EFFECTS OF ALCOHOL USE DISORDERS ON THE FAMILY PSYCHO-SOCIAL WELL-BEING IN IMENTI NORTH SUB-COUNTY, MERU COUNTY, KENYA

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A THESIS SUBMITTED TO THE GRADUATE SCHOOL
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF
AMASTER OF ARTS DEGREE IN COUNSELING PSYCHOLOGY

PAN AFRICA CHRISTIAN UNIVERSITY

JUNE, 2026

Declaration

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

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This Thesis has been submitted for examination with my approval as the university supervisor

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Table of Contents

Declaration ..... **ii**
Dedication ..... **vi**
Acknowledgements ..... **vii**
Abstract ..... **viii**
List of Tables ..... **ix**
List of Figures ..... **x**
Abbreviations and Acronyms ..... **xi**
Operational Definition of Terms ..... **xii**
Chapter One: Introduction and Background to the Study **1**
Introduction 1
Background to the study 1
Problem statement 7
Purpose of the study 8
Objectives of the study 8
Research questions 9
Assumptions of the study 9
Justification of the study 10
Significance of the study 11
The scope of the study 12
Delimitations of the study 14
Chapter summary 15
Chapter Two: Literature Review **16**
Introduction 16
Empirical review 18
Emotional well-being of families affected by alcohol use disorder 18
Emotional effects 18
Personal distress 21
Social well-being in families affected by alcohol use disorder 23
Family disruptions 25
Coping mechanisms 27
Coping strategies among families affected by alcohol use disorder 27
Personal interest 28
Frank talk 28

Self-care 29
Avoidance 30
Conflict 31
Mitigating the effects of alcohol use disorders on the psycho-social well-being of families 32
Formal support 32
Informal support 34
Family psycho-education 36
Theoretical framework 38
Conceptual framework 42
Synthesis of the Research Gap 44
Chapter summary 45
Chapter Three: Research Methodology 46
Introduction 46
Research design 46
Target population 47
Sampling technique and sample size 47
Types of data 49
Research instrument 51
Family Member Questionnaire (FMQ) 51
Interview schedule 53
Focus group discussions 54
Validity and reliability of the instrument 55
Validity testing 56
Reliability testing 57
Data analysis 58
Ethical considerations 59
Chapter summary 60
Chapter Four: Results and Discussion 61
Introduction 61
Return rate 61
Instrument pre-testing 62
Reliability test results 62
The effects of alcohol use disorders on the family emotional well-being 66

Descriptive statistics for emotional well-being 75
Alcohol use disorder and family social well-being 79
Statistical analysis of social well-being 84
Coping mechanisms employed by family members in response to challenges associated with alcohol use disorder 90
Strategies to address the effects of AUD on families' psycho-social well-being 96
Descriptive statistics 98
Correlation analysis 99
Regression analysis 101
Chapter Summary 105
Chapter Five: Summary of Findings, Recommendations, Areas for further Research and Conclusion 106
Introduction 106
Discussion of Findings 107
Emotional well-being of family members 107
Social well-being of family members 109
Coping strategies employed by family members 110
Strategies to mitigate the effects of alcohol use disorder on family well-being 112
Conclusions 114
Recommendations 116
Recommendation for further research 118
References 120
Appendix I: Informed Consent Form 138
Appendix II: Family Member Questionnaire (FMG) 140
Appendices III: Interview Guide for Family Members 143
Appendix IV: Interview Guide for Local Chiefs 145
Appendix V: Focus Group Discussion Guide 147
Appendix VI: Research Permit 148
Appendix VII: Research Letter 149
Appendix VIII: ISERC Approval Letter 150

Dedication

I dedicate this thesis to my family and friends for their staunch understanding, support and encouragement during this challenging but fulfilling period of this research work. May the Almighty God complete and fulfill your heart desires.

Acknowledgements

I sincerely thank the Lord Almighty for His grace and favor throughout this challenging yet fulfilling journey. My heartfelt appreciation also goes to my friends for their unwavering support, even during times of disconnect from social circles. I am deeply grateful to Dr. Lucy Gachenia; my supervisor, for her incredible support and guidance. Her calm and thoughtful mentorship has been invaluable, not only in shaping my academic career but also in enriching my personal growth.

I also extend my sincere appreciation to Nkubu High School class of 1994 for their motivation and support, Professor Margaret Mwenje; former Dean of Students at the School of Humanities and Social Sciences, for her instrumental role in my academic endeavors. Additionally, my gratitude goes to Dr. Elizabeth Kamau, former Head of the Psychology Department, and the entire Pan Africa University staff across various departments. Your dedication and exceptional service are truly acknowledged—may God bless you all abundantly. Finally, to my cohort—May the good Lord richly bless you all.

Abstract

Alcohol Use Disorder (AUD) among youths aged 15–24 is a growing public health concern that disrupts not only individuals but also the psycho-social well-being of their families. In Imenti North Sub-County, Meru County, families experience emotional distress, social disruptions, and limited coping resources; however, interventions have primarily targeted the affected youths, often overlooking the family context. This study examined the effects of AUD on family emotional and social well-being and identified the coping strategies employed by family members. Guided by the Stress Strain Coping Support model (Jim Orford) and Family Systems Theory (Murray Bowen), the study adopted a convergent parallel mixed-methods design. Data were collected from 30 family members using a researcher developed Family Member Questionnaire (FMQ), as well as from 15 in-depth interviews and three focus group discussions. The FMQ demonstrated strong reliability (Cronbach's $\alpha > 0.80$). Quantitative data were analyzed using descriptive and inferential statistics, while qualitative data were analyzed thematically. The findings revealed high levels of emotional distress, including anxiety (86.7%), persistent worry (90%), depression (70%), difficulty concentrating (60%), and sleep disturbances (53%). Socially, families reported frequent quarrels (76.6%), financial strain (76.7%), social isolation (70%), and disrupted family events (67%). Coping strategies included prayer (63.3%), open communication, engagement in personal interests, and self-care, which collectively accounted for 65% of coping engagement. In contrast, avoidance and conflict were found to be fewer effective strategies. The study concludes that AUD profoundly undermines family psycho-social well-being and recommends culturally responsive, family centered, and community-based interventions to reduce stigma, strengthen support systems, and improve access to professional care.

List of Tables

Table 1: Response Rates for Quantitative and Qualitative Data Collection Methods.62

Table 2:Reliability Analysis Results for FMQ 65

Table 3: Frequency and Percentage of Responses to Emotional Well-being Items (N = 30) 67

Table 4: Mean and Standard Deviation for Emotional Well-being 75

Table 5: Correlation Analysis 76

Table 6: Linear Regression Analysis for Emotional Wellbeing 78

Table 7: Frequency and Percentage of Responses to Social Well-being Items(N = 30) 79

Table 8: Mean and Standard Deviation for Social Well-being 85

Table 9: Correlation Matrix for Social Well-being.....86

Table 10: Multiple Regression Analysis for Social Well-being 88

Table 11: Frequency and Percentage of Responses to coping Mechanisms (N = 30) .90

Table 12: Correlation Matrix for Coping Mechanisms (FMQ) 92

Table 13: Regression Analysis Predicting Coping Strategy Use among Family Members.....93

Table 14: Support Systems Utilized by Family Members (N = 30) 96

Table 15: Mean Scores and Standard Deviations of Support Systems (N = 30) 98

Table 16: Correlation Matrix of Support Systems 100

Table 17: Multiple Regression Predicting Support Structures 101

List of Figures

Figure 1 Conceptual Framework 42

Abbreviations and Acronyms

AJADA:	African Journal of Alcohol and Drug Abuse
AUD:	Alcohol Use Disorder
CBT:	Cognitive Behavioral Therapy
CDC:	Center for Disease Control
DALY'S:	Disability Adjusted Life Years
GBD:	Global Burden of Disease
NACOSTI:	National Commission for Science Technology and Innovation.
SPSS:	Statistical Package for Social Sciences
UK:	United Kingdom
UNODC:	United Nations Office on Drugs and Crime
UNDP:	United Nations Development Programme
USA:	United States of America
WHO:	World Health Organization

Operational Definition of Terms

Alcohol Use Disorder (AUD): According to the National Institute on Alcohol Abuse and Alcoholism, Alcohol Use Disorder (AUD) is a medical condition marked by an inability to control or stop alcohol consumption, despite its negative social, occupational, or health effects. In this study AUD is the harmful and excessive use of Changaa and Busaa that affects individual and the family.

Busaa: A traditional fermented alcoholic beverage is widely brewed in East Africa and prepared by fermenting grains such as maize, millet, and sorghum (Sunheron, n.d.) In this study Busaa is an intoxicating and addictive beverage commonly found in informal settlements.

Chang'aa: *Chang'aa* is a traditional Kenyan home-brewed distilled spirit made by fermenting grains such as millet, maize, or sorghum and then distilling the product to produce alcoholic beverage (Gitari et al., 2021). In this study Changaa is home brewed distilled spirit commonly found in informal settlements.

Coping mechanisms: According to Campas et al. (2024) it is the mental and behavioral approaches that individuals adopt to manage emotional responses and reduce the impact of stressful situations. In this study, coping mechanisms are the behavioral and cognitive strategies family members of youths with AUD use to manage stress and maintain psychosocial well-being.

Emotional Well-being: The ability to manage emotions, cope with stress, and maintain positive relationships. It includes self-awareness, resilience, and emotional regulation, all contributing to mental health and life satisfaction (Diener et al., 2020). In this study, emotional well-being refers is the emotional experiences and personal distress arising from the effects of Alcohol Use Disorder (AUD).

Families: According to Barnard (2024), families are groups of individuals connected by marriage, adoption, or biological ties. This study adopts the same definition and focuses on immediate family members.

Family member: An individual who shares a genetic connection with the AUD victim or is married to the victim. In this study, family member refers to an immediate relative, such as a father, mother, elder brother, sister, or spouse.

Illicit Brew: Alcoholic drinks made through unregulated and unauthorized processes (Gitari et al., 2021). In this study, 'illicit brew' refers specifically to Chang'aa and Busaa, traditional alcoholic beverages commonly produced and consumed outside legal regulatory frameworks due to their affordability.

Psycho-social Well-being: The interaction of psychological and social factors affecting mental health, relationships, and coping. It includes emotional resilience, social support, and a sense of belonging (World Health Organization, 2021). In this study, psycho-social well-being refers to the emotional, social well-being and the coping mechanisms of families associated with having a youth with Alcohol Use Disorder (AUD).

Social Well-being: Salehi, A., et al. (2017) defines social well-being as the capacity of individuals or families to establish and sustain healthy relationships within a society. In this study, social well-being is the social connections and disruptions associated with having a youth with AUD in the family.

User: In the context of Alcohol Use Disorder (AUD), a user is an individual who experiences impaired control over alcohol intake, often leading to dependence, health complications, and negative social or psychological effects (American Psychiatric Association, 2020). In this study, a user refers to an individual who

engages in harmful and excessive consumption of alcohol which affects the individual and the immediate family

Chapter One: Introduction and Background to the Study

Introduction

The global fabric of life has historically been ravaged by the relentless grip of Alcohol Use Disorder; a condition that has engendered dysfunction within individuals and families alike. It has been observed that, despite the evident harm endured by families, the focus has predominantly shifted towards the user. This study aims to evaluate the effects of Alcohol Use Disorder on the family psycho-social well-being in Imenti North Sub County, Meru County. The introductory chapter provides a comprehensive overview of key aspects of the study, including the background, problem statement, study purpose, objectives, and inquiries. Moreover, it outlines the study's assumptions, justification, significance, scope, as well as its limitations and delimitations. The chapter concludes with a summary.

Background to the study

Alcohol consumption has long been linked to various negative consequences, affecting both the user and their family. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines Alcohol Use Disorder (AUD) as a medical condition characterized by an impaired ability to control or stop alcohol consumption, despite its harmful effects on physical health, social relationships, and work responsibilities. The severity of AUD is categorized into three levels: mild, which includes two to three symptoms; moderate, which consists of four to five symptoms; and severe, which involves six or more symptoms (APA, 2013).

Global surveys further indicate that alcohol use among adolescents remains widespread across many regions (World Health Organization [WHO], 2018). International school-based data show that alcohol consumption is among the most common risk behaviors among adolescents aged 13–17 years (Farnia et al., 2024). Early

initiation of alcohol use has been associated with substance dependence, poor academic outcomes, and engagement in risky behaviors later in life (WHO, 2018). Additionally, adolescents who begin drinking early often demonstrate poor coping mechanisms and increased emotional distress (Farnia et al., 2024). These findings emphasize the importance of early prevention and intervention strategies targeting adolescents globally (WHO, 2018; Farnia et al., 2024).

Furthermore, global burden of disease studies indicate that alcohol use contributes significantly to morbidity and mortality among adolescents and young adults worldwide (World Health Organization [WHO], 2018). Alcohol-related injuries, mental health disorders, and risky behaviors increase vulnerability among young people, particularly in regions with limited prevention and treatment services (WHO, 2024). In many settings, adolescents may use alcohol as a coping mechanism for stress, family conflict, and socio-economic challenges, which increases the likelihood of problematic drinking patterns (Farnia et al., 2024). These factors further elevate the risk of Alcohol Use Disorder and long-term negative outcomes among adolescents and young adults (WHO, 2018). Therefore, strengthening family-based and community-based interventions remains essential in addressing adolescent alcohol use at the global level (WHO, 2024).

Smith et al. (2023) report that around 27% of adolescents globally consume alcohol, with binge drinking notably common in developed regions like North America and Europe. The WHO (2018) also notes rising alcohol-related harm among youth in Asia and Latin America, where regulatory policies are inconsistent. Family structures play a key role in shaping drinking behaviors, with studies showing that parental attitudes and household drinking patterns influence adolescent alcohol use (Lopez et al., 2023).

In Africa, adolescent alcohol consumption is a growing concern, particularly in urban areas where access to alcohol is increasing. A study by Chen et al. (2023) found that over half (54.8%) of undergraduate students in Johannesburg who had ever consumed alcohol were involved in risky drinking behaviors. Uganda, records one of the highest adolescent alcohol consumption levels, exceeding 10 liters of pure alcohol per capita annually (New Vision, 2023). In South Africa, a study by Moyo et al. (2022) indicates that 30% of high school students have engaged in binge drinking at least once in the past month. Many of these youths live in family settings meaning that their AUD may inevitably affect the other family members.

The WHO's Global Status Report on Alcohol and Health (2018) further highlights Africa's increasing trend of hazardous drinking, with Southern and Eastern regions experiencing alarmingly high rates of binge drinking among young individuals. A study by Onoalapo et al. (2022) also reveals that out of the 22 highest-ranking alcohol-consuming nations, 10 are in Africa, emphasizing the continent's urgent need for targeted intervention strategies. Unregulated alcohol sales, weak enforcement of legal drinking age policies, and a lack of public awareness campaigns contribute to the worsening AUD crisis (Moyo et al., 2022).

According to data analysis by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA, 2022), 12.2% of Kenyans aged 15 to 65 consume alcohol regularly, with 10.4% suffering from alcohol use disorders. Alarmingly, individuals begin drinking at an average age of 11 years, with some reports indicating initiation as early as four years old. A study by Papas et al. (2020) highlights that traditional and illicit brew, such as chang'aa and busaa, play a significant role in Kenya's alcohol consumption and the prevalence of Alcohol Use Disorders (AUD). Despite aggressive law enforcement efforts, the study indicated that chang'aa and busaa

remain deeply entrenched in local culture, persisting across generations.

Gitari et al. (2021) investigated the effects of consuming Kaanga, a traditional illicit brew in Meru County, Kenya, in a study published in the European Journal of Environment and Public Health. The study emphasizes the serious health hazards linked to the intake of this locally brewed alcoholic beverage. The National Council for Population and Development (2015) found that substance abuse, including traditional brews, contributes to school dropouts and declining education standards. NACADA (2019) reported that Meru County had the highest seizures of illicit alcohol in Kenya, totaling 143,314 liters, indicating widespread consumption. These issues highlight the urgent need to assess Alcohol Use Disorder's (AUD) and the family's emotional well-being, social stability, and coping mechanisms.

Additionally, Meru County ranks among the regions with the highest prevalence of alcohol consumption in Kenya. According to a 2022 survey by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), 41% of respondents in Imenti North Sub-County admitted to consuming alcohol (NACADA, 2022). Nationally, AUD affects 10% of individuals aged 15–65 years, with the highest prevalence recorded in the Western region at 17%, followed by the Eastern region, including Meru County, at 8.2%. The widespread availability and affordability of illicit brews further fuel this crisis. These statistics reflect a deeply entrenched drinking culture in Meru County, which not only affects individual health but also destabilizes families and weakens community structures.

Alcohol Use Disorder (AUD) affects not only individuals but also their families, disrupting emotional and social well-being (Anderson, 2012). Families function as interconnected systems where relationships create co-dependencies, making them particularly vulnerable to the effects of AUD (McCrady and Flanagan ,2021).

Bonds formed through marriage, blood, or adoption reinforce these connections, as highlighted by Barnard (2024), while Reiter's (2014) meta-analysis further emphasizes the emotional interdependence within families. Families of individuals suffering from AUD often experience psychosocial disruptions, including anxiety, social alienation, and impaired attachment (Kariuki, 2010; Lander et al., 2013). As primary units of attachment, families are deeply affected by a loved one's substance use disorder, experiencing emotional and relational strain (Lander et al., 2013).

Psycho-social well-being refers to the interrelationship between psychological processes and social experiences that shape an individual's mental health, emotional functioning, and overall quality of life. Psycho-social well-being reflects how individuals perceive themselves, regulate emotions, and interact with their social environment in ways that enable them to function effectively and adapt to life challenges. According to Eiroa-Orosa (2020), psycho-social well-being involves the integration of emotional stability, social relationships, and effective coping abilities that allow individuals to maintain positive mental functioning. In addition, the World Health Organization highlights that mental and psycho-social well-being involve the ability of individuals to cope with everyday stressors, maintain productive roles in society, and contribute meaningfully to their communities (WHO, 2022). Similarly, the United Nations Development Programme notes that psycho-social well-being plays an important role in strengthening resilience and social functioning, particularly among individuals and families exposed to stressful circumstances such as substance abuse and family conflict (UNDP, 2023).

Psycho-social well-being is commonly understood through several interrelated dimensions, including emotional well-being, social well-being, and coping mechanisms. Emotional well-being relates to an individual's ability to regulate

emotions, manage stress, and maintain a sense of psychological balance in the face of life difficulties. Individuals with strong emotional well-being are better able to respond to challenges constructively and maintain optimism during stressful experiences. Recent studies by Ryff and Keyes, (2023) further emphasizes that emotional well-being contributes significantly to psychological adjustment and helps individuals maintain mental stability in challenging social environments. In the present study, emotional well-being is examined through constructs related to emotional reactions and personal distress among family members living with individuals affected by Alcohol Use Disorder.

Another important component of psycho-social well-being is social well-being, which refers to the quality of an individual's relationships, sense of belonging, and level of participation within social networks and community structures. According to Keyes (2020), social well-being reflects the extent to which individuals feel connected to others, supported by their social environment, and able to contribute to society. Families affected by Alcohol Use Disorder frequently experience disruptions in these social relationships. Social stigma, family conflict, and withdrawal from community interactions may weaken support networks and reduce opportunities for social engagement (Kelley et al., 2017; Orford et al., 2013; Park & Schepp, 2015). Recent evidence also shows that families dealing with substance misuse often experience reduced social support and increased isolation, which can negatively affect their psychological resilience and overall functioning (Copello & Orford, 2022; Templeton et al., 2021). In this study, social well-being was examined through constructs related to family relationships, social connections, and disruptions in social interaction caused by youth alcohol use disorder.

Coping mechanisms represent another key dimension of psycho-social well-

being because they determine how individuals respond to stress and emotionally challenging situations. Coping strategies are generally categorized as problem-focused coping, which aims to address the source of stress, and emotion-focused coping, which helps individuals regulate emotional responses to stress (Aldao et al., 2010; Park, 2017). In families affected by Alcohol Use Disorder, coping strategies often emerge as family members attempt to deal with the stress and instability associated with alcohol misuse. Studies indicate that relatives of individuals with substance use disorders frequently adopt coping responses such as tolerance, emotional distancing, or attempts to confront and change the behavior of the affected individual (Templeton et al., 2021).

However, certain coping patterns, including avoidance and emotional disengagement, may become maladaptive and contribute to increased psychological distress among family members (Peirce et al., 2000). In this study, coping mechanisms are explored through behaviors such as engaging in personal interests, open communication, self-care practices, and avoidance strategies used by family members to manage emotional and social challenges associated with youth Alcohol Use Disorder. Despite this clear indication of the effects of AUD extant studies have mainly focused on the individual a gap that this study sought to address by focusing on the psycho-social well-being of the families

Problem statement

Alcohol Use Disorder (AUD) among youths aged 15–24 significantly affects family members, leading to emotional distress, family disruptions, and social disruptions. Parents and siblings often experience emotional effects such as anxiety, depression, and social isolation due to the instability caused by AUD-related behaviors such as aggression, withdrawal, and neglect of responsibilities (Smith et al., 2023, Jones & Taylor, 2020).

While some studies have documented the emotional and psychological strain experienced by close relatives of individuals with Alcohol Use Disorder, most are cross-sectional and limited in scope. For example, studies in Kenya reported significant psychological distress, stigma, and financial burden among family members (Githae, 2019; Kabira, 2019; Ndetei et al., 2016). Similarly, international research indicates that families experience anxiety, depression, and social isolation due to alcohol misuse, yet many studies remain limited and cross-sectional in nature (Copello et al., 2006; Orford et al., 2013).

Consequently, there remains a lack of comprehensive investigations that explore how parents, siblings, and spouses are affected over time (Githae, 2016). This study aimed to address this gap by examining the effects of AUD on the family's psycho-social well-being in Imenti North Sub-County, Meru County. By providing context-specific insights, the study aims to highlight the need for family-centered interventions that support both youth recovery and the overall well-being of affected family members in Imenti North Subcounty, Meru County.

Purpose of the study

The purpose of the study was to establish the effects of alcohol use disorder on the family psycho-social well-being in Imenti North Sub- County, Meru County.

Objectives of the study

The following objectives guided this study:

i. To examine the effects of alcohol use disorders on the family emotional well-being in Imenti North Sub County, Meru County.
ii. To establish the effects of alcohol use disorders on the family social well-being in,Imenti North Sub County, Meru County.
iii. To investigate the coping mechanisms employed by family members to address

the challenges posed by alcohol use disorder in Imenti North Sub County, Meru County

iv. To assess strategies that can be put in place to mitigate the effects of alcohol use disorders on the psycho-social well-being of families in Imenti North Sub County, Meru County.

