-Square test results indicate the following: for age, among 120 respondents aged 18-31, 46 (14.4%) had low support, 72 (22.5%) had moderate support, and 152 (47.5%) had high support, with a Chi-Square value of 3.468 and a pvalue of 0.177. Among 140 respondents aged 32-45, 16 (5.0%) had low support, 8 (2.5%) had moderate support, and 26 (8.1%) had high support, contributing to the overall Chi-Square result. For gender, 180 males had 54 (16.9%) at low support, 74 (23.1%) at moderate, and 172 (53.8%) at high support, resulting in a Chi-Square value of 3.708 and a p-value of 0.157. Regarding religious background, 240 Christians showed 28 (8.8%) low, 36 (11.3%) moderate, and 71 (23.1%) high support, with a Chi-Square value of 6.918 and a p-value of 0.14. In terms of socio-economic status, among 120 high-income respondents, there were 46 (14.4%) low, 72 (22.5%) at moderate, and 152 (47.5%) at high support, with a Chi-Square value of 3.468 and a p-value of 0.177. Educational attainment showed that among 160 university-educated individuals, there were 4 (1.3%) at low, 2 (0.6%) at moderate, and 14 (4.4%) at high

support, yielding a Chi-Square value of 3.633 and a p-value of 0.726. Finally, marital status indicated that among 160 married individuals, 4 (1.3%) was low, 2 (0.6%) was moderate, and 14 (4.4%) had high support, with a Chi-Square value of 3.633 and a p-value of 0.726. Overall, all p-values exceeded 0.05, indicating no statistically significant relationship between sociodemographic characteristics and levels of social support.

Relationship between alcohol dependence and social support

Pearson's correlation was used for the relationship between alcohol dependence and social support among alcoholic patients undergoing treatment at Machakos Level 5 Hospital, Machakos County. A scatter plot was used to A scatter plot presented in Figure 1 was used to visually represent the data, illustrating the distribution of patients' alcohol dependence scores against their levels of social support.

Figure 1: Relationship between alcohol dependence and social support among alcoholic patients undergoing treatment at Machakos Level 5 Hospital
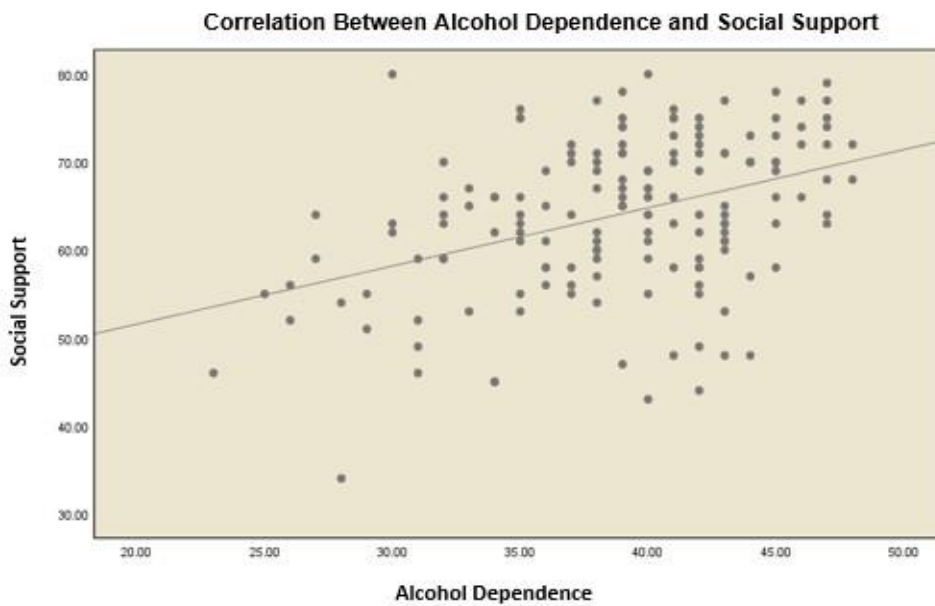
The analysis showed that the data was scattered, indicating a low degree of relationship between alcohol dependence and social support. The scatter plot alone could not establish whether the two variables were positively or negatively correlated, nor could it determine the significance of that relationship. Therefore, Pearson's correlation coefficient was computed to quantify the relationship between alcohol dependence and social support. The statistical data generated by this test are presented in Table 3.

Table 6: Relationship between alcohol dependence and social support among alcoholic patients undergoing treatment at Machakos Level 5 Hospital.

