

**FAMILY ATTRIBUTES ON ALCOHOL USE-DISORDER AMONG
RECOVERING CLIENTS IN SELECTED REHABILITATION CENTERS
WITHIN NAIROBI CITY COUNTY, KENYA**

MARYPIAH WAIRIMU GATURA KURIA




**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENT FOR THE AWARD OF DOCTOR OF PHILOSOPHY
DEGREE IN COUNSELLING PSYCHOLOGY OF
MOUNT KENYA UNIVERSITY**

APRIL 2024

DECLARATION AND APPROVALS

This thesis is my original work and has not been previously presented for any other award or conferment in any other institutions.

Signed..........Date 15/04/2024

Marypiah Wairimu Gatura Kuria

REG NO. PhDCOUNS/2014/62550

This thesis has been submitted for examination with our approval as University supervisors.

Signed..........Date 16/04/2024

Dr. Florence S. A K'Okul

Senior Lecturer

Department of Psychology, Humanities and Languages

Mount Kenya University

Signed..........Date 17/04/2024

Dr. Elijah Kirimi M'Arimi

Senior Lecturer

Department of Psychology, Humanities and Languages

Mount Kenya University

DEDICATION

This thesis is dedicated to you, my family for all you did for me to get here. I'm truly indebted. Thank you and God bless.



ACKNOWLEDGEMENTS

The completion of this thesis is attributed to divine favour, love, and wisdom from the Almighty. I extend my deepest gratitude to my supervisors, Dr. Florence K'Okul and Dr. Elijah Kirimi M'Arimi, for their invaluable guidance, support, and encouragement throughout this journey. Special thanks to Caleb Kuria and Daniel Kuria for typesetting and proofreading work, and to Peter Kuria Njuguna for his technical support in ensuring stable internet access. To the staff, in the Dean, School of Social Sciences office, for the timely feedback and guidance. Special appreciation to Mr. Isaac Kipsang (librarian), for his dedication towards helping me access relevant secondary materials, and Mr. Kevin Odhiambo Aoko for the development of auto-generated references. Much thanks to Mr. Agoi Onzere for providing psychosocial support during data collection. Finally, to my colleague lecturers of Mount Kenya University, and my family for their unwavering support. God bless you all.

ABSTRACT

Alcohol Use Disorder (AUD) is a burden to individuals, families, and the society. In most societies, the first socialization is mainly the family; particularly parents. This study assessed the influence of family attributes on AUD among recovering clients in selected rehabilitation Centers in Nairobi City County, Kenya. The objectives of the study were; to find out the influence of family culture on AUD among recovering clients, to examine the extent family socio-economic status influence AUD, to investigate the influence of parenting styles on AUD, and lastly to assess the influence of family alcohol use on AUD. The study was guided by three interrelated theories; the Family System Theory (FST), Social Learning Theory (SLT), and Choice Theory (CT). *Ex post facto* research design guided the study with a target population of 187 recovering clients composed of 161 males and 26 females. Following Krejcie and Morgan's (1970) table of sample size determination, the sample size (n =152 males) and (n = 26 females). The representative sample was attained by using Stratified and Simple Random Sampling methods. Pilot study was conducted in Kiambu County in NACADA accredited rehabilitation Centers to determine the validity of the data collection tools while the Split-half method was used to determine the reliability of the research instruments. A reliability level of 0.79 was accepted for the study. Qualitative data was collected through Focus Group Discussion (FGD), and analysed using the content analysis under themes in line with the study objectives. Quantitative data was collected using 5-point Likert structured questionnaires. Data collected from the field was analysed using descriptive and inferential statistics. Inferential statistics involved hypothesis testing through the Statistical Package for Social Sciences (SPSS) version 25 for windows. Pearson's correlation Coefficient and Chi-square tests were used to test the hypotheses and generate relationships between variables. The level of statistical significance was $p = .05$. Respective test results showed that, family culture, family socioeconomic status, family alcohol use, as well as parenting styles had significant correlation with alcohol use disorder exhibited by recovering clients in selected rehabilitation Centers within Nairobi City County, Kenya. The researcher recommends abstinence from alcohol use if there is a family member suffering from AUD, education on productive financial management and the training in effective parenting styles. Following these finding, the researcher also recommended more studies on personal factors and alcohol use disorder, and the protective factors against AUD.