Research questions

i. What are the effects of alcohol use disorder on the family emotional well-being inImenti North Sub County, Meru County?

ii. What are the effects of alcohol use disorder on family social well-being in ImentiNorth Sub County, Meru County?

iii. What are the coping mechanisms employed by the family members to address the challenges paused by alcohol use disorder in Imenti North Sub County, Meru County?

iv. What strategies can be put in place to mitigate the effects of alcohol use disorder on family psycho-social well-being in Imenti North Sub County, Meru County?

Assumptions of the study

The study made the following assumptions**:**

i. Alcohol Use Disorder (AUD) negatively affects the emotional well-being of families in Imenti North Sub County, Meru County.

ii. AUD negatively affects the social well-being of families in Imenti North Sub County, Meru County.

iii. AUD undermines the coping mechanisms of families in Imenti North Sub County, Meru County.

iv. Respondents will provide honest and authentic information in interviews and

questionnaires regarding the effects of alcohol use disorder on their families' psycho-social well-being.

Justification of the study

The study on Alcohol Use Disorder (AUD) and its influence on families' psycho-social well-being is crucial, given the profound toll AUD takes not only on the individual but also on the family unit as a whole. McGovern et al. (2021) highlights that treatment for AUD has predominantly focused on the individual, often overlooking the significant negative consequences experienced by family members. As Rushton et al. (2023) points out, an estimated 80–100 million people globally suffer adverse effects due to living with individuals struggling with AUD. This statistic illustrates the far-reaching implications of the disorder, affecting families emotionally, socially, and coping mechanisms. Understanding these effects is essential for developing holistic interventions that support both individuals with AUD and their families.

Moreover, research underscores that limiting interventions to the affected individual undermines both treatment effectiveness and the essential role families play as support systems. Christian et al. (2012) emphasize that family members, particularly parents, are crucial to the recovery process. Neglecting their well-being can hinder treatment outcomes and increase the likelihood of relapse. Similarly, Lander et al. (2013) argue that AUD disrupts emotional, social, and functional dynamics within families. These disruptions can lead to strained relationships, financial instability, and mental health issues among family members.

Reiter (2014) further reinforces the need for a family-centered approach, asserting that families function as interconnected emotional units where distress in one member inevitably affects the entire system. This perspective highlights the importance of integrating family-oriented strategies in AUD interventions. Without addressing the

needs of family members, the negative ripple effects of AUD may persist even after an individual's treatment. A holistic approach ensures that families receive the necessary psychological and social support. This can improve recovery outcomes and strengthen familial relationships.

In Meru County, these challenges have prompted organizations such as NACADA to take action. NACADA has provided financial assistance for rehabilitation and accredited treatment centers to support families affected by AUD (Mutethia, 2021). Such efforts indicate the urgent need for comprehensive support mechanisms that go beyond individual treatment. Family -centered programs can help alleviate the burden on loved ones and improve overall well-being. Understanding the specific challenges faced by families in different regions can further inform effective interventions.

A key undertaking of the study was to examine these family-level effects, as neglecting them could undermine treatment outcomes and perpetuate relational and mental health challenges. Recent literature highlights that families play a central role in the recovery process, with family involvement improving treatment engagement, relapse prevention, and emotional stability among individuals with substance use disorders (Copello et al., 2021; Velleman & Templeton, 2016). Alcohol Use Disorder (AUD) continues to disrupt emotional and functional dynamics within families, leading to strained communication, role confusion, and increased psychological distress among family members (Orford et al., 2022). These disruptions often affect family functioning and reduce the effectiveness of treatment when family dynamics are not addressed.

Significance of the study

This study is important because it shifts attention from the individual struggling with Alcohol Use Disorder (AUD) to the wider family unit, where the emotional, social, and coping burdens are most felt. Focusing on youths in Imenti North

Sub-County, Meru County, it shows how consumption of illicit brews such as chang'aa and busaa destabilizes families by straining relationships, diminishing emotional well-being, and shaping coping strategies. The study contributes to theoretical understanding by demonstrating how one member's disorder influences the entire household, reflecting the interconnected nature of family systems. In practice, it offers guidance for counselors, psychologists, and social workers in developing family-based interventions that build resilience and strengthen bonds. At the same time, it provides evidence for policymakers, community leaders, and organizations such as NACADA to design more effective prevention and rehabilitation programs that recognize families as central to recovery and community stability.

The scope of the study

This study focused on Imenti North Sub-County, Meru County, specifically within Municipality Ward. The selected areas—Mjini, Majengo, and Shauri Yako—are characterized by their urban setting and documented high prevalence of Alcohol Use Disorder (AUD). Reports from the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA, 2022) and the Meru County Alcoholic Drinks Control Board (2021) identify these neighborhoods as alcohol abuse areas, citing contributing factors such as population density, youth unemployment, and easy access to alcoholic beverages. Additionally, local health facilities and social services in these areas frequently report cases of alcohol-related family disruption and psycho-social distress. Given these challenges, the study was confined to this geographical scope and did not extend beyond Imenti North Sub County. By concentrating on these specific locations, this study aimed to provide a localized understanding of how AUD affects families' psycho-social well-being.

The study targeted family members, including parents and elder siblings of

youths aged 15–24 struggling with AUD, a high-risk group identified in the 2022 NACADA Report. It explored the emotional, social, and coping challenges these families face in urban settings with high AUD prevalence. Only immediate family members that is parents' elder children and spouse were included due to daily encounters and close attachment. By focusing on this specific population and location, the study aimed to generate context-specific insights applicable to similar urban environments. It was hoped that the findings could inform targeted interventions, policy recommendations, and further research on mitigating AUD's psycho-social effects on families.

Limitations of the Study

This study faced several limitations that may have influenced the findings. Alcohol Use Disorder (AUD) is a sensitive issue often associated with stigma and shame, which may have led some respondents to provide incomplete or socially desirable responses. To mitigate this, confidentiality and participant anonymity were emphasized, and professional counseling support was available to address any emotional distress during interviews. Language barriers also posed a challenge, as some respondents had difficulty understanding English questionnaires. This was addressed by conducting face-to-face interviews in Kimeru or Kiswahili, supported research assistants fluent in local languages, to enhance clarity of responses The study relied on self-reported data, which may be subject to recall bias. To minimize these structured questions were used to guide respondents and promote more accurate reporting. In addition, time and resource constraints further limited the scope of data collection and analysis. These challenges were mitigated through flexible scheduling, repeated follow-ups, rapport-building with participants, and inclusion of buffer periods to accommodate rescheduled interviews. Despite these limitations, the measures put in place helped to

maintain data integrity and enhance the reliability of the study findings.

Delimitations of the study

This study was delimited to examining the effects of Alcohol Use Disorder (AUD) on family psycho-social well-being, with a specific focus on emotional and social well-being as well as coping mechanisms. By concentrating on these aspects, the study aimed to explore the effects of alcohol use disorders on the family psycho-social well-being in Imenti North Sub-County, Meru County. By narrowing the scope to AUD, the study aimed to provide targeted insights that could guide interventions and policies addressing alcohol-related family challenges.

The study was further confined to alcohol use with an emphasis on local brews prevalent in Imenti North Sub County, Meru County in particular Busaa and Changaa. Locally brewed alcohol plays a significant role in the community's drinking culture and presents unique challenges in terms of regulation and accessibility. The study did not consider commercially produced alcoholic beverages or external influences such as cross-border alcohol trade, which may have different consumption patterns and regulatory frameworks. This focus allowed for a more in-depth understanding of how locally brewed alcohol affects the psycho-social well-being of families. By concentrating on this specific type of alcohol, the study sought to capture the realities of communities in Imenti North more accurately, providing context-specific findings.

The study only included nuclear families, comprising biological parents, adult siblings, spouses, including single parents of youths aged 15–24 years who were struggling with AUD. This specific age range had been identified as a high-risk group for alcohol use, making it essential to examine its effect on their immediate family members. Other family structures—such as extended families, foster families, or guardians were not included, as their care giving dynamics may differ from those of

biological parents.

Geographically, the study was delimited to Municipality Ward within Imenti North Sub County and in particular Mjini, Majengo, and Shauri Yako informal settlements meaning other areas in and outside these areas were not be included in the investigation. This boundary ensured a localized, context-specific analysis, allowing for a deeper understanding of AUD's effects within a defined socio-economic environment. The decision to focus on Municipality Ward was based on its urban characteristics, where alcohol abuse is reported to be highly prevalent, particularly in the major slums of Mjini, Majengo and Shauri Yako. However, this also means the findings may not be generalizable to other regions with different demographic or cultural compositions.

In terms of methodology, the study adopted a convergent parallel approach, integrating quantitative surveys for statistical analysis and qualitative interviews for deeper insights. This combination allowed for a comprehensive exploration of both measurable trends and personal experiences of families affected by AUD. However, it did not include experimental or longitudinal study designs, limiting its ability to establish causal relationships over time. The study was also conducted within a fixed time frame, meaning the long-term effects of AUD on families were not assessed.

Chapter summary

The chapter has presented the background of the study, the problem statement, the study's purpose, research objectives, and research questions. Additionally, it has highlighted the justification, assumptions, significance, limitations, and delimitation of the study. The next chapter focuses on a review of existing literature related to the effects of substance use disorders on families' psycho-social well-being, and presents also the theoretical and conceptual framework.

Chapter Two: Literature Review

Introduction

This chapter reviews relevant literature on alcohol use disorder and its effect on families' psycho-social well-being. The first section presents empirical literature, thematically organized according to the study's specific objectives. The second section outlines the theoretical framework that underpinned the research. The final section introduces and discusses the conceptual framework that guided the study.

The chapter concludes with a summary. Alcohol Use Disorder (AUD) is a medical condition characterized by impaired control over alcohol use despite negative physical, social, or occupational consequences. The American Psychiatric Association defines AUD as a spectrum ranging from mild to severe, with symptoms including prolonged drinking, unsuccessful attempts to reduce intake, and neglect of responsibilities due to alcohol use (APA, 2013). Individuals with severe AUD often prioritize alcohol consumption over personal, social, and occupational obligations, leading to significant functional impairment.

Globally, AUD remains a major public health concern, particularly among adolescents and young adults. Glantz et al. (2020) found that most lifetime cases of AUD develop before age 18 and are frequently associated with mental health disorders. Similarly, Haque and Friedmann (2024) reported that over 29.5 million people are affected by AUD in the United States, with young adult males being the most affected group. In sub-Saharan Africa, Belete et al. (2024) reported that 23.3% of adolescents had consumed alcohol, while 7.7% met criteria for AUD. Additionally, university students in countries such as South Africa and Nigeria are particularly vulnerable due to peer pressure, academic stress, and family influence (Mthembu et al., 2023).

In Kenya, alcohol use among youth is increasingly becoming a public health concern. The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA, 2022) reported that 21% of youths aged 15–24 years had consumed alcohol, with factors such as peer pressure, academic stress, and alcohol advertising contributing to this trend (Mwangi & Ndungu, 2019). The problem is more pronounced in Meru County, where the availability of illicit brews such as chang'aa and busaa increases accessibility among youths. NACADA (2022) reported that 5.2% of youths aged 15–24 years in Meru County actively consume alcohol, exposing them to health risks including alcohol poisoning, liver damage, and risky behaviors.

Illicit brews are alcoholic beverages produced outside regulatory frameworks using unsafe or unregulated methods (NACADA, 2019). The 10th Bi-annual NACADA report indicated that Meru County recorded the highest seizures of illicit alcohol, totaling 143,314 liters (NACADA, 2021). Common brews in the region include busaa and chang'aa, which are associated with health complications and social problems such as violence, accidents, and risky sexual behavior (Kiptoo et al., 2020; NACADA, 2022). Informal settlements such as Majengo, Shauri Yako, and Mjini have been identified as high-risk areas for illicit alcohol consumption due to socioeconomic vulnerabilities and limited regulation (Standard Media, 2024; The Star, 2022).

AUD affects not only individuals but also their families. Families function as interconnected systems where challenges affecting one member influence the well-being of others (Dunst, 2023). Psycho-social well-being refers to emotional, psychological, and social functioning within individuals and families (Eiroa, 2020; Kumar, 2020). Families of youths with AUD often experience anxiety, depression, stress, and reduced coping capacity (Mardani et al., 2023; Olafsdottir, 2018). The World Health Organization (WHO, 2019) estimates that approximately 400 million people

live with AUD globally, highlighting its widespread impact on family functioning and stability.

Despite growing research on AUD, studies focusing on family psycho-social well-being remain limited. McGovern et al. (2021) noted that most research focuses on individuals rather than family systems. Similarly, Johnson et al. (2022) emphasized the need to explore family coping mechanisms and emotional well-being. This study therefore examined the effects of alcohol use disorder on family psycho-social well-being in Imenti North Sub-County, Meru County, focusing on emotional, social, and coping dimensions among families affected by youth AUD.

Empirical review

Emotional well-being of families affected by alcohol use disorder

The emotional well-being of families living with a member diagnosed with Alcohol Use Disorder (AUD) is a critical area of concern in psycho-social research. Families often bear the psychological consequences of AUD, including emotional strain, persistent worry, anxiety, and disruptions to everyday functioning. Emotional well-being in this context was examined through two core constructs: emotional effects, which encompass depression, anxiety, hopelessness, and feelings of being overwhelmed; and personal distress, which involved worry, irritability, intrusive thoughts, sleep disturbances, bodily weakness, and concentration difficulties. Prior studies have shown that caregivers of individuals with alcohol dependence frequently experience high levels of depression, anxiety, and stress, which fluctuate with the patient's drinking outcomes (Rajpurohit et al, 2023).

Emotional effects

Globally, Gilmartin (2011) conducted a longitudinal study of 254 spouses of individuals with chronic AUD in Ireland. Using semi-structured interviews and

standardized stress inventories, the study found that 72% of respondents exhibited symptoms of depression, with many also reporting anxiety and feelings of hopelessness. Orford et al. (2010) found that family members living with a relative who has an alcohol problem often report emotional exhaustion, persistent sadness, and feelings of being overwhelmed, highlighting the heavy psychological strain associated with alcohol use disorder in families. The present study addressed this limitation by employing validated family member questionnaires in a structured rural Kenyan context.

Regionally, Alcohol Use Disorder (AUD) has been shown to exert profound psychosocial strain on families, often manifesting as persistent stress, anxiety, strained relationships, and disrupted family functioning. In Nigeria, a study among households with adolescents engaged in harmful drinking found that parents experienced shame, emotional exhaustion, and strained relationships with extended family members due to stigma associated with youth alcohol problems (Abayomi et al., 2015). Similarly, in Uganda, caregivers of young people misusing alcohol reported emotional distress arising from repeated conflicts, police encounters, and disrupted schooling, which negatively affected family stability and social functioning (Kyakunzire et al., 2022). These findings highlight that youth AUD not only affects the individual but also disrupts family cohesion, communication, and emotional well-being.

Locally, Muchiri (2021) explored the impact of alcohol abuse on family functioning in Nyeri County using mixed methods and a sample of 166 respondents. The study reported increased levels of depression, anxiety, and breakdown in family relationships among affected households. Similarly, Birech (2003) studied 124 households in the Nandi community and documented persistent emotional weariness, depressive moods, and reduced family interaction among affected families. In Ongata

Rongai, Gitatui et al. (2019) used qualitative interviews and reported feelings of hopelessness, emotional instability, and social withdrawal among family members. These studies demonstrate that AUD contributes significantly to psycho-social distress within families, affecting both emotional well-being and social relationships.

However, despite these findings, several gaps remain in relation to the psycho-social well-being of families affected by AUD. First, most of the regional and local studies focus broadly on alcohol abuse and harmful drinking without specifically examining Alcohol Use Disorder among youths aged 15–24 years, yet this age group presents unique psycho-social challenges for families. Second, the reviewed studies largely emphasize emotional distress while giving limited attention to broader psycho-social dimensions such as family communication patterns, social stigma, coping mechanisms, and role disruptions within households. Third, many of the studies were conducted in different socio-cultural settings such as Nyeri, Nandi, and Ongata Rongai, whose cultural dynamics differ from Meru County, thereby limiting contextual applicability of findings.

Additionally, most of the previous studies used either quantitative or qualitative approaches independently, limiting comprehensive understanding of both measurable psycho-social effects and lived family experiences. Furthermore, limited research has specifically examined how families cope with the psycho-social burden of youth AUD, particularly in rural and semi-urban settings such as Meru County. Therefore, the present study sought to address these gaps by examining the psycho-social effects of Alcohol Use Disorder on families of youths aged 15–24 years in Meru County, with particular focus on emotional well-being, social relationships, and coping mechanisms using a mixed-methods approach. This generated context-specific evidence to inform counselling interventions and family support strategies.

Githae (2019) conducted a descriptive cross-sectional study in Kiambu County with 138 relatives of individuals diagnosed with AUD. Using self-administered questionnaires, the study revealed that 63% of respondents experienced depressive symptoms and feelings of helplessness. These emotional responses underscore the relevance of emotional effects in the African context. According to Githae (2019), a majority of family members with loved ones receiving inpatient treatment for alcohol use disorder in Kiambu County experienced considerable psycho-social strain, reflected in elevated stress, anxiety, and depressive symptoms, together with reduced general health outcomes

Personal distress

Globally, McDonell et al. (2020) explored the burden of substance use disorders on family members through a meta-analysis of 34 studies across Europe and North America. The analysis found high rates of intrusive thoughts, sleep disturbances, and psychosomatic symptoms like bodily weakness. The findings validate the inclusion of personal distress in assessing the effects of AUD on families' psycho-social well-being. Orford et al. (2017), in a 20-year qualitative synthesis, highlighted recurring patterns of irritability, chronic worry, and loss of concentration among affected relatives. These dimensions of personal distress are integral to understanding the hidden toll of AUD on families.

In the African context, youth Alcohol Use Disorder (AUD) often causes profound personal distress among family members, particularly parents and primary caregivers. Studies in South Africa reveal that parents of adolescents with substance use disorders frequently experience overwhelming fear, helplessness, anger, and sadness, as well as difficulties in trusting their children due to repeated relapses and broken promises (Hlungwani et al., 2020; Mathibela & Masombuka, 2025). South

African studies indicate that living with a youth misusing alcohol can strain parent–child relationships, disrupt communication, and create an environment of chronic tension in the household (Leighton et al., 2022; Rotheram-Borus et al., 2023). Parents often experience guilt, shame, and stigma from the community, leading to social withdrawal and reduced help-seeking behavior. Qualitative evidence further reveals that siblings of youth with AUD may experience secondary trauma, sadness, and resentment, particularly when parental attention becomes disproportionately focused on the troubled youth's needs (Mathibela & Masombuka, 2025).

In Uganda, study highlights that children and adolescents who abuse alcohol often expose their families to public embarrassment, legal issues, and community-level stigma, thereby intensifying caregivers' feelings of isolation and emotional burden (Tumwesigye et al., 2024). Across African contexts, personal distress related to youth AUD is not only shaped by the direct emotional impact of substance misuse but also by broader socio-cultural factors, including communal reputation, family honor, and the limited availability of youth-specific treatment services.

In Kenya Muchiri (2021) found that spouses of alcohol users in Nyeri reported difficulty sleeping, frequent irritability, and mental fatigue. These findings, derived from qualitative and quantitative instruments, support the personal distress construct. The study supports the concept that internalized psychological suffering is a major consequence of AUD in families. In Kiambu County, Githae (2019) documented significant personal distress among relatives of individuals with AUD, including physical symptoms such as weakness, sleep disruption, and concentration difficulties. Locally, a study by Nthuli (2024) at Machakos Level 5 Hospital that sampled 320 individuals reported that family members of persons with AUD suffered from intrusive

thoughts, irritability, and chronic insomnia. The study used standardized psychological scales, which lends credence to the reliability of its findings.

Synthesizing these studies reveals that families of individuals with AUD experience profound emotional disturbances, ranging from overt emotional reactions to internalized psychological suffering. While emotional effects are more visible and often expressed inter-personally, personal distress tends to be internalized and less detectable. Prior studies often merged these dimensions or failed to systematically measure them, a gap this research aimed to bridge by employing family member questionnaire (FMQ) in the rural context of Imenti North Sub-County.

Social well-being in families affected by alcohol use disorder

Social well-being refers to the quality of individuals' relationships and the extent of their engagement with community and family networks (Keyes, 1998; WHO, 2022). In families impacted by Alcohol Use Disorder (AUD), social well-being is often disrupted due to stigma, isolation, and deteriorating interpersonal dynamics. Guided by constructs from the Family Member Questionnaire (FMQ), this section analyzes two central aspects of social well-being: social connections, which include social isolation, withdrawal from communal life, and reluctance to host social events; and family disruptions, which encompass financial strain, interpersonal conflict, neglect of household duties, and social embarrassment.

Social connections

Globally, youth Alcohol Use Disorder (AUD) has been shown to disrupt family cohesion and diminish social connections, as parents and caregivers often withdraw from community activities to avoid stigma and judgment (Haugland et al., 2020). A

study by Serec et al. (2012) asserts that in Europe and North America reveal that parents of adolescents with problematic drinking reduce engagement in extended family events and social gatherings, leading to decreased access to informal support networks. This study also indicates that siblings of youths with AUD may experience peer rejection and secondary stigma, which can limit their own social participation (Orford et al., 2013). Qualitative evidence suggests that managing the behavioral and emotional consequences of a youth's alcohol misuse often shifts family roles, reducing available time for community involvement (Haugland et al., 2020). Collectively, these patterns highlight that youth alcohol misuse erodes both the internal relational fabric of the family and their broader social integration across diverse global settings (Orford et al., 2013).

Regionally, studies in Uganda have documented the social consequences experienced by families living with individuals with alcohol use disorder. For instance, Joshua Ssebunnya and colleagues conducted a community-based study in rural Uganda and found that alcohol misuse often resulted in strained family relationships, reduced social participation, and community stigma toward affected households (Ssebunnya et al., 2020). Families reported social isolation and diminished involvement in communal activities due to the disruptive behaviors associated with alcohol misuse, and many became socially withdrawn and excluded from community decision-making processes. This highlights how AUD erodes communal ties in African settings and supports the social connections construct. Ndirangu (2021) found that negative community reactions to alcoholism—including social sanctions and stigma—reduced alcohol-affected persons' participation in community activities and led to social exclusion, limiting families' willingness to attend or host social events. These findings directly reflect diminished social connections, validating this construct in the local context.

Family disruptions

Globally, Orford et al. (2010) conducted an extensive study across the UK and Australia using the Stress-Strain-Coping-Support (SSCS) model. With a sample of 354 family members, their findings showed that alcohol dependence caused chronic conflict, breakdown in family roles, financial instability, and increased domestic violence. This aligns with the construct of family disruptions and provided a theoretical foundation for the current study.