		Alcohol Dependence	Social Support
Alcohol Dependence	Pearson Correlation Sig. (2-tailed)	1	.402** .000
	N	320	320
Social Support	Pearson Correlation Sig. (2-tailed)	.402** 0	1
	N	320	320

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

Table 6 reveals a medium positive relationship between alcohol dependence and social support among alcoholic patients at Machakos Level 5 Hospital (N = 320, r = .402, p = .000). This suggests that higher levels of social support were moderately positively correlated with higher levels of alcohol dependence among the respondents. This finding may appear counterintuitive, as one would typically expect increased social support to correlate with reduced alcohol dependence. However, the statistical significance of the correlation at the 0.01 level indicates that this relationship is unlikely to have occurred by chance. Thus, this result supports the researcher's alternative hypothesis (H1), which posits that a significant relationship exists between alcohol dependence and social support among the studied population.

DISCUSSION

This present study examined the relationship between social support and alcohol dependence among patients at Machakos Level 5 Hospital, Machakos County, Kenya. The findings revealed that 55% of the respondents had high levels of alcohol dependence, 25% had moderate levels, and 19.4% exhibited low alcohol dependence. These results were consistent with previous studies that used the Alcohol Use Disorder Identification Test (AUDIT) to assess alcohol dependence levels in clinical rehabilitation settings. Vignesh et al. (2014) conducted a study in an alcohol addiction center in India and found that 65% of participants had high levels of alcohol dependence, 15% had moderate levels, and 13% exhibited low levels. Similarly, Pengpid et al. (2011) in a South African urban hospital found that 46% of participants had high dependence, 40% had moderate dependence, and 6% had low dependence. The results were however inconsistent with those of Elazia (2021) who conducted a study on the prevalence and social determinants of alcohol use disorders among patients attending primary care clinics in Nairobi. Their cross-sectional survey included 389 respondents and used the AUDIT tool for data collection. The study found that 80.4% of respondents were classified as low-risk users of alcohol (AUDIT score of 7 and below), 13.1% as hazardous/harmful users, 2.8% as high-risk, and 2.6% as alcohol-dependent (score ≥ 20). The comparable trends highlight alcohol dependence as a pervasive public health issue globally. In principle, this means that many patients in Machakos Level 5 Hospital struggle with alcohol dependence, just like patients in other rehabilitation settings around the world. The measures for the level of social support provided to alcoholic patients at Machakos Level 5 Hospital showed 66.3% of respondents reported high levels of social support, 32.4% experienced moderate support, and 1.3% reported low levels of support. These results were consistent with Maeng et al. (2022) conducted a study in South Korea assessing the effect of social support, including family support and friend support, on excessive alcohol use. Participants reported high levels of social support from both family and friends, with average scores of 94.71 (SD = 18.31) for family support and 86.69 (SD = 15.82) for friend support. In principle, most alcoholic patients in Machakos felt they had good support during their treatment irrespective of their sociodemographic backgrounds. On the relationship between alcohol dependence and social support among alcoholic patients at Machakos Level 5 Hospital, the results revealed a moderately significant positive association between alcohol dependence and social support (r = .402**; p < .000), n = 320 at a 0.01 significance level. This positive association suggested that as social support increases, alcohol dependence also tends to increase among the patients. This finding was surprising, as one might typically expect that higher levels of social support would correlate with lower levels of alcohol dependence. This unexpected result suggests that some forms of social support from family, friends, and peers may enable alcoholism, especially when the support network consists of alcoholics or individuals who are not fully committed to sobriety. This can create a situation where social support increases alongside alcohol dependence in the context. In the social support literature, this present finding is consistent with that made by Zywiak, Longabaugh and Wirtz (2002) found alcoholics undergoing rehabilitation in a controlled clinical trial in the United States of America were more likely to relapse if they stayed connected to social networks that encouraged or supported their drinking habits prior to treatment. The unique association may also be linked to the quality of social support received during rehabilitation. Spohra et al. (2019) explain that social support can significantly influence substance use, abstinence, and treatment compliance among substance-using probationers in the United States of America. In the African context, this phenomenon where increasing social support might contribute to increasing alcohol dependence can be attributed to several cultural, social, and economic factors. Research has shown that in many African societies, alcohol consumption is deeply embedded in cultural practices, where it is often used in social, ceremonial, and religious contexts as a means of bonding and celebration (Katembu & Okunya, 2018). As Obot (2000) explains, the normalization of alcohol in social life may be contribute to overconsumption and dependence. In