TABLE OF CONTENTS

DECLARATION AND APPROVALS	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
ABSTRACT	v
LIST OF TABLES	ix
LIST OF FIGURES	xii
LIST OF ABBREVIATIONS AND ACRONYMS	xiii
CHAPTER ONE: INTRODUCTION	1
1.1 Background to the Study	1
1.2 Statement of the Problem	6
1.3 Purpose of the study	7
1.4 Objectives of the Study	7
1.5 Research Hypotheses	7
1.6 Justification/ Significance of the Study	8
1.7 Scope of the Study	9
1.8 Limitations of the of the Study	10
1.9 Delimitations of the Study	10
1.10 Assumptions of the Study	11
1.11 Operational Definition of Terminations	11
CHAPTER TWO: LITERATURE REVIEW	13
2.1 Introduction	13
2.2 Family Culture and Alcohol Use Disorder	13
2.3 Family Socio-economic Status and Alcohol Use Disorder	18
2.4 Parenting Styles and Alcohol Use Disorder	23
2.5 Family Alcohol Use and Alcohol Use Disorder influences	29
2.6 Theoretical Framework	33
2.6.1 Family System Theory.	33
2.6.2 Social Learning Theory	35
2.6.3 Choice Theory	36
2.7 Conceptual Frame Work	36
2.8. Recap of the Literature Review	38
CHAPTER THREE: RESEARCH METHODOLOGY	40
3.1 Introduction	40
3.2 Research Design	40
3.3 Location of the Study	40
3.4 Target Population	41

3.5 Sampling procedures and Techniques:	42
3.6 Sample Size	43
3.7 Research Instruments	43
3.8 Piloting of the Research Instruments	44
3.8.1 The Validity of the Questionnaires	45
3.8.2. Reliability of the Research Instrument	46
3.9 Data Collection Procedures	46
3.10 Data Analysis	47
3.11 Ethical Considerations	49
CHAPTER FOUR: RESEARCH FINDINGS ANALYSIS AND PRESENTATION	51
4.1 Introduction	51
4.1.1 Response Rate of the Respondents	51
4.1.2 Demographic Data	52
4.2 The impact of family culture on alcohol use disorder among individuals undergoing rehabilitation in selected Centers located in Nairobi City County.	56
4.3 Influence of Family Socio-economic Status on Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers located within Nairobi County.	74
4.4 Influence of Parenting Styles on Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers located within Nairobi County.	94
4.5 Influence of Family Alcohol Use on Alcohol Use Disorder among Recovering Clients in selected rehabilitation Centers in Nairobi county Kenya	110
CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	140
5.1 Introduction	140
5.2 Summary of the Study	140
5.3 Conclusions	145
5.4 Recommendations for the Authorities for Implementation	146
5.5 Service Users or Beneficiaries.	146
5.6 Other Stakeholders	146
5.7 Further Research	147
REFERENCES	147
Appendices	157
Appendix 1: NACADA Accredited Rehabilitation Centers in Kiambu County ...	157
Appendix 2: Psychosocial Support Plan	160
Appendix 3: Questionnaire for the Alcohol Recovering Clients	161
Appendix 4: ERC Certificate	181
Appendix 5: Introduction Letter	182
Appendix 6: Research License	183

Appendix 7: Authority for data collection at Precision Counselling & Rehabilitation Home186
Appendix 8: Introduction Letter from the Researcher to the Respondents.....187
Appendix 9: Consent Form for Recovering Clients in Selected Rehabilitation Centers188
Appendix 10: Map of Nairobi County.....189
Appendix 11: Similarity Index.....190