In a U.S.-based survey, Ray et al. (2017) used a longitudinal approach involving 210 families, demonstrating that parental alcohol misuse disrupted daily routines, led to loss of employment, and caused intergenerational conflict. These disruptions were long-lasting and altered family structures, supporting the need to examine not just psychological effects but social and economic ones as well. Velleman and Templeton (2016) conducted a narrative literature review covering over 40 international studies on family impact of AUD. Findings consistently documented emotional withdrawal, chronic worry, and psychosomatic distress among family members. While broad, this global synthesis validates the dual constructs of emotional effects and personal distress relevant to the Kenyan context.

Regionally a mixed-method study by Thomas et al. (2017) found that marital, inter-generational, and sibling relationships significantly influence overall family well-being, underscoring the importance of healthy family dynamics. External stressors such as Alcohol Use Disorder (AUD), compromises family stability (Thomas et al., 2017). The above study focused on alcohol Use Disorder, anxiety and depression as enhancers of family's instability. The current study explored effects of AUD on the family emotional well-being.

Recent evidence highlights the substantial psycho-social impact of substance use on families and young people. A systematic review by Ebrahim, Adams, and Demant (2024) examined substance use across *sub-Saharan Africa*, synthesizing data from 60 studies involving over 83,000 young people aged 10–24. The study found significant prevalence of alcohol, khat, stimulants, and tobacco use, and identified family-related risk factors such as parental substance use, strained parent-child relationships, and low parental monitoring, which contributed to emotional strain and social disruption within households. These findings emphasize the relevance of family and social contexts in understanding substance use dynamics in the region.

Similarly, in the United States, population-level data indicate that nearly 19 million children lived in households with at least one parent diagnosed with a substance use disorder in 2023, with increased risks of mental health challenges, emotional distress, and behavioral problems among affected children (McCabe, Schepis, & McCabe, 2025). Collectively, these studies highlight the pervasive emotional and psychological burden experienced by family members and underscore the importance of addressing personal distress and familial functioning in interventions for substance-affected households.

Locally, Wanjiru (2018) studied 176 families in Meru County using both interviews and observational checklists. Her findings revealed that alcohol-related conflicts often occurred during family gatherings, leading to emotional outbursts, ruined celebrations, and threats of physical harm. Families also reported neglect of basic roles such as child supervision and household management. These patterns confirm the centrality of family disruptions in Kenyan households affected by AUD. Additionally, a 2022 study by Omondi and Kimani involving 140 households in Tharaka Nithi used PSUDS and FMQ tools to explore family experiences. The findings

indicated increased family quarrels, economic hardship, neglect of personal and family appearance, and frequent disruptions to cultural and religious events. This study closely mirrors the constructs used in the present research and offers a strong comparative base.

Coping mechanisms

Coping mechanisms are cognitive and behavioral strategies individuals use to manage stressors and challenges, aiming to minimize distress and maintain emotional balance. These mechanisms can be categorized as adaptive, such as seeking social support or engaging in positive reappraisal, or maladaptive, such as substance use or emotional avoidance (Aldao et al., 2010; Fauerbach et al., 2020). Families' coping mechanisms refer to the collective strategies and behaviors that family members employ to manage stressors, challenges, and crises, aiming to maintain family functioning and cohesion (Dunkley et al., 2020). These mechanisms can include communication strategies, seeking of external support, or adopting problem-solving approaches, which help reduce family-wide emotional distress and maintain well-being (Davidson et al., 2019). Families may also use maladaptive coping strategies, such as avoidance or denial, which can disrupt family dynamics and hinder the resolution of issues (Seligman et al., 2021).

Coping strategies among families affected by alcohol use disorder

Families affected by Alcohol Use Disorder (AUD) often adopt a range of coping strategies to manage the psychological, social, and relational disruptions that result from prolonged exposure to problematic drinking behavior. Guided by constructs aligned FMQ instruments, this section critically reviews empirical studies centered on five key coping mechanisms: personal interest, frank talk, self-care, avoidance, and conflict.

Personal interest

Engagement in personal interests is a form of adaptive coping that allows family members to regain emotional balance by investing in hobbies, social circles, or spiritual growth. Globally, Orford et al. (2010) conducted a cross-national study in the UK involving 1,045 affected family members using the SSCS and self-report interviews. They found that family members frequently turned to religious participation, educational pursuits, and recreational activities to reclaim personal identity and mental space. While informative, the study did not disaggregate data by family role (e.g., spouse vs. child), a limitation the current study addresses by stratifying respondents. In South Africa, Mokwena and Huma (2014) surveyed 213 spouses of individuals with AUD using structured questionnaires and focus groups. The findings revealed that participation in church groups, women's associations, and farming cooperatives helped family members cope with emotional strain. However, the study focused mainly on urban townships, missing rural family dynamics.

Locally, in Shauri Yako, Embu County, Muriithi (2018) explored how unrecorded alcohol use affects households, revealing links to family disputes, financial challenges, environmental harm, and health problems, based on data collected through both surveys and interviews; these findings are particularly relevant to Imenti North Sub County, where subsistence farming is common, supporting the consideration of engaging in personal or productive activities as a coping strategy for families affected by alcohol-related challenges.

Frank talk

Open communication—termed here as "frank talk"—is a constructive coping mechanism through which family members express their frustrations, set boundaries, and seek solutions together. Globally, Copello et al. (2005) evaluated 500 families

across Europe using semi-structured interviews and the SSCS model. Their findings demonstrated that families who engaged in honest discussions reported reduced psychological tension and fewer domestic conflicts. However, cultural differences in communication norms were not fully considered, an area the present study explores in a Kenyan rural context.

Regionally, Chikere and Mayowa (2018) conducted a qualitative study in Nigeria with 94 respondents from families of alcohol-dependent persons. Findings showed that "family meetings" were central to encouraging dialogue, which led to improved mutual understanding. Despite its contribution, the study did not explore the emotional toll on those initiating frank discussions. Locally, Wanjiru et al. (2020) studied 122 households in Nyandarua using ethnographic methods. They reported that candid conversations, especially when led by matriarchs or religious leaders, helped de-escalate conflicts.

Self-care

Self-care refers to behaviors individuals adopt to maintain or restore physical, emotional, and psychological health amid stress. Globally, McDonell et al. (2017) explored the self-care practices of 740 family members in the U.S. using longitudinal data. respondents practiced meditation, took mental health days, or engaged in physical activities. These were correlated with lower anxiety and depression scores. Although comprehensive, the study lacked cultural contextualization for non-Western families.

In Zimbabwe, Mashingaidze and Tafirenyika (2016) conducted a cross-sectional study among 156 caregivers of individuals with substance use disorders. The findings revealed that maintaining regular meal schedules, prayer routines, and sleep hygiene were effective in mitigating distress. In Kenya, women often engage in self-care practices that include the use of herbal remedies and participation in community

health programs, which provide education and support for maintaining physical and mental well-being. These strategies not only help manage stress but also promote overall resilience and empowerment within their households and communities (Path, 2025).

Avoidance

Avoidance is a maladaptive coping strategy in which individuals withdraw emotionally, socially, or physically to escape distressing realities. Lavee and Benjamin (2015) studied 612 families in Israel through psychological inventories and found that emotional and physical withdrawal led to long-term relational detachment. Though the short-term relief was evident, over time, avoidance exacerbated family disconnection. The current study expands on this by evaluating avoidance as a coping mechanism in relation to the effects of AUD on the family's psycho-social well-being.

Families of individuals with Alcohol Use Disorder (AUD) sometimes cope by avoiding or withdrawing from the affected family member to reduce immediate conflict. However, research indicates that avoidance-based coping strategies among family members of individuals with substance use disorders can exacerbate psychological distress, increasing stress, emotional strain, and negatively affecting overall quality of life (Naguib, El Sheikh, & Alqadi, 2025). In contrast, families who combine support with appropriate engagement—such as participating in treatment discussions or seeking social support—tend to experience better psychological outcomes and stronger family cohesion (Cucciare et al., 2024), although this evidence is limited to nuclear families. While direct national surveys on families avoiding adolescents with AUD are limited, existing research in Kenya provides evidence that caregivers sometimes adopt avoidance as a coping strategy. For instance, Jepkoech (2022) found that some parents of adolescents undergoing rehabilitation at Mathari

National Teaching and Referral Hospital, Nairobi, emotionally withdrew or minimized interaction with their affected children to cope with stress. Similarly, Gitau (2022) highlighted that families of individuals with AUD in Kiambu County experienced anxiety, fear, and distress, which sometimes resulted in avoidance behaviors; however, the study did not examine the long-term psychological impact of these avoidance strategies or include diverse family structures beyond the sampled communities, leaving a gap in understanding the broader implications of such coping mechanisms.

Conflict

Conflict as a coping strategy reflects the escalation of verbal or physical altercations as a form of releasing tension or confronting alcohol-related behaviors. Globally, Orford et al. (2010) found that families living with a relative who misuses substances often face intense conflicts, including aggression, disputes over resources, and ongoing emotional stress. The lack of structured support exacerbates these challenges, leaving family members feeling isolated and struggling to maintain household stability. While rich in qualitative depth, the study did not distinguish between instigators and reactors of conflict.

In Kenya, studies that specifically examine family conflict as a coping mechanism for households affected by Alcohol Use Disorder (AUD) is limited. However, Githae (2019) investigated the psycho-social burden experienced by close family members of individuals undergoing inpatient treatment for AUD in Kiambu County. The study revealed that family members often endure significant emotional strain, including anxiety, depression, and stress. Additionally, participants reported frequent interpersonal disputes and role conflicts within the household, suggesting that conflict may function, implicitly, as a way of coping with the pressures and challenges associated with living with a family member who has AUD. These findings informed

the current study's broader scope by showing how conflict becomes an embedded family dynamic when other coping mechanisms fail.

The literature reveals a spectrum of coping strategies adopted by families dealing with the psychological and relational consequences of AUD. Personal interest and self-care serve adaptive functions, while avoidance and conflict often exacerbate dysfunction. Frank talk emerges as a crucial tool in navigating the challenges constructively. Most prior studies either lacked cultural specificity or failed to account for rural family systems, a gap the current study sought to addresses in Imenti North Sub-County by using stratified data collection through. FMQ to capture nuanced coping patterns.

Mitigating the effects of alcohol use disorders on the psycho-social well-being of families

Families affected by Alcohol Use Disorder (AUD) often turn to a range of mitigating strategies to manage psycho-social disruptions caused by a loved one's drinking behavior. These interventions fall broadly into two categories: formal support, which includes professional services such as counseling, psycho-education, and health or social care interventions; and informal support, which entails the emotional and practical support extended by family members, friends, and the wider community. This section presents a critical review of global, regional, and local studies addressing these mitigation strategies, highlighting their methodologies, populations studied, findings, and how they relate to the current study in Imenti North Sub-County, Meru County.

Formal support

Globally, Templeton et al. (2009) conducted a qualitative study in the United Kingdom involving 30 family members of individuals with substance use disorders. The study used semi-structured interviews to explore experiences with support services.

Findings revealed that systemic family therapy and structured counseling significantly alleviated family stress. However, a noted limitation was the urban-centered sampling, which may not represent rural experiences such as those in Imenti North. This gap reinforces the need for context-specific research into how formal interventions function in rural Kenyan settings.

In a Canadian context, Jackson et al. (2017) employed a cross-sectional survey with 102 caregivers of persons with AUD. The study focused on the availability and utilization of mental health services and found that access to psychotherapy and addiction counselors correlated with lower levels of depression and anxiety among caregivers. However, the high-resource health infrastructure in Canada presents a limitation for its applicability in low-income regions like Meru County, where health services may be under-resourced or inaccessible. Copello et al. (2010) carried out a multi-country randomized controlled trial across Europe using the 5-Step Method among 270 family members. This structured psycho-educational intervention was found to significantly improve coping and reduce psychological strain. While robust in methodology, the study did not examine variations in service uptake between high- and low-resource contexts. The study, focused on Meru County, therefore filling this gap by exploring how such structured interventions might be adapted to local contexts with limited resources.

Across Africa, evidence underscores the importance of psycho-education in supporting families affected by alcohol dependency. In South Africa, Shadung (2024) found that integrating psycho-educational sessions with family therapy and support groups in residential and inpatient programs improved participants' understanding of addiction, strengthened coping strategies, and enhanced family relationships. In Uganda, the United Nations High Commissioner for Refugees (2018) highlighted that

structured educational support for families, particularly those affected by HIV, reduced stigma and improved treatment adherence. In Botswana, Mupara (2021) reported that psychoeducation was a key component of alcohol and substance use prevention programs, increasing awareness and mitigating alcohol-related risks. However, the studies noted limited outreach to rural families, restricting the applicability of findings to settings such as Imenti North Sub County.

In Kenya, research has demonstrated that psycho-education is effective in supporting families affected by alcohol dependency. Giusto et al. (2025) conducted a study in Eldoret on a peer-delivered psycho-social intervention for fathers with depression and alcohol use challenges, showing that structured psycho-educational sessions improved understanding of alcohol-related problems while enhancing family functioning and child well-being. Key aspects such as involving family members and addressing stigma contributed to creating a supportive environment for recovery. Similarly, Gitau et al. (2022) studied the psychological impact of alcohol use disorder on families in Ndumberi Town, Kiambu County, finding that anxiety significantly affected family dynamics. Together, these studies underscore the importance of psycho-educational interventions in helping families cope with alcohol-related challenges, reducing psychological stress, and promoting healthier family functioning in Kenyan communities.

Informal support

On a global scale, Orford et al. (2010) developed the Stress-Strain-Coping-Support (SSCS) Model through a multi-country qualitative study involving 379 respondents. The study emphasized that informal support from peers, relatives, and community groups significantly alleviated strain in families. However, the study acknowledged that cultural and socio-economic differences influenced the

effectiveness of support. The study aimed to localize these insights by examining how such support mechanisms operate in the socio-cultural context of Imenti North Sub-County, Meru County.

In the United States, Tracy and Wallace (2016) conducted a longitudinal study involving 200 caregivers of persons with substance abuse issues. Findings showed that informal peer and family support contributed to reduced caregiver burnout and better coping outcomes. However, the effectiveness of such support was found to be inconsistent and dependent on the quality of interpersonal relationships. This limitation highlights the importance of assessing not just the availability but also the reliability of informal support, a key objective of the present study.

Regionally informal support systems, including kinship networks and religious communities, are crucial in assisting families affected by youth alcohol use in Africa. Muswerakuenda (2023) found that church-based support significantly aids youths recovering from substance abuse, although stigma and discrimination can limit access to these resources. Similarly, Onya et al. (2012) reported that community factors, such as adult antisocial behavior and crime, influence adolescents' use of home-brewed alcohol in rural South Africa. These studies highlight the complementary role of informal and formal support systems in addressing alcohol use among youths. However, reliance on informal networks alone can lead to resource depletion and emotional fatigue, underscoring the need to integrate formal services for sustainable family support

Mwenda (2017), in an ethnographic study of 40 families in Meru County, found that informal community groups such as churches and burial societies played a significant role in reducing social stigma and facilitating collective coping. The study, however, lacked a structured analysis of psycho-social well-being. The present study

expands on Mwenda's work by focusing specifically on emotional and social well-being outcomes among families. Lastly, Kithinji and Muriuki (2020) conducted a case study in Igembe Central involving 10 families. The study revealed that informal support fostered emotional resilience but also highlighted that caregivers sometimes experienced burnout in the absence of structured support. This supports the argument that while informal support is valuable, it must be complemented by formal services—a key issue the present study sought to address.

Family psycho-education

Psycho-education has emerged as an effective strategy for mitigating Alcohol Use Disorder (AUD), particularly among young adults aged 15 to 24, by equipping individuals and their families with essential knowledge about addiction, coping mechanisms, and treatment options. This approach fosters a supportive environment for recovery, enhances family resilience, and reduces relapse rates. Esteban et al. (2023) conducted a systematic review of 18 studies examining family-based interventions, including psycho-education, and found that educating families significantly improved communication, problem-solving, and treatment adherence. These studies, conducted across various locations with diverse sample sizes, highlighted the broad applicability of psycho-educational programs. Similarly, a meta-analysis by Geijer-Simpson et al. (2023) on family-involved interventions for adolescents aged 12–17 with AUD and mental health issues concluded that psycho education reduced alcohol consumption and improved family resilience.

A mixed-methodology study guided by the Kirkpatrick Model, conducted by Shanmugam (2020) on the effect of psycho education for families of substance users, revealed positive changes in family members' reactions and behaviors after participating in psycho-education programs. The study, conducted in Malaysia,

determined that raising awareness among users' significant others fosters hope and promotes realistic beliefs and rational approaches to the challenges of substance use disorder. Findings demonstrated that psycho-education programs equip families with strategies to navigate the complexities of living with a loved one affected by AUD. This awareness not only improves familial relationships but also reduces stigma and fosters a more supportive recovery environment. These results align with broader research demonstrating the long-term benefits of psycho-education in addressing addiction-related challenges within families.

Existing studies indicate that psycho educational interventions can improve the psycho-social well-being of families affected by alcohol use disorder. For example, Shanmugam (2020) in Malaysia applied a mixed-methods design and found that structured education enhanced family understanding and coping skills. Similarly, Rushton et al. (2023) conducted a systematic review of 19 studies, showing that psycho-education contributed to better psychological functioning among caregivers. In Uganda, Ertl et al. (2021) evaluated a mobile inpatient treatment approach that incorporated psycho-educational sessions and observed improvements in family support and overall well-being. These findings suggest that integrating psycho-education into treatment programs can play a key role in supporting families of individuals with AUD.

Although there is currently no Kenyan study explicitly evaluating a structured psycho-education program for families of youth with alcohol use disorders (AUD), related interventions are instructive. The Tuko Pamoja family therapy program—delivered by lay counselors—includes psycho-educational modules on communication and conflict resolution and has demonstrated reductions in family violence, harsh discipline, and alcohol-related problems among caregivers and children (Anderson et

al., 2022; Ateka & Puffer, 2020). A life skills education plus psycho-education program for institutionalized adolescents in Kenya significantly decreased emotional and behavioral problem scores for up to nine months (Mutiso et al., 2017). Meanwhile, Blue Cross Kenya's Youth United Against Alcohol initiative delivers life skills, counseling, and family/community engagement for youth aged 14–24, functioning effectively as a psycho-educational prevention model (Blue Cross Kenya, 2023; Odhiambo & Magwaro, 2023). Collectively, these findings suggest psycho-educational interventions involving youth and families are feasible and impact-ful in Kenya, yet a formal program targeting families of youths with AUD remains absent. This current study in Imenti North Sub County, Meru County, aimed to contribute valuable knowledge on psycho-education effect in this region.

Theoretical framework

This study was guided by two complementary theoretical perspectives: the Stress-Strain-Coping-Support (SSCS) Model and Family Systems Theory. These theories provided a conceptual foundation for understanding how Alcohol Use Disorder (AUD) affected the psycho-social well-being of families, particularly in terms of emotional distress, social functioning, and coping mechanisms.

Stress-Strain-Coping-Support (SSCS) Model

The Stress-Strain-Coping-Support (SSCS) Model, developed by Orford et al. (2010), explains how family members of individuals with alcohol use disorders experience psychological and social strain due to ongoing exposure to alcohol-related behaviors. The model identifies substance misuse by a close relative as a chronic stressor that can lead to emotional exhaustion, depression, anxiety, family conflict, and social isolation. Recent literature continues to support this perspective, indicating that families exposed to persistent alcohol misuse often experience cumulative stress,

emotional strain, and deteriorating family functioning (Copello et al., 2021; Orford et al., 2022). To manage this strain, family members adopt coping strategies such as avoidance, confrontation, enabling behaviors, or seeking external support. Social support systems, including community groups, religious institutions, and counseling services, play a critical role in buffering the negative effects of these stresses (Copello et al., 2021; Velleman & Templeton, 2016). By framing coping in this way, the model highlights that family members are not "sick" or "codependent," but normal individuals managing persistent challenges (Orford et al., 2010; Copello et al., 2021).

While developed in Western contexts, the SSCS Model remains relevant in Kenya, where extended family and community networks often provide emotional and practical support. Recent studies in sub-Saharan Africa indicate that families frequently rely on communal support, faith-based interventions, and informal networks to cope with substance-related stress (Ebrahim et al., 2024; Ssebunnya et al., 2020). However, cultural coping practices, such as consulting elders or traditional healers, may not be fully captured by the model (Singh et al., 2018). Additionally, the linear depiction of stress leading to support may oversimplify the repeated and complex struggles families face with alcohol problems (Orford et al., 2013). In this study, the model served as a theoretical lens to examine emotional well-being, social functioning, and coping behaviors of family members affected by AUD in Imenti North Sub-County. It also informed the development of the Family Member Questionnaire (FMQ), particularly items measuring emotional effects, social disruptions, and coping mechanisms.

Family Systems Theory

The Family Systems Theory, proposed by Bowen (1978), views the family as an interconnected emotional unit, where changes or dysfunction in one member affect the entire system. The theory emphasizes that when one family member develops a

persistent problem—such as alcohol dependence—the rest of the family system is disrupted as roles, responsibilities, and emotional dynamics shift to maintain balance. These adjustments often lead to negative consequences such as conflict, role reversal, communication breakdown, and emotional withdrawal.

In this study, the Family Systems Theory was used to understand how AUD affected the structure and functioning of the family unit, rather than focusing solely on the individual with the disorder. It helped to interpret the relational and systemic consequences of alcohol use, such as increased conflict, breakdown in communication, and emotional disconnection among family members. This theory was particularly relevant in guiding the analysis of coping mechanisms and the need for family-centered interventions, including therapy and support group participation, which were explored as moderating variables.

By integrating the SSCS Model and Family Systems Theory, the study adopted a comprehensive approach to understanding both the individual and relational dynamics associated with AUD in families. The SSCS Model explains how substance misuse by a relative creates psychological and emotional strain for family members, prompting various coping strategies and highlighting the buffering role of social support systems. On the other hand, the Family Systems Theory views the family as an interconnected emotional unit, where the presence of AUD in one member disrupts relational roles, responsibilities, and emotional balance across the entire family. Together, these theories offered a multi-dimensional framework for examining how families experience, respond to, and are affected by alcohol-related challenges.

Strengths and weaknesses of the theories

These theories have their strengths and weaknesses as described below

Stress–Strain–Coping–Support (SSCS) model

The SSCS Model is useful because it explains that family members living with someone who has alcohol problems are not "sick" or "codependent," but normal people dealing with constant stress. It shows how family members use different coping methods and how support from friends, community, or churches can help reduce the emotional and social strain (Copello et al., 2010; Orford et al., 2010). This makes the model very relevant in Kenya, where many families rely on extended relatives and community groups for support. However, the model was developed in Western countries and may not fully explain cultural ways of coping, such as turning to elders or traditional healers (Singh et al., 2018). It also presents coping as a straight line from stress to support, which can oversimplify the complex and repeating struggles families face with alcohol problems (Orford et al., 2013).