other communities, alcohol consumption often serves as a rite of passage into adulthood or mark of integration into the community in some African communities (Papas et al., 2010). This practice may lead to the development of habitual drinking among the initiates or peers to conform to group norms, which increases the risk of dependence. Moreover, some African communities have normalized the use of alcohol as coping strategy for stress, grief and economic hardships. Patel et al. (2020) explain that men in low-resource areas in Kenya often turn to drinking with peers facing similar struggles as a form of social support. However, this practice may unintentionally lead to alcohol dependence. In some rural and urban-poor communities, alcohol is both affordable and readily available, making it a frequent gift or means of support. Friends or family may offer alcohol in place of other assistance due to its low cost, potentially resulting in problematic drinking, as shown by Peltzer et al. (2011). Additionally, some communities sustain intergenerational patterns of alcohol use, with elders actively encouraging younger people to join drinking traditions as a way to foster community and family bonds (Morojele et al., 2012). These cultural practices, combined with close social ties, contribute to alcohol dependence across generations. Understanding these factors in the African context highlights the complexity of alcohol dependence in relation to social support. Interventions might need to focus on promoting alternative social activities, increasing awareness about the dangers of alcohol dependence, and fostering supportive networks that encourage healthier coping strategies.

The present study is novel as it is the first to examine the relationship between social support and alcohol dependence among patients in a rehabilitation context at Machakos Level 5 Hospital in Kenya. This research addresses an important gap in the literature, as no prior studies have investigated this relationship within the Kenyan context. The findings reveal a unique association that warrants further investigation, suggesting that increased social support may correlate with higher levels of alcohol dependence among patients in rehabilitation. This raises important questions about the nature and quality of the support provided to individuals undergoing rehabilitation for alcohol dependence. Further research is needed to explore whether specific forms of support that normalize drinking such as pro-drinking friends, peers, and relatives may make it difficult for alcoholic patients to maintain sobriety or adhere to the treatment program. In contrast, supportive sobriety measures, such as encouragement to participate in rehabilitation programs, involvement in recovery groups, and fostering environments that promote abstinence, are likely to have a positive impact on recovery outcomes. These types of support provide the emotional and practical help necessary to sustain sobriety and reinforce healthier behaviors. Understanding how these different types of support influence outcomes is crucial for developing more effective intervention strategies in rehabilitation settings. This dynamic has not been well documented in previous studies from other regions. This discovery calls for a reevaluation of how support systems in rehabilitation are designed. It suggests that not all forms of support are beneficial, and some may even hinder recovery.

CONCLUSIONS

In conclusion, the present study explored the relationship between social support and alcohol dependence among patients at Machakos Level 5 Hospital, revealing a moderately significant positive correlation between the two. This unexpected finding suggests that certain forms of social support may contribute to higher alcohol dependence, particularly when the support comes from social networks that enable or normalize drinking behaviors. These results highlight the complexity of social support in the context of alcohol rehabilitation and suggest that not all support is beneficial. The study's findings are consistent with other research indicating that social networks that promote alcohol use can undermine recovery efforts. Importantly, this study fills a gap in the literature by being the first to examine this relationship in a Kenyan context, raising critical questions about the quality and composition of social support networks in rehabilitation settings. Further investigation is needed to explore how different types of support—particularly those promoting abstinence and recovery—can positively influence treatment outcomes. Understanding these dynamics is vital for designing more effective interventions to support sobriety in rehabilitation environments.

RECOMMENDATIONS

Based on the study's conclusions, several recommendations can be made to enhance the effectiveness of rehabilitation for patients with alcohol dependence. For patients undergoing rehabilitation, it is crucial to

actively engage in support systems that promote sobriety, such as recovery groups, counseling sessions, and environments that foster abstinence. Rehabilitation center staff should carefully assess the quality of social support networks that patients rely on, ensuring they encourage healthy behaviors and discourage enabling behaviors that may normalize drinking. For family members, neighbors, friends, and other social support providers, it is essential to offer support that reinforces sobriety rather than unintentionally promoting alcohol use. They should be educated on how to be a positive influence by encouraging participation in treatment and abstinence-focused activities. Counseling psychology practitioners should focus on helping patients identify and build healthier social connections, providing therapeutic interventions that address the influence of negative support systems on recovery. Finally, future researchers should further investigate the complex relationship between social support and alcohol dependence, particularly exploring how different types and sources of support impact rehabilitation outcomes. Longitudinal studies could provide deeper insights into the role of social support over the entire course of recovery.

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