Family Systems Theory (FST)

The Family Systems Theory looks at the family as a whole unit, showing that when one person has alcohol problems, the entire family is affected. It helps explain changes in roles, conflicts, and communication problems within families (Bowen, 1978). Research also shows that when families are included in treatment, recovery outcomes are often better than when treatment focuses only on the individual (Neger & Prinz, 2015). This makes the theory especially important in cultures like Kenya, where families are closely connected. However, the theory has some weaknesses. Some of its ideas are very broad and hard to measure in real research according to Carr (2019) research on family therapy and systemic interventions. It can also be difficult to apply if not all family members want to take part in therapy, which is common in alcohol-affected families because of stigma or broken relationships (Lander et al., 2013).

This study adopts the Stress-Strain-Coping-Support (SSCS) Model and the Family Systems Theory (FST) because they explain how the independent variable,

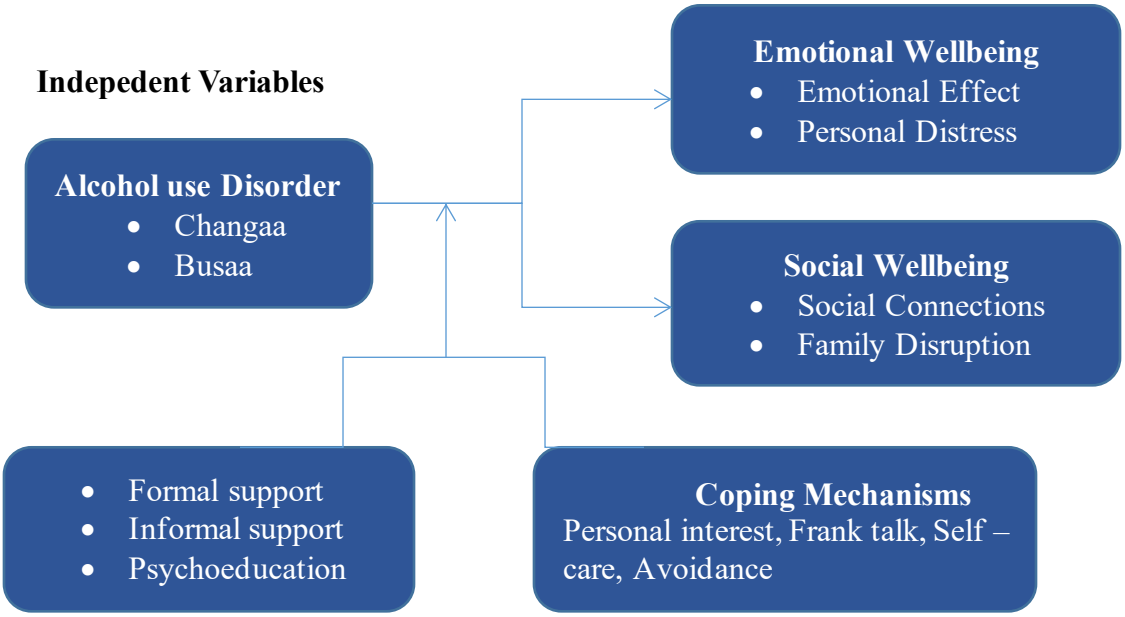
Alcohol Use Disorder (AUD), influences family psycho-social well-being. The SSCS Model views AUD as a primary stressor that produces strain in family members, resulting in emotional distress such as depression, anxiety, and hopelessness, thus aligning with the variable of emotional well-being (Orford et al., 2010). It also emphasizes coping strategies—ranging from avoidance to frank talk and help-seeking—as mediators of adjustment, while highlighting the protective role of social support in maintaining social well-being (Orford et al., 2013). Similarly, FST conceptualizes AUD as a systemic disruption that destabilizes family roles, boundaries, and communication, leading to social isolation, conflicts, and financial strain, which relate to social well-being (Bowen, 1978; Goldenberg & Goldenberg, 2013). FST further explains how families adopt both adaptive and maladaptive coping patterns in response to the AUD-affected member, reinforcing the focus on coping mechanisms (Kelley et al., 2009). Together, these theories demonstrated how AUD undermines emotional and social functioning while shaping coping responses within family systems.

Conceptual framework

The conceptual framework guiding this study is based on the Psycho-social Model of health, which posits that mental, emotional, and social well-being are interdependent and are influenced by both individual and contextual factors. In this study, Alcohol Use Disorder (AUD) acts as the independent variable, while the family members psycho-social well-being represents the dependent variable. The relationship is moderated by coping strategies and mitigating factors. In this study the conceptual framework is visually represented in Figure 1.

Figure 1: *Conceptual Framework*

Depedent Variables



The conceptual framework shows Alcohol Use Disorder (AUD) was the independent variable, exerting strain on the psycho-social functioning of family members. The dependent variable, psycho-social well-being, was examined through two key dimensions: emotional well-being and social well-being. Emotional well-being comprises two constructs—emotional effects (including depression, anxiety, hopelessness, and feeling overwhelmed) and personal distress (including worrying, irritability, intrusive thoughts, bodily weakness, poor concentration, and sleep disturbances). Social well-being, on the other hand, is analyzed through social connections (such as social isolation and withdrawal from friends or gatherings) and family disruptions (such as financial hardship, conflict, threats, neglect of appearance, and interference with social life).

To explain variations in psycho-social outcomes among families affected by AUD, the framework incorporates coping strategies as moderating variables. These strategies include; personal interests (e.g., engaging in prayer, hobbies), frank talk (open discussions of the issue), self-care (emotional expression, exercise), avoidance

(ignoring or distancing from the problem), and conflict (verbal or physical confrontations). The way family members cope with the stress caused by AUD can either buffer or exacerbate its emotional and social impacts. These strategies are shaped by both individual agency and the availability of external resources.

Lastly, the framework integrates mitigating factors, which further moderate the effect of AUD. These include formal support systems (e.g., counseling, psycho-education, health and social care services) and informal support systems (e.g., assistance from friends, extended family, or religious groups). Such support systems can enhance resilience by offering emotional relief, practical help, or professional intervention. By situating the study within this conceptual framework, the research provides a comprehensive understanding of how AUD affects families in Imenti North Sub-County and identifies the factors that can lessen or intensify its psycho-social effects.

Synthesis of the Research Gap

While extensive studies have examined the prevalence and health impacts of Alcohol Use Disorder (AUD), most have focused on the individual rather than the family system. Global and regional studies highlight rising alcohol consumption among youths and its associated risks, yet little is known about the psycho-social toll on parents, siblings, and spouses. In Kenya, and particularly in Meru County, existing studies emphasize prevalence rates, illicit brews, and regulatory challenges but rarely address the emotional distress, social disruptions, and coping struggles experienced by affected families. This gap in knowledge overlooks the reality that families function as interconnected units where one member's AUD inevitably destabilizes others. Therefore, there is a pressing need for context-specific study on the psycho-social consequences of youth AUD on families to inform family-centered interventions.

Chapter summary

This chapter commenced with a discussion of the conceptual literature, followed by a review of empirical literature, structured in alignment with the study's four objectives. Next, the theoretical framework underpinning the study was presented, providing a foundation for understanding the research. Finally, the conceptual framework, which serves as a guide for the study, was introduced and explained. The chapter that follows details the research design and methodology employed in the study.

Chapter Three: Research Methodology

Introduction

This chapter outlines the study methodology employed in this study, which examines the effects of alcohol use disorder on the family's psycho-social well-being. It encompasses the research design, target population, sampling procedure, and sample size. Furthermore, it provides an overview of the research instruments, data analysis techniques, and the validity and reliability of the instruments, along with a discussion of the pilot study. Finally, ethical considerations are addressed, and the chapter concludes with a summary.

Research design

According to Siedlecki (2020), research design refers to the comprehensive framework outlining how a study is conducted, encompassing the strategies, methods, and procedures utilized to achieve the research objectives. Similarly, Aggarwal and Anganathan (2019) emphasize that study design provides a structured approach that facilitates an objective evaluation by ensuring the systematic collection and analysis of critical data pertinent to the study.

To investigate the effects of alcohol use disorder on the family's psycho-social well-being the study employed a convergent parallel mixed-method research design, which integrates both qualitative and quantitative methodologies to enhance the depth and breadth of analysis (Smajic et al., 2022). Mixed-methods research has been widely recognized for its ability to compensate for the limitations inherent in single-method approaches, thereby, yielding more robust and comprehensive findings (Creswell & Creswell, 2022). Sahin and Ozturk (2019) assert that mixed-methods study involves the systematic combination of qualitative and quantitative data to offer a holistic understanding of the research problem.

Quantitative research design is particularly useful for establishing relationships between independent and dependent variables, as it employs statistical tools to ensure objectivity and generalizability (Bryman, 2021). Conversely, qualitative research design incorporates verbatim reports from respondents, allowing for an in-depth exploration of lived experiences and contextual factors (Asenabi, 2019).

Target population

The target population in research refers to the entire group of individuals, organizations, or entities that a study aims to investigate and draw conclusions about (Babbie, 2020). For this study, the target population comprised immediate family members of youths aged 15–24 years living with Alcohol Use Disorders (AUDs), as they constitute the primary support system for the affected youths. This group was of particular interest because family influence, support systems, and coping mechanisms play a crucial role in shaping the experiences and treatment outcomes of young people struggling with AUDs. Understanding the perspectives, challenges, and strategies employed by these family members provides valuable insight into family dynamics, the effectiveness of interventions, and policy recommendations aimed at addressing the psycho-social effects of AUDs. Among the 30 participants in the study, 18 (60%) were female and 12 (40%) were male, reflecting a slight over representation of females to capture a comprehensive understanding of the emotional, social, and coping experiences within families affected by AUDs.

Sampling technique and sample size

The number of immediate family members of youths aged 15–24 years with Alcohol Use Disorder (AUD) in the informal settlements of Municipality Ward—Majengo, Mjini, and Shauri Yako—remains unknown due to limited existing data. To

address this gap, the researcher conducted an exploratory study prior to the main data collection process. Exploratory research is appropriate where information is inadequate, as it helps refine sampling strategies and improve the relevance of selected participants (Stebbins, 2001). This preliminary step enabled a better understanding of the target population and informed the overall sampling approach. It also ensured that the study remained contextually grounded and focused on the intended respondents.

Purposive sampling was employed to identify individuals with direct experience of the phenomenon under study. This technique is suitable for exploratory and mixed-methods research because it ensures that participants possess rich and meaningful insights (Etikan et al., 2016). Chiefs and assistant chiefs played a key role in identifying eligible respondents due to their familiarity with community dynamics. To enhance accurate identification, the researcher conducted psycho-education sessions to equip them with knowledge on recognizing symptoms of AUD. Their involvement improved access to the target population and strengthened the recruitment process. Consequently, the selected participants were relevant to the study objectives.

To cater for potential dropouts, 45 participants were initially selected for the study. However, due to reasons such as withdrawal and unavailability, only 40 questionnaires were issued to respondents. Out of these, 30 were properly completed and deemed suitable for analysis. For the quantitative strand, this final sample size of 30 family members was considered adequate. The participants were equally distributed across the three settlements, with 10 respondents from each area. This distribution ensured balanced representation within the study setting.

According to the CLT, as the number of observations increases, the distribution of sample means approaches normality regardless of the population's original distribution. Statistical literature widely recognizes that a minimum of 30 respondents

is sufficient for this approximation to hold, thereby, supporting the use of parametric statistical procedures even when data are not perfectly normal (Ghasemi & Zahediasl, 2012, Hogg, et al., 2019). On this basis, the choice of 30 respondents was considered adequate to ensure both the reliability and validity of the study's findings.

The qualitative strand of the study comprised in-depth interviews and Focus Group Discussions (FGDs), designed to capture rich, contextually grounded insights into the psycho-social effects of Alcohol Use Disorder (AUD) on affected families. In-depth interviews were conducted using purposive sampling to select 15 respondents. These included nine immediate family members of youths aged 15–24 years with AUD, drawn from the pool of 30 participants who had taken part in the quantitative survey (three from each settlement: Majengo, Mjini, and Shauri Yako), and six local administrators, including a chief and an assistant chief from each settlement. The interviews followed an unstructured schedule aligned with the study's conceptual framework, focusing on emotional well-being, personal distress, and social well-being.

To complement these interviews, three FGDs were conducted with 15 family members, also purposively selected from 30 respondents who had completed the Family Member Questionnaire (FMQ). This ensured that the qualitative and quantitative strands were methodologically linked, with FGDs providing deeper explanatory insights into patterns identified in the quantitative data. The FGDs were organized to encourage cultural appropriateness and openness in dialogue, thereby enriching the understanding of family coping strategies and shared experiences.

Types of data

Research data refers to systematically collected information used to support or refute a hypothesis or answer research questions (Hassan, 2024). It is broadly categorized into primary and secondary data, where primary data consists of firsthand,

unpublished information gathered directly from respondents, while secondary data refers to information previously collected and processed by another entity (Taherdoost, 2021). Primary data was preferred in this study as it ensured the collection of high-quality, context-specific information directly from the target population. Gathering firsthand data from respondents enhances the accuracy and relevance of findings. This study focused on primary data collection to explore the psycho-social effects of AUDs on the family psycho-social well-being in Imenti North Sub County, Meru County.

This study collected primary data from immediate family members of youths aged 15–24 years struggling with Alcohol Use Disorder (AUD) in Imenti North Sub County, Meru County. Gathering firsthand data from these respondents was essential to understanding their lived experiences and the psycho-social effect of AUDs on families. Primary data collection methods vary and may include questionnaires, surveys, experiments, and interviews (Kabir, 2016). Since self-reported experiences and perspectives were crucial to this study, questionnaires and interviews were the most appropriate data collection tools. Utilizing primary data ensured that insights are specific, timely, and directly applicable to the research objectives.

To obtain quantitative data, this study utilized the Family Member Questionnaire (FMQ), administered to 30 immediate family members of youths aged 15–24 years with Alcohol Use Disorder (AUD). For the qualitative component, the study employed in-depth interviews and focus group discussions (FGDs) to capture rich, context-specific insights. In-depth interviews involved 15 respondents: nine family members (three from each settlement) and six local government administrators specifically a chief and an assistant chief. The administrators participated exclusively in interviews, providing institutional and community-level perspectives. FGDs included 15 family members who had earlier completed the Family Member

Questionnaire (FMQ). These respondents were purposively selected from the pool of 30 FMQ respondents and organized into three groups: five male family members, five female family members, and five elderly caregivers. This categorization ensured cultural appropriateness and provided safe spaces for open discussion.

By integrating structured quantitative reviews with detailed qualitative narratives, the mixed-methods approach provided a comprehensive understanding of family distress, coping mechanisms, and potential interventions in communities affected by youth AUD (Creswell & Plano Clark, 2018).

Research instrument

Family Member Questionnaire (FMQ)

The Family Member Questionnaire (FMQ) was specifically developed by the researcher for this study to examine the psychosocial effects of Alcohol Use Disorder (AUD) on immediate family members of affected youths aged 15–24 years living in the informal settlements of Majengo, Mjini, and Shauri Yako. Designed as a semi-structured tool, the FMQ integrated both quantitative and qualitative elements, enabling a comprehensive exploration of the diverse experiences of respondents. Its structure closely aligned with the study's conceptual framework, which positioned AUD as the independent variable and psycho-social well-being as the dependent variable, with coping strategies and mitigating factors acting as moderating variables (Kawachi & Berkman, 2001; Umberson & Montez, 2010).

The emotional well-being section of the FMQ was structured around two core constructs: emotional effects and personal distress. Emotional effects were assessed through items related to depression, anxiety, hopelessness, and feelings of being overwhelmed (Bottorff et al., 2014; Dawson et al., 2005), while personal distress focused on worrying, irritability, intrusive thoughts, bodily weakness, concentration

difficulties, and sleep disturbances. These items were supported by literature indicating a strong correlation between familial conflict and adverse mental health outcomes among families of individuals with AUD (Laslett et al., 2010; Orford et al., 2010). The social well-being section explored two constructs—social connections and family disruptions. Social connections assessed social isolation, reduced interpersonal engagement, and withdrawal from gatherings (Benishek et al., 2011), whereas family disruptions were examined through indicators such as financial strain, quarrels, neglect of physical appearance, and disruption of family events (Laslett et al., 2010; Room et al., 2019).

Coping strategies were measured through items reflecting how family members managed the strain of living with an AUD-affected relative. These included personal interests, frank talk, self-care, avoidance/disengagement, and conflict. Mitigating factors, also serving as moderators, were categorized into formal and informal support systems. Formal support included access to counseling, psychoeducation, and professional services, while informal support encompassed help from extended family, friends, or religious communities. These dimensions were critical in capturing how protective factors influence family resilience and emotional recovery from AUD-related stress (Velleman & Templeton, 2005).

The FMQ utilized a Likert-scale format for most items (ranging from “Strongly Disagree” to “Strongly Agree”) to facilitate quantitative analysis, while open-ended questions were included to elicit narrative insights. This mixed-format approach enabled both statistical comparison and contextual richness, particularly valuable in studies of sensitive issues like addiction (McDonagh, 2015). Grounded in Family Systems Theory and the Stress-Strain-Coping-Support (SSCS) Model by Orford et al.

(2010), the FMQ captured the interconnected experiences of stress, coping, and support within the family unit.

Interview schedule

In-depth interviews were employed to obtain rich, detailed narratives on the psycho-social effects of Alcohol Use Disorder (AUD) from both family and institutional perspectives. A total of fifteen respondents were purposively selected, comprising nine immediate family members of youths aged 15–24 years with AUD; three from each of the target settlements of Majengo (S1), Mjini (S2), and Shauri Yako (S3) drawn from the pool of 30 respondents and an additional of six local government administrators, specifically the chief and assistant chief from each settlement. Family respondents were included based on three criteria: (a) being an immediate relative of a youth with AUD, (b) residing in the settlement for at least one year, and (c) willingness to engage in candid, in-depth discussions. The administrators were selected for their active roles in addressing alcohol-related issues at the community level and their intimate knowledge of affected households, making them valuable key informants. All sessions were conducted in neutral, private settings to ensure confidentiality, audio-recorded with informed consent, and later transcribed for thematic analysis. This approach allowed for an in-depth exploration of both personal lived experiences and broader community-level insights.

The interviews followed an unstructured guide, allowing respondents to speak freely about their experiences, emotions, and coping strategies. Topics included the emotional effects of AUD (such as depression, anxiety, and hopelessness), personal distress (including sleep disturbance, worrying, and poor concentration), and the social impacts (such as social isolation, withdrawal from community life, and family disruptions like conflict or financial strain). The interviews were conducted in neutral,

private settings, convenient and comfortable for respondents, and all sessions were audio-recorded with informed consent. The recordings were then transcribed and subjected to thematic analysis, facilitating the identification of key themes aligned with the study's conceptual dimensions

Focus group discussions

Focus Group Discussions (FGDs) were conducted to elicit collective perspectives and shared experiences on the psycho-social effects of Alcohol Use Disorder (AUD) within affected families and their communities. Three FGDs were organized, each comprising five respondents purposively selected from the pool of 30 family members who had completed the Family Member Questionnaire (FMQ), yielding a total of 15 respondents. Group composition was structured to enhance cultural appropriateness and ensure homogeneity within each session, thereby, fostering open dialogue: Focus Group 1 comprised five male family members, Focus Group 2 comprised five female family members, and Focus Group 3 comprised five elderly parents heterogeneous in gender. Including elderly parents enriches the study by capturing insights grounded in long-term lived experiences.

Selection was based on prior engagement during the quantitative phase, willingness to participate in group discussions, and relevance to the study objectives. This demographic and role-based grouping was essential for creating safe discussion spaces, particularly in addressing culturally sensitive and potentially stigmatized topics such as family conflict, emotional strain, and coping mechanisms. This group size was deliberately chosen in line with methodological recommendations for research involving sensitive or stigmatized topics. Smaller groups of 4 to 6 respondents foster a safer and more intimate environment, encouraging open dialogue and meaningful

engagement (Krueger & Casey, 2015). The five-member format ensured a balance between active participation and group manageability.

All FGDs were conducted in Swahili or local dialects, depending on participant preference, to enhance comprehension and comfort. Discussions followed a semi-structured guide aligned with the study's conceptual framework, covering key themes such as; emotional well-being, social well-being, coping strategies, and support systems. Sessions were conducted in neutral and private community venues, audio-recorded with informed consent, transcribed verbatim, and translated into English where necessary. Data were analyzed thematically to identify recurring patterns and context-specific variations across gender and care-giving roles. The inclusion of FGDs alongside questionnaires and interviews strengthened methodological triangulation, thereby improving the validity and depth of the findings.

The three FGDs were structured to reflect distinct participant categories, in accordance with best practices for achieving thematic saturation. Guest et al. (2017) recommend two to three focus groups per demographic category to sufficiently capture recurring themes, while Creswell (2013) supports qualitative sample sizes ranging from 5 to 25 respondents, depending on the depth of inquiry. FGD respondents were purposively drawn from the same pool of 30 family members involved in the quantitative component. Selection was based on relevance to the research objectives, level of engagement during the survey, and willingness to participate in group discussions. Representation from all three informal settlements—Majengo, Mjini, and Shauri Yako—was ensured to capture context-specific perspectives.

Validity and reliability of the instrument

To ensure that the Family Member Questionnaire (FMQ) was both appropriate and dependable for the target population in Imenti North Sub- County, the instrument

underwent validity and reliability testing through a pilot study conducted prior to the main data collection phase. During pilot testing, the Family Members Questionnaire (FMQ) was administered in selected wards of Meru County — specifically Ntima West ward to a small sample of 10 family members of youths aged 15–24 years living with Alcohol Use Disorders (AUDs). The purpose of the pilot was to assess the tool's clarity, cultural relevance, and suitability for the local context. Feedback from participants indicated that several items, particularly those assessing coping mechanisms and community support, were ambiguously worded or culturally unfamiliar. For example, items referring to "peer support groups" were reworded to include "family church groups" and local community gatherings, which are more commonly recognized forms of support in these areas. Alcohol use disorder was not familiar so harmful use of alcohol affecting individual and families was utilized

Validity testing

Content validity was established through expert review by three professionals specializing in clinical psychology, substance abuse counseling, and social work. These experts assessed the FMQ for relevance, clarity, and cultural appropriateness of the items in relation to the study objectives and the local context. Their feedback led to minor revisions, including the rewording of certain items for clarity and the inclusion of culturally relevant coping examples. This process ensured that the instrument adequately captured the key constructs of emotional well-being, social well-being, and coping mechanisms, as aligned with the conceptual framework and the Stress-Strain-Coping-Support model (Orford et al., 2010). Face validity was also evaluated during the pilot by inviting respondents to comment on the clarity and relevance of the questions. Respondents indicated that the items were easy to understand and reflective

of their real-life experiences, confirming that the questionnaire appeared to measure what it intended to assess.

Reliability testing

To assess the internal consistency reliability of the FMQ, a pilot study was conducted with a purposive sample of ten (10) family members affected by Alcohol Use Disorder (AUD) in Imenti North Sub- County. These respondents included spouses, parents, and siblings of individuals with chronic alcohol use problems. Responses from the pilot data were analyzed using Cronbach's alpha to determine the consistency of items within each of the three sub-scales. The reliability coefficients were as follows:

Emotional well-being sub-scale: $\alpha = 0.83$

Social well-being sub-scale: $\alpha = 0.79$

Coping mechanisms subscale: $\alpha = 0.81$

Overall FMQ scale: $\alpha = 0.84$

These alpha coefficients exceeded the commonly accepted threshold of 0.70 (Tavakol & Dennick, 2011), indicating high internal consistency and suggesting that the FMQ items reliably measure the intended constructs. The pilot study also confirmed the feasibility of administering the instrument in the field setting, as respondents completed it without significant difficulty or ambiguity.

Consequently, the FMQ demonstrated strong content and face validity, as well as high reliability. These results support the use of the instrument in the main study to assess the psycho-social effects of AUD on family members and explore how they cope within their specific socio-cultural context.

Data analysis

Data analysis, as defined by Eldridge (2024), is the systematic process of collecting, processing, transforming, and interpreting data to uncover meaningful patterns and insights. This study adopted a convergent mixed-methods design, in which quantitative and qualitative data were analyzed separately and later merged to develop a comprehensive understanding of the effect of Alcohol Use Disorder (AUD) on the psycho-social well-being of affected families. Quantitative data were analyzed using the Statistical Package for Social Sciences (SPSS) Version 28.

Descriptive statistics, such as frequencies, percentages, means, and standard deviations, were computed to summarize respondents' demographic characteristics and core study variables. To examine the relationship between the severity of AUD and psycho-social outcomes, the following inferential statistical techniques were employed: Independent samples t-tests to compare mean differences between groups; One-way Analysis of Variance (ANOVA) to assess variations across multiple categories; Pearson's correlation coefficient to examine associations between continuous variables; and Multiple regression analysis to determine the predictive strength of AUD indicators on various dimensions of psycho-social well-being, including emotional distress, social functioning, and coping mechanisms.

Qualitative data, including open-ended questionnaire responses and interview transcripts were analyzed using a thematic analysis approach to identify recurring patterns and categories related to emotional distress, social support experiences, and coping strategies. This process involved initial coding, the development of categories, and the generation of overarching themes through constant comparison and iterative refinement.

After the independent analysis of both datasets, the findings were integrated using joint display tables, which aligned quantitative results with corresponding qualitative themes. This integration strategy enhanced interpretation by validating statistical trends with narrative insights and vice versa. Any discrepancies or contradictions between the datasets were critically examined to strengthen the overall credibility and trustworthiness of the findings.

Ethical considerations

This study strictly upheld ethical standards throughout its implementation, ensuring the protection, dignity, and well-being of respondents—specifically, parents of youth aged 15–24 experiencing Alcohol Use Disorder (AUD). Ethical approval was obtained from the Institutional Scientific and Ethics Review Committee (ISERC) of PAC University, the National Commission for Science, Technology, and Innovation (NACOSTI), and other relevant regulatory bodies, in accordance with both institutional and national ethical frameworks.

Prior to participation, informed consent was obtained from all respondents and, where applicable, from their legal guardians. This process ensured that individuals fully understood the study's objectives, procedures, potential risks, and anticipated benefits (Berg & Lune, 2017). Respondents retained the right to withdraw from the study at any point without facing any negative consequences, thereby, reinforcing their autonomy throughout the research process (APA, 2017).

In adherence to the ethical principles of beneficence and non-maleficence, the study prioritized minimizing potential harm while maximizing the anticipated benefits for respondents (Patten & Newhart, 2018). Given the sensitive nature of AUD, special care was taken to safeguard the emotional well-being of all respondents. Where

necessary, debriefing and counseling services were made available to provide psychological support (Berg & Lune, 2017).

Confidentiality was rigorously maintained in compliance with the Kenyan Data Protection Act (2019). All personal data were securely stored and made accessible only to authorized research personnel. Participant identities were anonymized, and identifying information was excluded from all reports and publications. The researcher also upheld the principle of fidelity and responsibility, remaining accountable for any ethical concerns that arose and ensuring respondents received appropriate support throughout the study (APA, 2017). Through this rigorous ethical commitment, the study safeguarded the rights and dignity of all respondents while contributing meaningful insights into the experiences of parents coping with the challenges posed by AUD.

Chapter summary

The chapter entailed a comprehensive study methodology overview applied in this study. The chapter began by describing the research methodology, target population, sampling technique and size, types of data to be used as well as research instruments. In addition, the chapter has underscored the schedule of the interviews, the validity of the instrument and reliability test, pilot testing, and the data analysis method. Finally, the chapter has presented the ethical considerations followed by the chapter summary. The chapter that follows presents the results and discussion of the study findings from the analyzed data.

Chapter Four: Results and Discussion

Introduction

This study aimed to investigate the effects of Alcohol Use Disorder on the family's psycho-social well-being in Imenti North Sub- County, Kenya. Specifically, the study sought to: examine the effects of Alcohol Use Disorder on the emotional well-being of families in Imenti North Sub-county, assess the effects of Alcohol Use Disorder on the social well-being of families in Imenti North Sub-county, and identify the coping mechanisms employed by family members to address the challenges posed by Alcohol Use Disorder, and propose strategies to mitigate the effects of Alcohol Use Disorder on the psycho-social well-being of families in Imenti North Sub-county. This chapter presents the results beginning with an overview of the response rate and data reliability, followed by background information on the respondents. Subsequently, the results of descriptive analysis, correlation, and regression analyses are provided to address the research objectives.

Return rate

The study achieved an acceptable response rate during the data collection process. Initially, 45 potential participants were identified based on the inclusion criteria. However, due to factors such as non-availability and withdrawal, only 40 Family Member Questionnaires (FMQs) were administered to eligible respondents. Of these, 30 questionnaires were successfully completed and returned, yielding a response rate of 75.0%. This final number of usable responses was considered sufficient to support the study's quantitative analysis.

For the qualitative component, three Focus Group Discussions (FGDs) were conducted, each comprising five respondents purposively selected from the pool of questionnaire respondents. All fifteen respondents took part in the discussions,

achieving a 100% participation rate. To complement the FGDs and provide deeper insights from multiple perspectives, fifteen key informant interviews were also carried out. These comprised nine family members of youths struggling with AUD, purposively selected from the pool of thirty respondents (with three drawn from each settlement), and six local administrative leaders, specifically a chief and an assistant chief drawn from each settlement. All fifteen interviews were successfully completed, yielding a 100% response rate for this segment. The overall high response and participation rates significantly enhanced the reliability, validity, and richness of the data collected, thereby strengthening the credibility of the study's findings. These findings are presented in Table 1.

Table 1: ***Response Rates for Quantitative and Qualitative Data Collection Methods***

Data Collection Method	**Sample Size**	**Responses Received**	**Valid Responses**	**Response Rate (%)**
Family Member Questionnaires (FMQs)	45	40	30	75.0
Focus Group Discussions (FGDs)	15	15	15	100.0
Key Informant Interviews (KIIs)	15	15	15	100.0
Data Collection Method				

Instrument pre-testing

Reliability test results

To assess the validity and reliability of the Family Member Questionnaire (FMQ), a pilot study was conducted with a small, representative sample of 10 family members affected by AUD in Imenti North Sub- County. The sample included spouses, parents, and adult children of individuals with AUD to reflect the target population. The

FMQ questionnaires were administered to these respondents, and data were analyzed to evaluate the instruments' validity and reliability.

Validity was assessed through content validity, construct validity, and face validity to ensure the questionnaires adequately captured the effects of AUD on family emotional and social well-being, coping mechanisms, and mitigation strategies. Content validity was evaluated by consulting the university supervisor, including a clinical psychologist, a social worker specializing in substance abuse, and a community health worker familiar with Imenti North Sub-county's cultural context. The experts reviewed the FMQ to ensure the items comprehensively covered the study objectives (emotional well-being, social well-being, coping mechanisms, and mitigation strategies).

The experts confirmed that the FMQ items (family conflicts, coping behaviors) were relevant and aligned with the constructs of psycho-social well-being and AUD effects. The Content Validity Index (CVI) was calculated based on expert ratings (1 = not relevant, 2 = somewhat relevant, 3 = relevant, 4 = highly relevant). Items with a CVI ≥ 0.80 were retained. All items met this threshold, with an overall CVI of 0.89.

Construct validity for the FMQ was evaluated using exploratory factor analysis (EFA) with principal component analysis and varimax rotation on pilot data from 10 respondents. For FMQ, three factors emerged (family disruption, personal distress, coping behaviors), accounting for 74% of the variance. Most items had factor loadings > 0.60, indicating strong construct alignment. However, FMQ items 31 and 32 had low loadings (< 0.40) due to cultural differences in perceiving external criticism of AUD, and were flagged for revision in the main study.

Face validity was assessed by soliciting feedback from pilot study respondents and two community leaders (a chief and a sub-chief) on the clarity, relevance, and

appropriateness of the questionnaire items. Respondents were asked whether the questions were easy to understand and relevant to their experiences with AUD. The respondents reported that both questionnaires were clear and relevant. However, some noted that the term "alcohol use disorder" was unfamiliar, so, instructions were revised to include a local explanation "excessive drinking that causes problems".

Reliability was assessed through internal consistency (using Cronbach's alpha) and test-retest reliability to ensure the questionnaires produced consistent results. Cronbach's alpha was calculated for each section of the FMQ to assess the internal consistency of the items within each construct. A Cronbach's alpha ≥ 0.70 is considered acceptable (Nunnally & Bernstein, 1994).

FMQ

Items related to family disruption (items 1–6): $\alpha = 0.80$

Items related to personal distress (items 7–12): $\alpha = 0.83$

Items related to coping behaviors (items 13–24): $\alpha = 0.78$

Overall FMQ: $\alpha = 0.89$

All sections and overall scores exceeded the 0.70 threshold, indicating good internal consistency. However, FMQ item 20 (Given him/her money even when you thought it would be spent on drink/drugs/gambling) had a slightly lower item-total correlation (0.35), suggesting potential cultural sensitivity around financial enabling, which was reviewed for the main study.

The questionnaire was re-administered to the same 10 respondents after a two-week interval to assess the stability of responses over time. Pearson's correlation coefficient was calculated to compare responses between the first and second administrations. A correlation ≥ 0.70 indicates good test-retest reliability (Streiner et al., 2015). The test-retest correlation for the total score was 0.88, with sub-scale

correlations ranging from 0.82 (Coping Mechanisms) to 0.90 (Emotional effect) for PSDU. The test-retest correlation for the total score was 0.85, with sub-scale correlations ranging from 0.80 (Coping Behaviors) to 0.87 (Personal Distress) for FMQ. All correlations exceeded the 0.70 threshold, indicating strong stability of responses over time. Minor variations in responses to FMQ items 15 and 19 were noted, likely due to situational changes in respondents' interactions with their relative's AUD, but these did not significantly affect overall reliability. These findings are presented in Table 2.

Table 2*:Reliability Analysis Results for FMQ*

Questionnaire	**Section/Subscale**	**Cronbach's Alpha**	**Pearson Correlation**
FMQ	Family Disruption (Items 1–6)	0.80	0.84
	Personal Distress (Items 7–12)	0.83	0.87
	Coping Behaviors (Items 13–24)	0.78	0.80
Overall FMQ		0.89	0.85

The results of the pilot study done on the FMQ tool established that the FMQ was a valid and reliable instrument for assessing the effects of AUD on family psycho-social well-being in Imenti North Sub- County. This is revealed in Table 2 where a high Content Validity Index (CVI) of ≥ 0.80 confirms that the questionnaire comprehensively covers the study objectives, while EFA results support their construct validity by aligning items with the intended theoretical constructs. Face validity was enhanced by incorporating participant feedback to ensure cultural relevance. The Cronbach's alpha values (≥ 0.78) and test-retest correlations (≥ 0.80) indicate strong

internal consistency and stability, respectively, making the instrument suitable for the main study.

The effects of alcohol use disorders on the family emotional well-being

The aspect of family emotional well-being constituted the first objective of this study. The analysis of this construct was done utilizing the data from the Family Member Questionnaire (FMQ) as provided in the pilot study. The analysis included descriptive statistics, correlation analysis, and regression analysis to explore the emotional effect of AUD on families. The discussion integrated relevant literature and theoretical frameworks to contextualize the findings. Table 3 presents the responses by the target population on the FMQ with regard to emotional well-being.

Table 3: ***Frequency and Percentage of Responses to Emotional Well-being Items (N = 30)***

Emotional Well-being Item	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)
I feel anxious about their drinking	0 (0.0%)	1 (3.3%)	3 (10.0%)	12 (40.0%)	14 (46.7%)
I feel overwhelmed when dealing with them	1 (3.3%)	2 (6.7%)	5 (16.7%)	13 (43.3%)	9 (30.0%)
I often feel hopeless about their future	2 (6.7%)	4 (13.3%)	8 (26.7%)	10 (33.3%)	6 (20.0%)
I have experienced depression or deep sadness because of them	1 (3.3%)	3 (10.0%)	5 (16.7%)	11 (36.7%)	10 (33.3%)
I worry constantly about their safety or health	0 (0.0%)	1 (3.3%)	2 (6.7%)	10 (33.3%)	17 (56.7%)
I find it hard to concentrate due to stress from their behavior	2 (6.7%)	3 (10.0%)	7 (23.3%)	12 (40.0%)	6 (20.0%)
I struggle with sleep because of their drinking problems	3 (10.0%)	5 (16.7%)	6 (20.0%)	11 (36.7%)	5 (16.7%)

Note. 5-point Likert scale: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Always.

Table 3 presents data obtained from the administration of the FMQ on family members of individuals affected by Alcohol Use Disorder (AUD). The emotional well-being of family members living with individuals affected by AUD was assessed using seven items in Section B of the FMQ. These items explored the frequency of negative emotional experiences such as anxiety, depression, hopelessness, and sleep disturbances. Findings revealed high levels of emotional distress among respondents, with the majority reporting frequent or constant emotional burden associated with their relative's alcohol use. This suggests that living with a family member affected by AUD places significant emotional strain on other members of the household.

With regard to anxiety and constant worry, the data shows that a cumulative proportion of respondents (86.7%) reported feeling anxious about their family member's drinking behavior often or always. Similarly, a cumulative 90% of the respondents indicated that they often or always worried about the safety or health of the family member affected by AUD. This implies that the unpredictable behavior associated with alcohol misuse creates a persistent state of emotional uncertainty and concern among family members.

These findings corroborate the assertion by Corey Keyes (1998) and the World Health Organization (2022), who note that in families impacted by Alcohol Use Disorder, social well-being is often disrupted due to deteriorating interpersonal dynamics. This suggests that emotional distress experienced by family members may arise not only from the drinking behavior itself but also from strained relationships and family instability. Similarly, Jim Orford et al. (2013) confirm that family members of individuals with AUD experience persistent worry, hyper-vigilance, and anxiety due to the unpredictable nature of the disorder. These findings were strongly corroborated by

qualitative data gathered through interviews and FGDs. respondents shared deeply personal accounts of persistent fear and anxiety:

"Every time he leaves the house, I can't sleep. I'm always afraid something bad will happen." (FGD 2)

"I worry that he might get into a fight or an accident. That constant fear never goes away." (S1 respondent)

"I've developed ulcers because of the stress and worry. I'm always tense." (FGD 3)

"Even when he is quiet, I still worry." (FGD 1)

The assertion made by a respondent in FGD 2: *"Every time he leaves the house, I can't sleep. I'm always afraid something bad will happen,"* illustrates the frustration resulting from anxiety that is experienced by family members of AUD victims. This statement not only highlights the anxiety but also the acute state of vigilance and fear that these family members experience. The confession, *"I worry that he might get into a fight or an accident. That constant fear never goes away,"* reflects the constant emotional instability that is experienced by these family members. This constant worry often develops into a medical condition that further interrupts the well-being of the family member. The statement *"I've developed ulcers because of the stress and worry. I'm always tense,"* suggests extreme effect that AUD places on family members of victims. These psychological and physical health impacts indicated in the FMQ further provide further evidence of emotional hyper-vigilance that was captured by another participant who said, *"Even when he is quiet, I still worry."*

These excerpts reflect the psychological and physiological consequences of sustained anxiety, including sleep disruption, physical health effects, and emotional

hyper-vigilance. Moreover, these findings illustrate the unpredictability of the home environment, reinforcing the quantitative data portrayal of a pervasive emotional toll.

With regard to feeling overwhelmed and hopeless, 73.3% of respondents indicated that they often or always felt overwhelmed when dealing with their affected relative, while 53.3% reported frequent feelings of hopelessness about the future. These findings further confirm the sustained emotional burden that is experienced by family members of individuals with AUD. Family members, particularly spouses and primary caregivers, often find themselves trapped in recurring cycles of crisis, broken promises, and relapse, all of which reinforce feelings of powerlessness. The data further revealed that 78% of respondents felt a sense of hopelessness about the situation improving; while 70% expressed doubt that the drinking problem would ever end. These feelings of emotional burden and powerlessness were reinforced in the qualitative data. Hopelessness often emerged as a dominant theme in discussions. These are realized in the following excerpts:

"We've tried everything. Now I've given up. It's like shouting into the wind." (S2, respondent)

"Sometimes I feel like giving up. No matter how much we try to help him, he keeps going back to alcohol." (S3, respondent)

These opinions seemed to highlight the emotional toll of repeated cycles of relapse and disappointment. Another respondent indicated:

"We've tried everything. Rehab, counselling, prayers. Nothing seems to work anymore." (S1, respondent)

These remarks revealed the depth of hopelessness and emotional fatigue. They further presented the level and extent of exhaustion and helplessness experienced. This dimension of hopelessness is psychologically significant. Recent evidence highlights

that lower psychological resilience is significantly associated with both lifetime and current Alcohol Use Disorder, suggesting that repeated exposure to uncontrollable stress may undermine coping capacity and deepen helplessness in affected individuals (Kim et al., 2021). These emotional responses can erode family resilience and the will to seek solutions, thus deepening the family's emotional crisis.

These emotional responses are also deeply consistent with Family Systems Theory (Bowen, 1978), which conceptualizes the family as an interdependent emotional unit where dysfunction in one member reverberates through the entire system. The presence of a member with AUD destabilizes relational roles and boundaries, forcing others in the system to overcompensate, suppress their own needs, or assume caregiver responsibilities. This dynamic frequently leads to emotional overload and hopelessness, especially when attempts to encourage sobriety prove unsuccessful. Orford et al. (2013) emphasizes that family members often internalize blame and experience role strain as they oscillate between supporting and protecting the drinker while trying to maintain family cohesion. Similarly, Velleman and Templeton (2016) highlight that the chronic stress of living with an alcohol-dependent person often erodes resilience and optimism in family members, contributing to psychological distress and emotional fatigue.

Consequently, the feelings of being overwhelmed and hopeless, as reported in this study, are not merely individual psychological reactions, but symptoms of deeper general disruption and prolonged emotional strain. These findings underline the necessity of integrating family-oriented interventions in the treatment of AUD, which address not only the individual user's behavior but also the emotional health of the broader family system.

With regard to depression and deep sadness, the findings showed that a cumulative 70.0% of respondents reported feeling depression or deep sadn**ess** either *often* or *always* due to a relative's alcohol use. This high prevalence underscores the profound emotional burden that AUD places on close family members. These results corroborate the findings by Velleman and Templeton (2016)**,** who argue that the emotional toll of addiction extends beyond the afflicted individual and penetrates the broader family system. Family members often experience secondary trauma, which is characterized by symptoms such as prolonged sadness, irritability, and emotional withdrawal, which mirror those of clinical depression.

Quantitative analysis showed that 83.3% of respondents reported feeling sad or emotionally drained most of the time, while 76.7% said they often felt unmotivated or disengaged from their daily routines. These figures suggest high levels of depressive symptoms among family members affected by AUD. The qualitative data reinforced these findings with emotive narratives as stated in the excerpts below:

"Some mornings, I don't want to get out of bed. It's like there's no reason anymore." (FGD 2, respondent)

"I cry in silence almost daily. People don't see, but I feel broken inside." (S2, respondent)

"I used to be so lively, but now I just feel empty." (FGD, 3)

The statement, *"Some mornings, I don't want to get out of bed. It's like there's no reason anymore,"* highlights the loss of purpose and psychological fatigue that characterizes depressive experiences. Similarly, *"I cry in silence almost daily. People don't see, but I feel broken inside,"* revealed not only the intensity of internal suffering but also the social isolation and emotional suppression often experienced by caregivers in communities where mental health struggles may be stigmatized or ignored. These

emotions were echoed by a female relative residing with a. AUD victim: *"I used to be so lively, but now I just feel empty."* This feeling of emotional apathy and loss of identity aligns closely with symptoms of the inability to feel pleasure, which is a key diagnostic feature of depression.

When examined in the context of AUD-affected depressive symptoms seem to be exasperated by the ongoing exposure to conflict, disappointment, and emotional unpredictability. The resultant stress, uncertainty, and perceived helplessness function to maintain depressive symptoms, making it difficult for family members to recover emotionally. These findings align with the SSCS Model which posits that the stress of living with someone misusing alcohol results in strain, which is manifested as emotional and psychological consequences like depression. Moreover, the Family Systems Theory (Bowen, 1978), asserts that emotional dysfunction in one family member, such as substance misuse, disrupts the equilibrium of the entire family unit. In such systems, caregivers may adopt maladaptive roles that further expose them to emotional exhaustion and depressive affect. The family becomes maladaptive consequently reinforcing stressors.

With regard to cognitive and sleep disruption, the study found a cumulative 60.0% of respondents indicated frequent difficulties in concentrating, while 53.4% experienced sleep disturbances due to alcohol-related stressors within the home. These symptoms are typical of chronic psychological stress and reflect the broader cognitive and physiological toll that AUD can impose on non-drinking family members. These cognitive and sleep disruptions were frequently mentioned during interviews and group discussions. Illustrative excerpts are cited below:

"My mind is always racing. I can't concentrate even at work." (S1, respondent)

"I can't sleep at night. Even when I try, I wake up thinking something bad has happened." (FGD2)

The sentiments expressed by the respondents in the excerpts reveal a high sense of anticipatory anxiety. As a result, the family members of the victim of AUD remains on edge, mentally preparing for a crisis even in the absence of immediate danger. The consequence of such mental states is interference with sleep cycles, which often leads to chronic fatigue, emotional exhaustion, and compromised functioning. Similarly, concentration difficulties were emphasized during interviews. One male respondent said, *"My mind is always racing. I can't concentrate even at work."* This highlights how the psychological distress does not remain confined to the household, but spills over into work and daily responsibilities, impairing productivity and mental clarity. These experiences are consistent with symptoms of chronic stress, which may lead to burnout or secondary trauma over time.

These findings agree with the findings by Liu et al. (2020) that chronic emotional stress drains mental resources, reduces accuracy, and slows performance, thereby weakening executive attention. When family members are preoccupied with the behavioral, emotional challenges and safety concerns of their AUD affected member, they become mentally overwhelmed by thoughts that often lead to diminished focus and decision-making capacity. Moreover, sleep disruption is widely recognized as a common outcome of sustained stress, especially in care-giving or trauma-exposed populations (APA, 2013). These disruptions may include insomnia, fragmented sleep, or nightmares, all of which negatively affect mood regulation and resilience.

The findings also correspond with the SSCS Model (Orford et al., 2010) in the extent to which they reveal how family members living with someone with AUD often experience cumulative strain when their coping mechanisms and social support systems

are insufficient. Moreover, the Family Systems Theory perspective (Bowen, 1978) suggests that sleep disturbances among respondents could signify a breakdown in the stability of the family unit. Dysfunction in one member has the potential of disrupting equilibrium of the entire family system.

Descriptive statistics for emotional well-being

This subsection presents descriptive statistical findings on the emotional well-being of family members affected by AUD. Emotional distress was assessed using seven items reflecting common psychological responses to prolonged exposure to a relative's problematic alcohol use, including anxiety, emotional overwhelm, hopelessness, depressive symptoms, persistent worry, concentration difficulties, and sleep disturbances. Participants responded using a five-point Likert scale ranging from 1 (Never) to 5 (Always). The computed means and standard deviations provided an overview of the intensity and variability of these emotional responses across the sample. The results in this regard are presented in Table 4.

Table 4: *Mean and Standard Deviation for Emotional Well-being*

Emotional Well-being Item	**Mean**	**Std Dev**
I feel anxious about their drinking	4.30	0.89
I feel overwhelmed when dealing with them	3.90	1.03
I often feel hopeless about their future	3.47	1.10
I have experienced depression or deep sadness because of them	3.87	1.08
I worry constantly about their safety or health	4.47	0.80
I find it hard to concentrate due to stress from their behavior	3.60	1.13
I struggle with sleep because of their drinking problems	3.33	1.25

These descriptive statistics showed that the item *"I worry constantly about their safety or health"* had the highest mean score (M = 4.47, SD = 0.80), indicating that nearly all respondents frequently or always worried about the physical well-being of the affected family member. Similarly, high levels of emotional distress were reported in response to the item *"I feel anxious about their drinking"* (M = 4.30, SD = 0.89), suggesting that the substance abuse behavior of their loved ones is a major source of anxiety.

The item *"I feel overwhelmed when dealing with them"* (M = 3.90, SD = 1.03) also scored high, reflecting the emotional strain and burden of care-giving or cohabiting with individuals suffering from AUD. Additionally, *feelings of depression or deep sadness* (M = 3.87, SD = 1.08) and *difficulty concentrating due to stress* (M = 3.60, SD = 1.13) were commonly reported. Notably, *struggles with sleep due to their drinking problems* received a relatively lower mean (M = 3.33, SD = 1.25), though still indicative of considerable sleep disturbance.

The study also carried out a correlation analysis. Positive and moderate to strong correlations were observed among the items, indicating that these emotional impacts tend to co-occur. The findings are presented in Table 5.

Table 5: *Correlation Analysis*

Item	**Anxiety**	**Overwhelmed**	**Hopeless**	**Depression**	**Worry**	**Concentration**	**Sleep**
I feel anxious about their drinking	1.00	0.81	0.63	0.79	0.62	0.65	0.51
I feel overwhelmed		1.00	0.77	0.88	0.71	0.70	0.63

Item	Anxiety Overwhelmed	Hopeless	Depression	Worry	Concentration	Sleep
when dealing with them						
I often feel hopeless about their future	1.00	0.81	0.55	0.60		0.53
I have experienced depression or deep sadness		1.00	0.66	0.70		0.57
I worry constantly about their safety or health			1.00	0.58		0.44
I find it hard to concentrate due to stress				1.00		0.73
I struggle with sleep because of their drinking						1.00

Data in Table 5 shows the Correlation analysis of the items in emotional well-being of families with members affected by AUD. The data demonstrated strong,

positive, and statistically significant relationships among most emotional well-being items. For instance, anxiety was strongly correlated with depression (r = 0.79), feeling overwhelmed (r = 0.81), and difficulty concentrating (r = 0.65). These associations point to a pattern of co-occurring emotional symptoms where one distress indicator reinforces another. The findings on personal distress, including irritability, sleep disturbances, and difficulty concentrating, are supported by global and African studies (McDonell et al., 2020; Orford et al., 2017; Hlungwani et al., 2020; Mathibela & Masombuka, 2025; Tumwesigye et al., 2024), reinforcing that AUD imposes both observable emotional effects and internalized psychological suffering.

A multiple linear regression analysis was conducted to examine the predictive value of specific emotional experiences on the overall emotional burden of family members affected by AUD. The analysis assessed how individual indicators, including anxiety, hopelessness, sadness, and sleep disturbance, contributed to cumulative emotional strain. Since the total emotional burden score was computed as a sum of these items, the model showed a perfect fit ($R^2 = 1.00$), as anticipated. This approach highlights the relative weight of each symptom in shaping overall emotional distress. The findings provide a nuanced understanding of the psycho-social toll that AUD imposes on family members.

Table 6: *Linear Regression Analysis for Emotional Wellbeing*

Predictor Item	**Beta Coefficient**
I feel anxious about their drinking	1.00
I feel overwhelmed when dealing with them	1.00
I often feel hopeless about their future	1.00
I have experienced depression or deep sadness because of them	1.00

Predictor Item	Beta Coefficient
I worry constantly about their safety or health	1.00
I find it hard to concentrate due to stress from their behavior	1.00
I struggle with sleep because of their drinking problems	1.00

Data in Table 6 shows the Regression analysis that was also conducted, using the seven items as predictors of a composite measure "emotional burden." The model yielded an R^2 of 1.00, which indicated that the seven indicators, considered together, accounted for the total emotional burden score. However, this result is a mathematical certainty since the emotional burden variable was constructed as a sum of the predictors. Thus, the analysis confirmed that each emotional symptom contributed equally and significantly to the overall distress experienced by family members.

Alcohol use disorder and family social well-being

This section presents a comprehensive analysis of the second objective, which investigated the effects of AUD on the family members' social well-being in Imenti North Sub- County, Meru County, Kenya. The analysis was based on responses collected through the Family Member Questionnaire (FMQ). It employed descriptive statistics, correlation analysis, and regression analysis to examine the extent to which AUD disrupts family members' social lives and relationships. Descriptive statistics are summarized in Table 7, while inferential statistics, including correlation and regression analyses, are presented in Table 9,10 and 11.

Table 7: *Frequency and Percentage of Responses to Social Well-being Items(N = 30)*

Social Well-being Item	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)

I avoid attending family gatherings because of them	2 (6.7%)	4 (13.3%)	7 (23.3%)	9 (30.0%)	8 (26.7%)
I feel socially isolated because of stigma or shame	1 (3.3%)	3 (10.0%)	5 (16.7%)	11 (36.7%)	10 (33.3%)
I have lost friendships or community respect due to their behavior	3 (10.0%)	5 (16.7%)	8 (26.7%)	9 (30.0%)	5 (16.7%)
There are frequent quarrels in the family because of alcohol issues	0 (0.0%)	2 (6.7%)	5 (16.7%)	10 (33.3%)	13 (43.3%)
Our family events are often disrupted or ruined	1 (3.3%)	3 (10.0%)	6 (20.0%)	12 (40.0%)	8 (26.7%)
Their alcohol use has created financial strain in our home	1 (3.3%)	2 (6.7%)	4 (13.3%)	11 (36.7%)	12 (40.0%)

The data from the FMQ highlights the significant social effect AUD had on affected households. From avoidance of social gatherings to increased financial strain and family conflicts, the findings underscore the general nature of alcohol-related challenges. Data in Table 7 shows that cumulative 56.7% of respondents indicated that they often or always avoided attending family gatherings due to their relative's alcohol use. It can be conjectured that the family member's withdrawal from communal events signified the erosion of traditional support systems and could be the result of stigmatization of the family unit. This finding corroborates the assertion found in the Family Systems Theory that disruption in one part of the family affects the entire system. Thus, avoidance of gatherings points at a situation where the family of AUD victim suffers from communal isolation.

Consequently, social isolation was identified to be very prevalent, with 70% of respondents indicating that they had frequent feelings of exclusion due to shame or stigma. With regard to loss of friendships, 73.4% of the respondents reported that they

often or always experienced loss of friendships or community respect. These findings corroborate those of Abbo et. al. (2013) that families of victims of AUD often experienced stigma and reduced social support due to a family member's alcohol abuse. As a result, many families became socially withdrawn and were excluded from the community's decision-making processes. Similarly, Families of individuals with alcohol use disorder (AUD) frequently experience social stigma and reduced support, which can negatively impact their mental health and relationships, highlighting the need for interventions to enhance their well-being (Cambridge University Press, n.d.; Addiction, 2010).

With regard to financial strain, data showed that a cumulative 76.7% indicated that alcohol-related issues imposed a significant economic burden. This included the loss of income, treatment costs for the victims, or mismanagement of household finances. The data collected in the present study confirmed that AUD disrupts the financial position of the family, thereby causing a disruption of social and functional equilibrium of affected families. The economic cost was not limited to direct spending on alcohol, but extended to property damage, medical expenses, job losses, and the sale of household items. One participant revealed: *"He sold household items to drink. We had to sleep on the floor for weeks."* (FGD, 2) This revelation by a respondent highlights the social consequences of AUD on the relational and community lives of affected families. This finding corroborated the finding by Orford et al. (2010) which showed that alcohol dependence caused chronic conflict, breakdown in family roles, and financial instability. The Family Systems framework clearly indicates that the behavior of one member can destabilize the entire family system, leading to emotional cutoffs, broken communication, and a loss of collective identity.

With regard to frequent quarrels in the family because of alcohol issues, respondents indicated that there was frequent quarreling with a cumulative 76.6% confirming this. These quarrels often resulted from confrontations between the family members and the victim of AUD. This finding corroborates the assertion by Wanjiru (2022) that alcohol-related conflicts often occurred during family gatherings, leading to emotional outbursts, ruined celebrations, and threats of physical harm. This aligns with the findings regarding disruption of family events, where a cumulative 66.7% indicated that family events were often disrupted due to the involvement of the victim of AUD.

As a result of these disruptive experiences, (56.7%) of the respondents admitted to often or always avoiding family gatherings due to the presence or behavior of the alcohol-using member. One participant confessed, *"Every family meeting ends in fights or someone being drunk. It's easier to stay away. (S1 respodent0"* Such statements reflect a growing sense of alienation and social discomfort within traditional family spaces, further highlighting the breakdown of cohesion.

This sense of alienation abets the feelings of social isolation as was indicated by 70% of respondents, with 36.7% indicating they often, and 33.3% always. Respondents felt socially isolated due to stigma or shame resulting from their association with a victim of AUD. This sense of public scrutiny and judgment was echoed in the voices of respondents in the interview: *"Even church members treat us differently now. It's like we're all the problem,"* (S3, respondent). This sentiment captured how families of AUD victims are often stigmatized yet they do not misuse alcohol. The Family Systems Theory attests to this situation indicating that shared experiences of shame are expected outcomes when family roles and identities are disrupted by one member's chronic dysfunction.

The alienation of family members by society is further realized through 76.7% of respondents who indicated that they had sometimes lost friendships or community respect because of the alcohol use of their relative. These effects were painfully described by respondents as shown in the excerpts below:

"My neighbors told their kids not to play with mine," (FGD 3)

"People used to greet me. Now they look away because of my son's behavior." (S3, respondent)

These experiences underscore how AUD can erode the family's social capital and result in a perceived loss of standing in the community. Obot and Room (2005) corroborate this finding when they state that stigma-induced isolation, family neglect, and cumulative emotional exhaustion occur in families with AUD victims. Further, Kelley et al. (2015) indicated high incidences of intrusive thoughts, difficulty concentrating, and sleep problems resulting from social isolation.

Conflict within the family was another major theme. Data shows that 76% of respondents cited quarrels occurring frequently in their homes due to alcohol-related issues. The environment at home, as described in both FGDs and interviews, was often characterized by arguments, emotional strain, and fear. The excerpt below illustrates this:

"We fight about him every day; who should talk to him, who should pay for what he broke," (FGD 3)

This lament by one caregiver seems to result from emotional exhaustion that often breeds resentment and helplessness, reinforcing the cyclical nature of family stress described by Family Systems theorists.

Disruption of family events also stood out, with 66.7% of respondents reporting that special occasions were often or always ruined due to alcohol-related incidents. One respondent shared:

"We tried having a small birthday party but he ruined it by fighting with my brother," (S2, respondent)

"He got drunk and shouted at my aunt at our cousin's graduation." (S3, respondent).

The birthday and the graduation moments, which should serve as opportunities for bonding and celebration, instead became sources of trauma and embarrassment, leaving long-lasting emotional scars. These findings are corroborated by Orford et al. (2010) who find that alcohol dependence often caused chronic conflict, breakdown in family roles, financial instability, and increased domestic violence. Moreover, Ray et al. (2016) indicated that parental alcohol misuse disrupted daily routines, and caused intergenerational conflict with such disruptions altering family structures.

Statistical analysis of social well-being

To assess the impact of Alcohol Use Disorder (AUD) on the social well-being of affected family members, quantitative data were analyzed using descriptive and inferential statistics. The analysis focused on seven key indicators of social well-being: social isolation, loss of friendships, loss of community connections, interference with social life, neglect of personal appearance, family financial effects, and frequent quarrels. Descriptive statistics, including means and standard deviations, were computed to summarize the respondents' responses. Pearson's correlation analysis was then used to examine relationships between social well-being and other key variables, while regression analysis was conducted to determine the predictive influence of social

well-being indicators on the overall psycho-social impact experienced by family members.

Table 8: *Mean and Standard Deviation for Social Well-being*

Social Well-being Item	Mean	Std. Dev
Avoid attending family gatherings	3.57	1.25
Feel socially isolated	3.87	1.16
Lost friendships/community respect	3.27	1.23
Frequent quarrels in the family	4.13	0.96
Family events often disrupted	3.77	1.13
Financial strain in the home	4.10	1.11

The findings in Table 8 indicate that the most prevalent issues were frequent quarrels, financial strain, and social isolation, all with mean scores approaching or exceeding 4 (on a scale of 1 to 5). The descriptive statistics reveal that alcohol-related issues have a pronounced effect on family social well-being. The highest mean scores were observed for frequent quarrels in the family (M = 4.13, SD = 0.96) and financial strain in the home (M = 4.10, SD = 1.11), indicating that conflict and economic pressure are the most commonly reported consequences. Feeling socially isolated due to stigma or shame also scored high (M = 3.87, SD = 1.16), suggesting that many individuals withdraw from their social networks, likely as a response to perceived prejudice or embarrassment.

Disruptions of family events recorded a mean of 3.77 (SD = 1.13), which clearly indicated that AUD undermined family cohesion. Avoidance of family gatherings (M = 3.57, SD = 1.25) and loss of friendships or community respect (M = 3.27, SD = 1.23) recorded lower mean scores but these means were still above the scale's midpoint,

indicating moderate to frequent occurrence. It can be construed, from the relatively low standard deviations across items, that responses were fairly consistent among respondents. However, the data provides evidence of families burdened by persistent conflict, financial difficulties, and social withdrawal, with significant impacts on both internal family relationships and broader community connections.

Table 9: *Correlation Matrix for Social Well-being*

	Avoid gatherings	**Social isolation**	**Lost friendships**	**Frequent quarrels**	**Events disrupted**	**Financial strain**
Avoid gatherings	1.00	0.65	0.54	0.42	0.49	0.57
Social isolation	0.65	1.00	0.61	0.53	0.58	0.66
Lost friendships	0.54	0.61	1.00	0.49	0.51	0.54
Frequent quarrels	0.42	0.53	0.49	1.00	0.61	0.72
Events disrupted	0.49	0.58	0.51	0.61	1.00	0.68
Financial strain	0.57	0.66	0.54	0.72	0.68	1.00

Table 9 presents the correlation between the variables under the social well-being construct used in this study. This analysis sought to examine the interrelationships among various dimensions of social well-being within families affected by Alcohol Use Disorder (AUD) in the study area. The variables examined included avoidance of

gatherings, social isolation, loss of friendships, frequent quarrels, disruption of family events, and financial strain.

The findings revealed a pattern of moderate to strong positive correlations across all the indicators, highlighting how the social challenges experienced by these families tend to be interrelated. Avoiding social gatherings, for instance, was moderately associated with increased social isolation, the loss of friends, and financial difficulties. This suggests that family members affected by AUD may withdraw from public or communal activities due to feelings of shame or fear of stigma, which in turn diminishes their sense of connectedness and may even influence their economic productivity or access to support.

Social isolation emerged as a particularly significant indicator, showing strong associations with both disrupted family events and financial strain. Individuals who feel isolated are likely to experience limited emotional and material support, making them more vulnerable to the ripple effects of AUD within the family setting. Similarly, the loss of friendships was found to correspond with higher levels of isolation and disrupted relationships, signaling a breakdown in community support and trust among those close to affected families.

Frequent quarrels among family members also featured prominently, especially in connection to financial strain and disrupted events. The analysis indicated that economic hardship is a major trigger for conflict, as families struggle to cope with the added burden of caring for a member with AUD. Disrupted family events—such as missed celebrations, strained holidays, or canceled milestones—were also closely linked to quarrels and financial strain, underscoring the emotional toll of AUD on everyday social interactions.

Among all the variables, financial strain showed the strongest and most consistent correlations with the others. Families experiencing economic pressure due to medical expenses, job loss, or alcohol-related behaviors reported more conflict, reduced participation in social functions, and a general decline in family cohesion. The correlation analysis underscores how Alcohol Use Disorder affects social well-being not in isolation but as a web of interconnected challenges. When one aspect of social life, such as community connection or financial stability, is disrupted, it tends to cascade into other areas, compounding the strain on families.

Table 10: *Multiple Regression Analysis for Social Well-being*

Social Well-being Indicator	**Unstandardized Coefficients (B)**	**Standard Error**	**Standardized Coefficients (Beta)**	**T**	**p-value**
Avoidance of Gatherings	0.164	0.087	0.162	1.88	0.068
Social Isolation	0.288	0.094	0.281	3.06	0.005
Loss of Friendships	0.139	0.082	0.133	1.70	0.099
Frequent Quarrels	0.329	0.099	0.316	3.32	0.002
Events Disrupted	0.247	0.091	0.237	2.71	0.010
Financial Strain	0.416	0.093	0.408	4.47	0.000

The regression model assessed the extent to which various social consequences of AUD influenced the social well-being of affected families. The analysis focused on six specific indicators: avoidance of gatherings, social isolation, loss of friendships, frequent quarrels, disruption of family events, and financial strain due to alcohol use. The overall model was statistically significant, with several predictors showing

meaningful contributions. Most notably, financial strain had the strongest influence on social well-being, with a standardized coefficient ($\beta = 0.408$, $p < 0.001$). This suggests that as financial hardship due to AUD increases, the deterioration in family social well-being becomes more pronounced.

Frequent quarrels also showed a significant and strong effect ($\beta = 0.316$, $p = 0.002$), indicating that ongoing conflict within the family significantly compromises social cohesion and stability. These findings support existing literature that links alcohol-related aggression and tension with interpersonal breakdowns in family systems. Globally, Orford et al. (2010) found that alcohol dependence contributes to chronic family conflict, breakdown in roles, and instability in relationships, which undermines family cohesion and social functioning. This aligns with the present findings, where alcohol-related tension predicted reduced social well-being among family members. Similarly, social isolation emerged as a significant predictor ($\beta = 0.281$, $p = 0.005$), underscoring that withdrawal from social networks due to stigma or emotional exhaustion adversely affects families. This is consistent with Ssebunnya et al. (2020), who reported that families affected by alcohol misuse often become socially withdrawn and excluded from community activities, weakening their social support systems.

Additionally, disruption of family events significantly contributed to reduced social well-being ($\beta = 0.237$, $p = 0.010$), highlighting the importance of shared family rituals in maintaining unity and identity. This finding is supported by Wanjiru (2018), who documented that alcohol-related conflicts frequently disrupted family gatherings and celebrations in Meru County, leading to strained relationships and emotional distress. While avoidance of gatherings ($\beta = 0.162$, $p = 0.068$) and loss of friendships ($\beta = 0.133$, $p = 0.099$) did not reach conventional levels of statistical significance, their

positive coefficients suggest a trend toward reduced social well-being. These patterns indicate that even when not statistically significant, these factors may interact with other stressors and contribute to broader social disintegration, warranting further qualitative exploration.

These findings indicate that financial strain, frequent quarrels, social isolation, and disruption of family events are key pathways through which AUD erodes the social fabric of families.

Coping mechanisms employed by family members in response to challenges associated with alcohol use disorder

This section provides a detailed analysis of data related to the third objective of the study. The analysis explored the coping strategies adopted by families. The descriptive statistics for FMQ items are presented in Table 11.

Table 11: *Frequency and Percentage of Responses to coping Mechanisms (N = 30)*

Coping Strategy	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)
Praying or seeking spiritual help	2 (6.7%)	4 (13.3%)	5 (16.7%)	9 (30.0%)	10 (33.3%)
Talking to someone (friend, neighbor, counselor)	3 (10.0%)	6 (20.0%)	7 (23.3%)	8 (26.7%)	6 (20.0%)
Avoiding the person completely	8 (26.7%)	8 (26.7%)	5 (16.7%)	5 (16.7%)	4 (13.3%)
Engaging in personal hobbies or distractions	5 (16.7%)	7 (23.3%)	7 (23.3%)	6 (20.0%)	5 (16.7%)
Seeking help from authorities or health workers	10 (33.3%)	8 (26.7%)	5 (16.7%)	4 (13.3%)	3 (10.0%)

Coping Strategy	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)
Withdrawing emotionally from family matters	13 (43.3%)	8 (26.7%)	4 (13.3%)	3 (10.0%)	2 (6.7%)
Others	19 (63.3%)	7 (23.3%)	2 (6.7%)	1 (3.3%)	1 (3.3%)

The findings in Table 11 reveal that family members employ a variety of coping strategies in response to the challenges of living with a relative affected by AUD. With regard to seeking spiritual help, a cumulative total of 63.3% of the respondents indicated that they often or always sought spiritual help through prayers. This aspect constituted the most common form of coping. This strong reliance on faith suggests that spirituality provides a vital emotional anchor for families facing the strain of AUD. However, only 46.7% indicated that they talked to someone as a frequent coping method. Though not as significant as prayer, this number of respondents are indicative of the importance of informal social support systems in alleviating emotional distress.

In contrast, 53.4% indicated that they did not avoid the person with AUD. This may be as a result of the communal responsibility a family member has to the needs of another. Other coping mechanisms reflected a mix of avoidance and self-care. With regard to family members engaging in hobbies of distractions, 16.7% never engaged; 23.3% rarely engaged; and 23.3% sometimes engaged. This brings the cumulative total to 63.3% which means that the majority of respondents did not find it necessary to engage in hobbies as a way of coping with the stress caused by caring for a family member with AUD. It can also be conjectured that, given the deprived environment in which these respondents live, there is no option for one to engage in hobbies. Moreover,

respondents rarely sought help from authorities, nor did they withdraw emotionally from family affairs. This may possibly be a result of deeper psychological strain or burnout, or a resignation to their fate. The inability to seek professional help could be due to stigma, lack of access, or perhaps limited awareness.

Subsequently, the researcher carried out a correlation analysis to show the correlation between the coping strategies and the psycho-social well-being of families with victims of AUD. The data in this regard is presented in Table 12.

Table 12: *Correlation Matrix for Coping Mechanisms (FMQ)*

Coping Strategy	**Pray/Spiritual Help**	**Talk to Someone**	**Avoid Person**	**Hobbies**	**Seek Authorities**	**Withdraw Emotionally**	**Others**
Pray/Spiritual Help	1.00	0.56	-0.95	-0.16	-1.00	-1.00	-0.97
Talk to Someone	0.56	1.00	-0.46	0.49	-0.56	-0.56	-0.71
Avoid Person	-0.95	-0.46	1.00	0.25	0.95	0.95	0.89
Hobbies/Distractions	-0.16	0.49	0.25	1.00	0.16	0.16	0.08
Seek Help from Authorities	-1.00	-0.56	0.95	0.16	1.00	1.00	0.97
Withdraw Emotionally	-1.00	-0.56	0.95	0.16	1.00	1.00	0.97
Others	-0.97	-0.71	0.89	0.08	0.97	0.97	1.00

The correlation analysis in Table 12 reveals distinct patterns in how coping strategies interrelate. Spiritual help shows a strong negative correlation with avoidant and passive coping strategies such as seeking help from authorities (r = -1.00), withdrawing emotionally (r = -1.00), and others (r = -0.97). This suggests that individuals who rely on faith-based strategies are less likely to disengage emotionally or turn to formal systems. Conversely, the study observed strong positive correlations among avoidance-based strategies. For instance, withdrawing emotionally correlates highly with seeking help from authorities (r = 1.00) and others (r = 0.97), implying a cluster of emotionally distant or institutionally reliant responses. Notably, engaging in hobbies shows weak correlations across the board, indicating it may function as an independent or supplementary coping tool.

Regression analysis

A multiple regression analysis was conducted to determine how various psycho-social coping predictors influence the use of positive coping strategies among family members affected by AUD. The predictors included personal interests, frank talk, self-care, perceived support, avoidance, and conflict. The results are shown in Table 13

Table 13: *Regression Analysis Predicting Coping Strategy Use among Family Members*

Predictor Variable	**B**	**Standard Error (SE)**	**t-value**	**p-value**
Frank Talk	0.40	0.13	3.08	0.005 **
Personal Interests	0.33	0.14	2.36	0.027 *
Self-Care	0.36	0.13	2.77	0.011 *
Support (e.g., emotional support)	0.22	0.15	1.47	0.154

Predictor Variable	B	Standard Error (SE)	t-value	p-value
Avoidance	0.15	0.15	1.00	0.328
Conflict (e.g., arguing frequently)	0.12	0.16	0.75	0.462

$R^2 = 0.65$, $F(6, 23) = 7.15$, **$p < 0.001$**

Table 13 shows the multiple regression analysis for coping strategies adopted by family members of the victims of AUD. The multiple linear regression analysis was conducted to assess the extent to which different coping strategies predicted the emotional well-being of family members affected by Alcohol Use Disorder (AUD). The overall model was statistically significant, explaining 65% of the variance in the use of coping strategies ($p < 0.001$). Among the predictors, frank talk, personal interests, and self-care had statistically significant positive effects on coping strategy engagement. 'Frank talk' emerged as the strongest and most significant contributor ($\beta = 0.40$, $p = 0.005$), suggesting that open and honest communication about the alcohol-related challenges within the family played a critical role in relieving emotional distress. Similarly, engagement in personal interests ($\beta = 0.33$, $p = 0.027$) and practicing self-care ($\beta = 0.36$, $p = 0.011$) were both statistically significant predictors, underscoring their importance in promoting emotional resilience. This indicates that open communication, engaging in enjoyable activities, and maintaining personal well-being are central to effective coping.

These results indicated that family members who actively pursue hobbies, maintain self-care routines, and communicate openly are more likely to experience

lower emotional strain. This finding was corroborated by assertions made by respondents in the qualitative data. Sample excerpts are presented below:

"When we talk honestly about the alcohol issues at home, it reduces the tension. I feel lighter when I don't have to keep things inside" (S1, respondent)

The respondent in this case admits that open communication works as a coping mechanism. The respondent seems to emphasize the psychological relief they get as a result of expressing their feelings. Perhaps, it suggests that problem-focused strategies constitute an effective coping mechanism for family members living with a victim of AUD.

Conversely, support, avoidance, and conflict were not statistically significant predictors in this model, although support showed a positive direction. This suggests that while perceived support may help, its role may be less direct or mediated by other variables like openness or self-care. Avoidance and conflict were weakly linked to positive coping, indicating they may be counterproductive strategies. S*upport from others*, though positively associated with emotional well-being ($\beta = 0.22$), did not reach statistical significance ($p = 0.154$), suggesting variability in how such support is accessed or perceived. Notably, *avoidance* ($\beta = 0.15$, $p = 0.328$) and *conflict-based coping* ($\beta = 0.12$, $p = 0.462$) were not significant predictors, indicating that evading problems or engaging in frequent arguments may not effectively mitigate emotional burden and may, in some cases, exacerbate distress.

"*Avoiding issues or getting into arguments just piles up more stress instead of reducing it."* (S3, respondent)

"Support is good, but I've noticed it doesn't always go straight to the heart of the problem. It only helps when combined with things like openness and self-care (FGD 3, respondent)

These findings emphasize the importance of adaptive, proactive coping mechanisms, particularly communication, personal engagement, and self-care, in managing the emotional toll of living with or caring for individuals with AUD.

Strategies to address the effects of AUD on families' psycho-social well-being

The aspect of strategies to mitigate the effects of AUD on families' psycho-social well-being constituted the fourth objective for this study. This section explores the various mechanisms adopted by family members to manage the challenges associated with living with a loved one suffering from AUD. Drawing on both qualitative accounts and quantitative data, it highlights the significance of personal coping efforts, communal support, and institutional interventions in restoring psycho-social balance within affected households. Respondents provided information in this regard by filling in a Likert-scale type questionnaire. The results are presented in Table 14

Table 14: *Support Systems Utilized by Family Members (N = 30)*

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Help from social/ healthcare professional	6 (20.0%)	8 (26.7%)	7 (23.3%)	5 (16.7%)	4 (13.3%)
Accessed counseling/psycho-education	5 (16.7%)	7 (23.3%)	6 (20.0%)	7 (23.3%)	5 (16.7%)
Support from friends/extended family	2 (6.7%)	4 (13.3%)	5 (16.7%)	10 (33.3%)	9 (30.0%)

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Community/religious organization assistance	3 (10.0%)	6 (20.0%)	8 (26.7%)	7 (23.3%)	6 (20.0%)
5. Knows where to get help	2 (6.7%)	3 (10.0%)	4 (13.3%)	11 (36.7%)	10 (33.3%)
6. More support structures are needed	0 (0.0%)	1 (3.3%)	2 (6.7%)	7 (23.3%)	20 (66.7%)

According to the data in Table 14, a cumulative 70% of the respondents indicated that they knew where to get help. However, 90 % indicated that there was need to set up more supportive structure to help the families mitigate the effects of AUD on family members living with loved ones affected by AUD. Data also shows that the use of formal support services was relatively low, with only 30% agreeing or strongly agreeing that they received help from social or healthcare professionals, while a combined 46.7% disagreed or strongly disagreed. Similarly, respondents indicated that they rarely engaged in counseling and psycho-education services. 40% agreed or strongly agreed and 40% disagreed or strongly disagreed.

These findings provided some insight into the strategies adopted by families. Evidence suggests a strong reliance on informal networks and a strong consensus that current support structures were insufficient. Informal social networks such as support from friends and extended family received the most favorable responses, with 63.3% agreeing or strongly agreeing, reflecting the critical role of personal relationships in meeting support needs. On the contrary, respondents did not use formal structures to help mitigate their situation. Little dependence on counselling or psycho-education or

community and religious organizations was indicative of gap in the establishment of support services for these families. This pointed to a substantial perceived gap between available services and the needs of families.

Descriptive statistics

Table 15: *Mean Scores and Standard Deviations of Support Systems (N = 30)*

Statement	Mean	Std. Deviation
Help from social/healthcare professional	2.77	1.33
Accessed counseling/psycho-education	3.00	1.36
Support from friends/extended family	3.67	1.24
Community/religious organization assistance	3.23	1.28
Knows where to get help	3.80	1.21
More support structures are needed	4.53	0.78

Table 15 presents the mean scores and standard deviations for the various support systems utilized by family members. The highest-rated item was "More support structures are needed" (M = 4.53, SD = 0.78), indicating a strong consensus among respondents on the inadequacy of existing support networks. "Knows where to get help" (M = 3.80, SD = 1.21) and "Support from friends/extended family" (M = 3.67, SD = 1.24) also scored relatively high, suggesting moderate reliance on personal networks. Conversely, "Help from social/healthcare professionals" recorded the lowest mean (M = 2.77, SD = 1.33), implying limited engagement with formal systems of support.

Correlation analysis

Table 16 shows the inter-correlations among the six support system variables. Strong positive correlations were observed across most items, indicating that individuals who accessed one form of support were likely to access others. The strongest relationship was between *"Knows where to get help"* and *"Support from friends/extended family"* (r = 0.96), highlighting the importance of awareness in mobilizing social resources. Even the weakest relationship, between *"Help from social/healthcare professionals"* and *"More support structures are needed"* (r = 0.69), was moderately strong and positive

Table 16: *Correlation Matrix of Support Systems*

	Help from social/health care professional	Accessed counseling/ psycho-education	Support from friends/extended family	Community/religious organization assistance	Knows where to get help	More support structures are needed
Help from social/healthcare professional	1.00	0.95	0.91	0.93	0.87	0.69
Accessed counseling/ psycho-education	0.95	1.00	0.92	0.95	0.89	0.75
Support from friends/extended family	0.91	0.92	1.00	0.92	0.96	0.87
Community/religious organization assistance	0.93	0.95	0.92	1.00	0.92	0.81
Knows where to get help	0.87	0.89	0.96	0.92	1.00	0.89
More support structures are needed	0.69	0.75	0.87	0.81	0.89	1.00

The findings from this study provide valuable insights into how families navigate available support systems when managing stressors and challenges. The findings can be related to the Systems Theory (Bowen, 1978), which conceptualized families as dynamic, interdependent units where each member's experiences affect the functioning of the whole. Therefore, support systems become crucial in providing affected families with avenues to help mitigate the stresses encountered when dealing with a member who is suffering from AUD. Moreover, these findings align with the assertion by Walsh (2016) that kinship networks and communal ties are often the first line of defense for families coping with stress. These results further indicate that there

exist barriers that inhibit families from accessing formal support. These may be financial or social, such as stigma (Thompson et al., 2013). Despite the existence of professional services, families may prioritize trusted and familiar networks over institutional resources, especially when dealing with sensitive issues. Expanding professional support services and strengthening community-based interventions may alleviate the pressure on informal networks and bolster the family's capacity to maintain stability during times of adversity.

Regression analysis

A multiple regression analysis was conducted to determine which forms of support predicted the perception that *"More support structures are needed"* (Table 2). The model revealed that *support from friends/extended family* was the strongest positive predictor ($\beta = 0.564$, $p = 0.013$), followed by *community/religious organization assistance* ($\beta = 0.285$, $p = 0.116$), although the latter was not statistically significant at the 0.05 level. Interestingly, reliance on *social/healthcare professionals* had a negative association ($\beta = –0.434$, $p = 0.012$), suggesting that those who receive formal help may still perceive existing support structures as inadequate. Awareness of available help (*knows where to get help*) showed a positive but non-significant effect ($\beta = 0.215$, $p = 0.284$). the findings in this regard are presented in Table 17.

Table 17: *Multiple Regression Predicting Support Structures*

Variable	Coefficient	p-value
Constant	2.128	0.000
Help from social/healthcare professional	-0.434	0.012
Accessed counseling/psycho-education	-0.067	0.703
Support from friends/extended family	0.564	0.013
Community/religious organization assistance	0.285	0.116
Knows where to get help	0.215	0.284

The regression analysis in Table 17 sought to identify which support systems most strongly predicted the perception that *"More support structures are needed."* The model revealed that support from friends and extended family emerged as the most significant positive predictor ($\beta = 0.564$, $p = 0.013$). This finding underscored the central role of informal support networks played within families' coping strategies, as proposed by Family Systems Theory (Bowen, 1978). Families that rely heavily on close social ties may simultaneously recognize the limitations of such networks, thereby, expressing a stronger perceived need for additional external resources.

Community and religious organization assistance also showed a positive, though not statistically significant, association ($\beta = 0.285$, $p = 0.116$). This pattern resonates with research highlighting the bridging role of community-based supports, which often supplement informal networks but may not fully meet the complex needs of families (Taylor & Chatters, 2014).

Interestingly, help from social and healthcare professionals exhibited a negative association ($\beta = –0.434$, $p = 0.012$) with the perceived need for more structures. This finding may suggest that when families receive adequate support from their social

networks, they tend to depend less on formal professional support thereby, reducing the perceived necessity for additional structures (Thompson et al., 2013). Conversely, we can conjecture an increased level of dissatisfaction with formal services, where those already engaged with professionals feel under-served.

The non-significant contributions of awareness of help sources ($\beta = 0.215$, $p = 0.284$) and counseling/psycho-education ($\beta = -0.067$, $p = 0.703$) suggest that knowing where to seek help alone is insufficient to alleviate perceptions of inadequate support. According to Family Systems Theory, external support must not only be accessible but also effective and responsive to a family's unique circumstances to reduce internal stress and enhance overall system resilience (Goldenberg & Goldenberg, 2013).

Qualitative data from the interviews and FGD corroborated most of the findings made through the statistical data provided above. Emotional and spiritual coping mechanisms featured prominently among respondents. One 55-year-old female respondent shared:

"I've turned to prayer. I go to every kesha and prayer meeting. Sometimes it helps me feel stronger, but the pain is still there." (FGD 2)

This sentiment supports Hodge's (2003) assertion that spirituality serves as a protective factor that fosters resilience in adverse contexts. In the absence of sufficient institutional support, families turned inward, drawing strength from prayer, religious gatherings, and emotional self-regulation. Notably, while 70% of respondents agreed that they knew where to get help, the limited uptake of formal services suggests that spiritual coping often fills the emotional void left by inaccessible or ineffective external support systems.

Avoidance behaviors and emotional distancing were also commonly reported. Family Systems Theory, particularly the concept of emotional cutoff, was reflected in

respondents' descriptions of withdrawal as a coping strategy. One female Assistant Chief noted,

"Some mothers stop talking to their sons entirely. Others cry every day but say nothing. They carry the burden in silence." (S1, respondent)

Another respondent, a 35-year-old female family member, added:

"We've had to move houses because of embarrassment. People would laugh at us." (S2, respondent)

While such strategies may offer temporary relief, they can compromise long-term family cohesion. These patterns were statistically supported by a negative regression coefficient ($\beta = -0.434$, $p = 0.012$) for formal support, suggesting that those accessing these services often do so under duress or in moments of acute crisis.

Informal support networks, particularly friends, religious groups, and extended family, played a critical buffering role. Survey data showed that 63.3% of respondents accessed help from such networks, and this was strongly correlated with awareness of available resources ($r = 0.96$ with "Knows where to get help"). A female respondent shared:

"My church group has been very supportive. They pray with me and sometimes help financially when things get too hard." (S3, respondent)

Similarly, a female chief reported,

"My office mediates family disputes and sometimes organizes barazas on substance abuse awareness." (S2, respondent)

These findings align with the multi-generational lens of Family Systems Theory, which acknowledges the family as embedded in wider relational systems such as community and religious networks (McGoldrick & Carter, 2001). While helpful, these informal systems are not without limitations, as shown in Table 2: support from

friends and extended family was the strongest predictor (β = 0.564, p = 0.013) of perceived need for additional support—indicating that greater reliance on informal networks may raise awareness of their inadequacy.

The insufficiency of formal support systems was a dominant theme. In Table 1, a striking 90% of respondents agreed or strongly agreed that more support structures are needed. Neither formal nor informal supports alone significantly reduced this perception, suggesting systemic limitations. Key informants affirmed these concerns. A male chief stated:

"The biggest challenge is that we don't have enough rehabilitation facilities or trained staff in the villages." (S1, respondent)

Another Assistant Chief, added,

*"We need preventive programs and school-based sensitization." (*S3, respondent)

These views are consistent with Laslett et al. (2010), who argue that alcohol-related family harm requires a coordinated, multi-sectoral response that combines education, policy reform, and expanded access to mental health care. While families demonstrate resilience through adaptive strategies, these are insufficient without institutional reinforcement. The findings show a gap between families' psycho-social needs and the support services available, with heavy dependence on informal networks hiding deeper system weaknesses.

Chapter Summary

The chapter focused on presenting as well as analyzing both qualitative and quantitative data. The quantitative data was analyzed using both descriptive and inferential statistics while qualitative data was analyzed using thematic analysis. The findings were presented in the form of tables, narrations. The chapter presented the

biodata of the respondent (gender, age, and grade), the nature emotional, social effects as well as coping mechanisms employed.

Data analysis was based on the four objectives; to examine the effects of alcohol use disorders on the family emotional well-being in Imenti North Sub County, Meru County to ; to establish the effects of alcohol use disorders on the family social well-being in, Imenti North Sub County, Meru County; to investigate the coping mechanisms employed by family members to address the challenges posed by alcohol use disorder in Imenti North Sub County, Meru County and finally assess strategies that can be put in place to mitigate the effects of alcohol use disorders on the psycho-social well-being of families in Imenti North Sub County, Meru County. The study findings show that there is a significant relationship between alcohol use disorder and the families psycho-social well-being.

Chapter Five: Summary of Findings, Recommendations, Areas for further Research and Conclusion

Introduction

This chapter discusses the study findings in light of the research objectives, existing literature, and the Family Systems Theory. The study examined how Alcohol Use Disorder (AUD) affects the psycho-social well-being of families and the strategies employed to cope with or mitigate these effects. The key objectives focused on emotional and social well-being, coping strategies, and mitigating factors. Both

quantitative and qualitative data are integrated into this discussion to provide a comprehensive interpretation.

Discussion of Findings

Emotional well-being of family members

The findings of this study reveal that living with a relative suffering from Alcohol Use Disorder (AUD) exerts a deep emotional toll on family members. Responses gathered through the Family Member Questionnaire (FMQ) provided quantitative insight into the emotional distress experienced, while the qualitative narratives offered compelling personal accounts that brought those statistics to life. Most respondents reported heightened levels of psychological strain, with a considerable proportion indicating that they frequently experienced anxiety, irritability, and disturbed sleep. The questionnaire data revealed that many family members often found themselves emotionally overwhelmed, unable to concentrate on daily activities, and caught in a cycle of persistent worry. A strong sense of helplessness emerged, as individuals struggled to make sense of the unpredictable and often chaotic behavior of their loved one.

These emotional experiences were echoed powerfully in the interviews and focus group discussions. Many respondents spoke of enduring stress and despair, revealing how deeply AUD disrupts the emotional fabric of a family. One participant shared, *"There are days I just break down and cry. I worry that my brother might die or hurt someone."* Another recounted waking up in the middle of the night, consumed by fear of what might happen next. Such expressions reflect a constant emotional vigilance that has become part of daily life for many.

The emotional suffering described was not limited to anxiety and sadness but extended to a profound sense of emotional exhaustion. Respondents often expressed

feeling worn down by repeated attempts to support or reason with the affected family member, only to be met with disappointment or hostility. The absence of control over the situation left many feeling powerless, which, in turn, fed their emotional fatigue.

These findings are consistent with the broader literature on the emotional consequences of AUD within families. Scholars such as Orford et al. (2010) and Velleman and Templeton (2016) have documented the emotional trauma and psychological distress commonly experienced by families of those with substance use disorders. These studies, like the current one, illustrate that the emotional burden often parallels, and in some cases exceeds that experienced by the drinker themselves.

The Family Systems Theory provides a useful lens for interpreting these results. According to this framework, the family is viewed as an interconnected emotional unit, where changes or disruptions in one part of the system affect the whole. The presence of AUD in one member destabilizes the entire family dynamic, creating ripple effects that impact the emotional equilibrium of every individual. Emotional distress, therefore, is not isolated within the individual but becomes a shared experience — a systemic response to the dysfunction introduced by chronic alcohol misuse.

The cumulative effect of these emotional disruptions can lead to a breakdown in family cohesion, where communication becomes strained, trust erodes, and hope is gradually replaced by despair. It was evident that without intervention or support, many families are left to navigate this emotional landscape alone, often without the tools or resources to cope effectively. This study underscores the profound emotional suffering experienced by family members of individuals with AUD. These emotional effects align with existing literature, such as the work of Orford et al. (2010), which emphasizes the burden of emotional trauma carried by family members of substance users. According to the Family Systems Theory, such stress is systemic. Emotional

disturbances in one member disrupts the equilibrium of the entire family unit (Minuchin, 1974). The study confirms that unresolved AUD-related issues can trigger chronic stress across the family network.

Social well-being of family members

The presence of Alcohol Use Disorder (AUD) in a household not only destabilizes emotional well-being but also significantly impairs social functioning. This study revealed that family members of individuals struggling with AUD often experience various social challenges, including isolation, strained relationships, disrupted events, and financial stress, all of which erode their broader psycho-social well-being. Regression analysis of the social well-being indicators highlighted that financial strain emerged as the most significant predictor of social disruption among families, with a strong and statistically significant effect ($\beta = 0.416$, $p < 0.001$). Many respondents indicated that managing the consequences of AUD had led to depleted savings, increased debt, or dependence on extended family for financial support. This economic burden not only causes stress but also limits the family's ability to participate in social life, perpetuating exclusion and resentment.

Frequent quarrels within the household ($\beta = 0.329$, $p = 0.002$) and social isolation ($\beta = 0.288$, $p = 0.005$) were also strong predictors of deteriorating social well-being. Interviews captured the intensity of conflict within homes, often marked by arguments, emotional outbursts, or silent withdrawal. Families described a sense of walking on eggshells, avoiding social gatherings to prevent embarrassment or conflict. Additionally, disruption of family events ($\beta = 0.247$, $p = 0.010$) and avoidance of gatherings ($\beta = 0.164$, $p = 0.068$) contributed to the social breakdown, even if their statistical strength was comparatively lower. Events like birthdays, holidays, and weddings, usually moments of connection, became sources of dread or embarrassment.

Several respondents shared painful stories of weddings or family meetings being disrupted by the intoxicated relative, further eroding the family's social confidence and standing.

Loss of friendships ($\beta = 0.139$, $p = 0.099$) was also common, with many respondents reporting that their social networks had grown smaller or more distant over time. The stigma surrounding AUD, coupled with the unpredictability of the drinker's behavior, made it difficult for families to maintain connections, leading to a sense of isolation and abandonment. From the perspective of the Family Systems Theory, these findings emphasize that when one family member is entrenched in AUD, the family's broader relational system is destabilized. The family, as an emotional and social unit, becomes constricted and inward-looking, often closing itself off from extended networks in a bid to contain shame, manage conflict, and preserve internal stability. This pattern was evident in multiple narratives. Families reported pulling away from the community, either because they feared judgment or because they simply lacked the energy to maintain external relationships.

Coping strategies employed by family members

Faced with the multifaceted stressors associated with living with a loved one struggling with Alcohol Use Disorder (AUD), family members adopt a range of coping strategies to manage their emotional and social well-being. These coping mechanisms vary in effectiveness, and their selection often reflects the family's values, resilience, access to support, and level of disruption caused by the alcohol use. The regression analysis revealed that frank talk, personal interests, and self-care were statistically significant predictors of better psycho-social outcomes among family members. Frank talk ($\beta = 0.40$, $p = 0.005$) emerged as the most influential strategy. Families that prioritized open, honest conversations, whether within the family unit or with the

individual suffering from AUD—experienced lower levels of emotional distress and greater cohesion. Open dialogue appeared to restore a sense of agency among family members and reduced the emotional burden of secrecy and denial.

Equally impact, was the strategy of engaging in personal interests ($\beta = 0.33$, $p = 0.027$). Family members who immersed themselves in hobbies, work, or religious activities found these outlets essential for emotional restoration. Such personal pursuits provided a sense of identity beyond the care-giving role and enabled emotional distancing from the chaos surrounding the person with AUD. Self-care ($\beta = 0.36$, $p = 0.011$), such as getting adequate rest, attending church services, or joining support groups, also played a crucial role. Respondents who adopted self-care routines reported feeling more emotionally balanced and less reactive. These actions not only mitigated stress but also modeled resilience for other family members, especially children.

Conversely, strategies centered on avoidance and conflict were found to be less effective and even detrimental. While some respondents admitted to avoiding the person with AUD to preserve peace or sanity, this tactic often led to emotional detachment and unresolved tensions. Similarly, resorting to arguments or confrontations ($\beta = 0.15$, $p = 0.328$) frequently escalated household tensions without producing lasting change. Interestingly, strategies involving monitoring the person's behavior—such as checking where they went or hiding money—did not produce statistically significant improvements in psycho-social well-being. These reactive approaches, though well-intentioned, often bred mistrust and emotional exhaustion. Literature by Orford et al. (2010) supports this finding, suggesting that controlling behavior in addiction-affected families often leads to further strain rather than resolution.

The data clearly illustrated that families coping with AUD benefit most from strategies that promote open expression, individual growth, and emotional resilience. Conversely, strategies that center on blame, control, or emotional withdrawal tend to worsen the psycho-social strain. As such, interventions should focus not just on treating the individual with AUD, but also on equipping families with healthy, sustainable coping skills.

Strategies to mitigate the effects of alcohol use disorder on family well-being

The study revealed that a combination of personal, social, and systemic strategies is instrumental in mitigating the effect of Alcohol Use Disorder (AUD) on families. These strategies emerged from both the coping approaches adopted by family members and the extent to which formal and informal support systems were accessible. The most effective mitigation strategies revolved around fostering communication, building emotional resilience, and ensuring access to supportive services. These findings reflect a need for comprehensive, family-centered approaches in managing the psycho-social burden of AUD.

A prominent theme across the data was the role of effective communication in enhancing family cohesion and emotional stability. Open and consistent communication allowed family members to express their concerns and frustrations in constructive ways, thus reducing emotional suppression and isolation. Family systems theory (Minuchin, 1974) underpins this approach, emphasizing the importance of stable communication patterns in maintaining functional family structures. This dynamic facilitated collective problem-solving and enabled families to distribute emotional burdens more equitably.

Personal empowerment strategies, including self-care and the pursuit of individual interests, also emerged as vital. These strategies provided psychological

distance from the stress of living with an individual affected by AUD. Engaging in such activities allowed family members to develop a sense of agency; thus, contributing positively to their emotional well-being. Orford et al. (2010) highlight that such personal empowerment not only fosters resilience but also counteracts feelings of helplessness commonly reported among those affected by a family member's substance use.

The presence and utilization of formal and informal support systems constituted another key mitigation pathway. Formal support systems, such as counseling, psycho-education, and spiritual care, provided emotional validation and structured guidance. Informal networks, including extended family and peer groups, played a buffering role, stepping in to maintain stability when immediate caregivers were incapacitated by stress. This reflects the broader view of the Family Systems Theory, which holds that the family unit can adapt dynamically by drawing on its wider social ecosystem.

The study also found that economic pressures and social strain significantly undermine family well-being in AUD-affected households. Regression analysis confirmed that financial strain and frequent interpersonal conflict were among the strongest predictors of compromised social functioning. As such, strategies that mitigate these stressors are essential. These interventions do not merely address material needs; they also reduce tension and conflict, contributing to overall psycho-social stability.

Lastly, while emotional avoidance was generally unproductive, strategic avoidance of high-conflict scenarios proved beneficial. Learning to delay confrontation until sobriety returned helped prevent escalation and emotional fatigue. This aligns with coping frameworks described by Velleman and Templeton (2005), which advocate for the management of volatile interactions through de-escalation strategies. Such

approaches help preserve emotional resources, reduce harm, and support the long-term resilience of families navigating AUD-related challenges.

Conclusions

This study set out to investigate the psycho-social impact of Alcohol Use Disorder (AUD) on family members in Imenti North Sub- County, Meru County, with a focus on emotional and social well-being, coping mechanisms, and mitigation strategies. The results revealed a deeply entrenched and multidimensional problem as AUD is not only a personal affliction but a systemic family crisis with wide-ranging emotional, social, and relational consequences.

The findings point to emotional turbulence as one of the most immediate and persistent outcomes of AUD. Family members, particularly spouses, siblings, and parents, reported feelings of fear, helplessness, shame, and psychological exhaustion. Many lived under the constant burden of unpredictability, worry, and emotional strain, with some expressing symptoms that resemble clinical depression or anxiety. These effects were not isolated; they were pervasive and deeply rooted in the family's everyday experiences. These findings affirm that AUD destabilizes the emotional equilibrium of the family. The affected member's behavior becomes a point of systemic disruption, causing ripple effects that alter interpersonal relationships, emotional climate, and decision-making dynamics within the home.

Socially, the disorder fractured the family's internal and external networks. Families experienced social withdrawal, loss of respect within the community, and disruptions in social support. Some respondents reported being avoided by neighbors, losing friendships, or becoming isolated due to the shame associated with their relative's alcohol problem. This mirrors existing literature that highlights the stigma-by-association often carried by families of individuals with substance use disorders

(Orford et al., 2013). In some cases, social disintegration extended into the nuclear family itself—marriages strained to the breaking point, and children became emotionally detached or rebellious.

Financial consequences further compounded social and emotional stress. Resources were frequently diverted to fund the drinker's habits, manage crises (e.g., arrests, medical emergencies), or replace damaged property. Families often suffered economic hardship, which in turn intensified quarrels, resentment, and feelings of helplessness. Thus, emotional and social decline were not independent phenomena but intricately linked, each feeding into the other. Despite these challenges, families demonstrated remarkable resilience through diverse coping strategies. Some adopted positive strategies, such as open communication, self-care, religious faith, and emotional distancing for self-protection. Others, however, relied on maladaptive responses, including denial, suppression, and avoidance—strategies that may offer short-term relief but fail to address the root of the problem and sometimes exacerbate family breakdown.

Notably, regression results showed that positive coping strategies like frank talk, personal interests, and self-care significantly predicted better psycho-social outcomes. This suggests that emotional resilience and healthy coping can mitigate the damaging effects of AUD. However, such strategies require emotional resources, knowledge, and often, external support—which were not equally available to all families in the study. Families that had access to formal and informal support systems reported better adjustment, even amid ongoing struggles. This underscores the importance of a multi-sectoral support structure that can buffer the family from complete breakdown.

In conclusion, the study confirms that AUD is not merely an individual affliction but a chronic family stressor with far-reaching emotional, social, and economic consequences. The disease manifests in relational ruptures, emotional fatigue, and social stigma, all of which require collective and systemic responses. The findings challenge policymakers, health professionals, educators, and community leaders to move beyond individual-based interventions and to embrace family-centered support models that acknowledge the interdependence of family members. Only by addressing the emotional and social health of the family as a whole can we hope to mitigate the long-term psycho-social consequences of AUD.

Recommendations

Based on the study's findings, it is evident that mitigating the psycho-social effect of Alcohol Use Disorder (AUD) on families requires multilevel, integrated, and sustained interventions. The following recommendations are proposed for key stakeholders:

1. Within families and community networks, grassroots interventions can bolster resilience and cohesion. Strengthening peer support structures, such as community-based support groups for families of individuals with AUD, can provide emotional validation and a platform for sharing practical coping strategies. Promoting proactive coping methods—including frank communication, pursuit of personal interests, self-care practices, and seeking psycho-social assistance should be

prioritized over non-adaptive strategies such as emotional avoidance or chronic confrontation. Moreover, religious institutions and traditional cultural structures remain pivotal in many Kenyan communities and should be mobilized to provide support, reduce stigma, and foster family solidarity amidst the challenges of AUD.

2. At the policy level, government agencies have a critical role in institutionalizing family support mechanisms within national health frameworks. The Ministry of Health, alongside allied ministries, should develop and implement policies that mandate family involvement in rehabilitation efforts and allocate specific budgetary resources to support family counseling services. Furthermore, psycho-social support services must be subsidized, particularly in rural and underserved areas such as Imenti North, to ensure equitable access for vulnerable populations. A national awareness campaign should also be launched to demystify the impacts of AUD on families, reduce stigma, encourage early help-seeking behavior, and reframe AUD from a moral failing to a pressing public health concern.
3. Educational and research institutions must contribute to long-term solutions by mainstreaming content on substance use, family health, and mental health literacy into their academic programs. This will ensure that future educators, counselors, and healthcare professionals are equipped to address the multifaceted challenges posed by AUD within family settings. In addition, research institutions should invest in longitudinal studies to explore the extended psycho social trajectories of families affected by AUD. Particular attention should be given to children and adolescents in these households, whose experiences remain under-explored and who represent a critical demographic in breaking inter-generational cycles of addiction and trauma.

4. Collectively, these interventions underscore the need for a coordinated and compassionate approach that views families not merely as passive victims of substance use, but as central agents of change. Supporting the psycho-social well-being of families is both a moral imperative and a strategic necessity for national development. In doing so, Kenya can begin to dismantle the systemic harm caused by AUD, restore household stability, and nurture community resilience.

Recommendation for further research

While this study has provided valuable insights into the strategies for mitigating the effects of Alcohol Use Disorder (AUD) on the psycho-social well-being of families in Imenti North Sub- County, several areas emerged that warrant further investigation. The following are recommendations for future research:

i. Future research should focus on long-term outcomes of families that have undergone support interventions for AUD to assess the sustainability and effectiveness of various mitigation strategies over time.
ii. A deeper exploration into how AUD affects male-headed versus female-headed households differently could inform the development of gender-sensitive interventions and support mechanisms.
iii. More studies are needed to assess the psycho-social, educational, and behavioral outcomes of children living in households affected by AUD, as they are often the most vulnerable and overlooked.
iv. Research should be conducted to examine how national alcohol-related policies are implemented at the grassroots level, and their real-world effectiveness in mitigating the effect of AUD on families.

v. Further studies could explore how cultural norms and traditional practices in Meru County influence alcohol consumption patterns and the community's response to AUD, including help-seeking behaviors.

vi. Comparative research between Imenti North and other sub-counties or counties in Kenya could provide broader insights into regional differences and inform context-specific policy formulation.

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Appendix I: Informed Consent Form

Dear Participant,

Introduction and Purpose: My name is Benrogers Murithi Maitima I am a student at the Pan Africa Christian University pursuing a Master of Arts degree in Counselling Psychology. In fulfillment of the requirement for the course, I am undertaking academic research titled: "Effects of alcohol use disorder on the family psycho-social well-being in Imenti North Sub County, Meru County" The purpose of the study is to establish the effects of Alcohol use disorder on the family psycho-social well-being in Imenti North Sub County, Meru County.

Your involvement: If you choose to participate, you will be asked to complete a self- administered structured questionnaire. The questionnaire will include questions about your experiences and perceptions of how Alcohol Use Disorder (AUD) affects emotional well-being, social relationships, and coping mechanisms, both for yourself and within your family. Your responses will help deepen the understanding of the challenges families face in supporting youths with AUD. Your participation involves completing a brief questionnaire, which will take only a few minutes. You will receive the questionnaire and can complete it at your own pace in a private location of your choice.

Risk and Benefits: There are minimal risks associated with participating in this study. Some questions may evoke personal feelings or memories related to the effect of Alcohol Use Disorder (AUD) on emotional well-being, social relationships, and coping mechanisms within your family, which could cause temporary discomfort. However, you are not required to answer any questions that you find uncomfortable. The benefit of participating is that your insights will contribute to a better understanding of the challenges faced by families affected by youth AUD and the factors influencing

their stability.

Confidentiality: Your responses will be kept strictly confidential. All data will be stored securely and reported in aggregate form, so your individual responses will not be identifiable.

Voluntary Participation and Withdrawal: Participation in this study is entirely voluntary. Your decision to participate or not will not affect your relationship with the researcher or any organization. If you decide to participate, you may withdraw at any time before or during the research without any consequences.

Contact Information: If you have any questions about the study or need further information, please contact me on 0795212250 or write to ethicsreview@pacuniversity.ac.ke

Consent: I have read and understood the information provided above regarding the study. I understand that my participation is voluntary, and I am free to withdraw at any time without any penalty. I consent to participate in the study.

Participant's Signature: Date:

Appendix II: Family Member Questionnaire (FMG)

Section A: Background Information

Please tick or fill in where appropriate.

1. Sex: ☐ Male ☐ Female ☐ Other

2. Age: _____

3. Relationship to the youth:

☐ Mother ☐ Father ☐ Sibling ☐ Guardian ☐ Other (specify): _____

4. Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

5. Residence: ☐ Mjini ☐ Majengo ☐ Shauri Yako

6. Level of education:

☐ No formal education ☐ Primary ☐ Secondary ☐ Tertiary/College ☐ University

7. Occupation: _____

Section B: Emotional Well-being

Please indicate how often you experience the following feelings because of your family member's alcohol use.Scale: 1 –Never | 2 – Rarely | 3 – Sometimes | 4 – Often | 5 – Always

Statement	1	2	3	4	5
I feel anxious about their drinking.					
I feel overwhelmed when dealing with them.					
I often feel hopeless about their future.					
I have experienced depression or deep sadness because of them.					
I worry constantly about their safety or health.					
I find it hard to concentrate due to stress from their behavior.					
I struggle with sleep because of their drinking problems.					

Section C: Social Well-being

Statement	1	2	3	4	5
I avoid attending family gatherings because of them.	☐	☐	☐	☐	☐
I feel socially isolated because of stigma or shame.	☐	☐	☐	☐	☐
I have lost friendships or community respect due to their behavior.	☐	☐	☐	☐	☐
There are frequent quarrels in the family because of alcohol issues.	☐	☐	☐	☐	☐
Our family events are often disrupted or ruined.	☐	☐	☐	☐	☐
Their alcohol use has created financial strain in our home.	☐	☐	☐	☐	☐

Section D: Coping Strategies

What strategies do you use to cope with the effects of AUD?

(Tick all that apply)

☐ Praying or seeking spiritual help

☐ Talking to someone (friend, neighbor, counselor)

☐ Avoiding the person completely

☐ Engaging in personal hobbies or distractions

☐ Seeking help from authorities or health workers

☐ Withdrawing emotionally from family matters

☐ Others (specify): _____

Section E: Mitigating Factors / Support Systems

Statement	1	2	3	4	5
I have received help from a social worker or healthcare professional.	☐	☐	☐	☐	☐

I have accessed counseling or psycho-education on substance abuse.	☐	☐	☐	☐	☐
Friends or extended family have been supportive during difficult times.	☐	☐	☐	☐	☐
Community or religious organizations have offered meaningful assistance.	☐	☐	☐	☐	☐
I know where to get help if I need it.	☐	☐	☐	☐	☐
I believe more support structures are needed for families like mine.	☐	☐	☐	☐	☐

Section F: Additional Comments

If there is anything else you would like to share about your experience or suggestions for better support, please write below:

_____

Appendices III: Interview Guide for Family Members

Section A: General Background

Can you tell me about your family and your relationship with a young person who uses alcohol?

How long have they been using alcohol, and how did it start?

Section B: Emotional Well-being

How has their alcohol use affected you emotionally?

Have you experienced stress, anxiety, sadness, or trouble sleeping? Can you describe this?

What are the most difficult emotional moments you've faced?

Section C: Social Well-being

In what ways has your relationship with others (friends, neighbours, extended family) changed?

Have you or your family been excluded from community events or gatherings because of this situation?

Do you feel supported or judged by your community?

Section D: Coping Mechanisms

How do you manage or respond to the stress caused by their alcohol use?

What do you usually do when things feel overwhelming?

Have you ever tried to talk to the youth about their behavior? What happened?

Section E: Support Systems

Have you sought help from anyone—friends, community members, church, or professionals?

What kind of support has been most helpful to you, if any?

Are there services or people you wish you could access but haven't?

What changes would you like to see in your community or support systems to help families in your situation?

Appendix IV: Interview Guide for Local Chiefs

1. Emotional Well-being of Family Members

In your experience, how does alcohol use by a youth affect the emotions and mental state of family members?

Have you encountered family members expressing signs of stress, anxiety, depression, or emotional exhaustion?

Are there any common complaints or emotional reactions that family members report when seeking your help?

2. Social Well-being of Family Members

In what ways does alcohol use by a youth affect the family's social relationships or position in the community?

Have you observed cases where families become socially isolated, avoid gatherings, or face community stigma?

Are there family conflicts or disruptions (e.g., quarrels, threats, neglect, financial strain) that you can link to alcohol use in youths?

3. Coping Strategies Employed by Family Members

Based on your interactions, what are some of the ways families try to deal with a youth's alcohol problem?

- Do they confront the issue directly?
- Do they try to ignore or avoid the issue?
- Do some turn to prayer, hobbies, or emotional withdrawal?

How effective do you think these strategies are?

4. Mitigating Factors / Support Systems

What formal support systems (e.g., counseling, medical help, government programs) are available to these families?

Are there informal support networks, such as religious groups, friends, or extended family, that provide help?

What role do you or your office play in helping families cope with alcohol-related issues?

5. Reflections and Recommendations

What challenges do you face as a local administrator in addressing the effects of alcohol use among youth?

What support do you think would help improve the psycho-social well-being of families affected by AUD in your area?

Are there policies or community initiatives you would recommend?

Appendix V: Focus Group Discussion Guide

What are some common issues that families in this area face with young people?

In your experience, how common is alcohol use among youths in this community?

1. Emotional Well-being

How does the alcohol use of a young family member affect your emotional health?

Have you or others experienced anxiety, depression, or hopelessness as a result?

What are some of the hardest emotional challenges you've faced in this situation?

2. Social Well-being

How does alcohol use by a youth affect your relationships with others in the family?

Have you experienced social withdrawal, stigma, or isolation from your community?

How does the problem affect daily family routines and gatherings?

3. Coping Strategies

What are some ways you and your family try to deal with the situation?

Have you ever turned to prayer, hobbies, or other activities to cope?

4. Mitigating Factors / Support Systems

Have you received any help from local leaders, churches, friends, or counselors?

What kind of support has been helpful, and what support do you wish was available?

Are there services in the community that you would recommend to others?

If you could tell community leaders one thing to improve the lives of families dealing with alcohol use, what would it be?

What gives you hope or strength when dealing with these challenges?

Appendix VI: Research Permit

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **313851**

Date of Issue: **20/March/2025**

RESEARCH LICENSE



This is to Certify that Mr.. BENROGERS MURITHI MAITIMA 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 Meru on the topic: EFFECTS OF ALCOHOL USE DISORDERS ON THE FAMILIES' PSYCHOSOCIAL WELLBEING IN IMENTI NORTH SUBCOUNTY, MERU COUNTY. for the period ending : 20/March/2026.

License No: **NACOSTI/P/25/417072**

313851

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

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

See overleaf for conditions

Appendix VII: Research Letter

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

7th March 2025

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION & ETHICS CLEARANCE LETTER FOR MAITIMA BENROGERS MURITHI REG. NO: MACP/21939/0/21

Greetings! This is an introduction letter for the above named person a final year student at Pan Africa Christian University (PAC University), pursuing a Masters of Arts in Counseling Psychology.

He is at the final stage of the programme and therefore preparing to collect data to enable him finalize on the thesis. The thesis title is ***"Effects of Alcohol Use Disorders on The Families' Psychosocial Wellbeing in Imenti North Subcounty, Meru County"***

We kindly request that you allow him obtain a research permit so as to proceed and collect data to inform his research from Selected families in Imenti North Subcounty, Meru County, Kenya.

Warm Regards,

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

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Appendix VIII: ISERC Approval Letter

Pan Africa Christian University

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REF: PAC/ISERC/79/03/25 Date: 07/03/2025
TO: BENROGERS MURITHI MAITIMA
PAC UNIVERSITY

Dear Madam,
RE: EFFECTS OF ALCOHOL USE DISORDERS ON THE FAMILIES' PSYCHOSOCIAL WELLBEING IN IMENTI NORTH SUBCOUNTY, MERU COUNTY

This is to inform you that PAC_ *ISERC* has reviewed and approved your above research proposal. Your application approval number is PAC/ISERC/79/12/25. The approval period is 7th March 2025 – 20th March 2026.

This approval is subject to compliance with the following requirements;

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

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

Yours sincerely,

Dr. Jane Kinuthia

Chair, ISERC