LIST OF TABLES

Table 1 Target Population of the Recovering Clients in the Rehabilitation Centers in Nairobi County.....	42
Table 2 Sample Size for the Study.....	43
Table 3 Data analysis Tools.....	48
Table 4 Response Rate of the Respondents.....	51
Table 5 Age at which the respondents started using alcohol and alcohol use disorder ..	53
Table 6 Living arrangement for the respondents before they were 18 years old.....	55
Table 7 Father’s relationship with their off springs.....	57
Table 8 Mother’s relationship with her off springs and alcohol use disorder.....	59
Table 9 Sibling’s Relationship and Gender.....	62
Table 10 Family Members ’Emotional Support and Gender for the Recovering clients	66
Table 11 Family Culture and Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers located within Nairobi County.....	69
Table 12 Chi-Square test Results for Family Culture and AUD.....	73
Table 13 Living Arrangements and Respondents’ Highest level of Education Completed.....	77
Table 14 Living arrangements and respondents’ monthly income in Kenyan shillings, before developing AUD.....	79
Table 15 Respondents’ living arrangements before they were 18 years old and living structures for the recovering clients.....	81
Table 16 Respondents’ age at which they started alcohol use and the highest level of Education completed by the recovering clients.....	82
Table 17 Respondents’ age at which they started alcohol use and their income before they got into AUD.....	84

Table 18 Respondents' age at which they started alcohol use and the highest level of Education completed by their father	86
Table 19 Descriptive statistics of the respondents' age in years at which they started alcohol use and the highest level of Education completed by their mother.....	88
Table 20 Highest education level and Alcohol use disorder among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya	90
Table 21 Chi-square test result for family socio-economic status and Alcohol Use Disorder among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya	93
Table 22 Descriptive statistics (percentages and frequencies) of father's parenting styles and gender	95
Table 23 Descriptive statistics (percentages and frequencies) of mother's parenting styles and gender	101
Table 24 Relationship between parenting styles and alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi county Kenya....	107
Table 25 Pearson Chi-square results for parenting styles and AUD among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya....	110
Table 26 Descriptive statistics on family alcohol use and Gender for the recovering clients in selected rehabilitation Centers located within Nairobi County.....	111
Table 27 Relationship between Family Alcohol Use and Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers in Nairobi County	117
Table 28 Chi-square tests Results for Family Alcohol Use and AUD among the Recovering Clients in selected rehabilitation Centers in Nairobi county Kenya..	120
Table 29 They took larger amounts of alcohol than they intended.....	120

Table 30 They persistently desired to cut down or regulate alcohol use but still went back to alcohol	123
Table 31 They spent most of their productive time on alcohol related activities	124
Table 32 They experienced an intense desire or urge for alcohol when they were in an environment where they previously got alcohol from	127
Table 33 They failed to accomplish their main social, academic or official responsibilities	130
Table 34 They continued the use of alcohol despite having persistent or recurrent social or interpersonal problems caused by the effect of alcohol.....	131
Table 35 They needed increased amount of alcohol to experience the previous intoxication.....	134
Table 36 If they reduce or did not take alcohol, they experienced the withdraw symptoms	137

LIST OF FIGURES

Figure 1: Relationship between Families' Attributes and Alcohol Use Disorder.....	38
Figure 2 : Diagrammatic representation of respondents' age during the data collection.....	52
Figure 3: Diagrammatic representation of the respondents' highest education level completed	75
Figure 4: Diagrammatic representation of the respondents' highest education level completed	76



LIST OF ABBREVIATIONS AND ACRONYMS

AUD:Alcohol Use Disorder

BIS:Barratt Impulsiveness Scale

CDC:Centre for Disease Control and prevention

CT:Choice Theory

DSM-5:Diagnostic and Statistical Manual of Mental Disorders

FGD:Focus Group Discussion

FST:Family System Theory

HED:Heavy Episode Drinking

MoHSS:Ministry of Health and Social Services

NACADA:National Campaign against Drug Abuse

NACOSTI:National Commission for Science Technology and Innovation

PPMCC: Pearson product moment correlation coefficient

PRSIP: Persistent or Recurring Social or Interpersonal Problems

SES:Socio-economic Status

SLT:Social Learning Theory

UNIDC: United Nations International Drug Control

UNODC:United Nations office of Drug Abuse and Crime

WHO:World Health organisation

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Alcohol Use Disorder (AUD) has been realized to have symptoms and progression that can be predicted and influenced by the person's genes and life situation just like many other diseases (Agostinelli & Grube, 2005). Individuals diagnosed with AUD must meet certain principles delineated in the Diagnostic and Statistical Manual of Mental Disorders [DSM -5] (DSMMD). The severity of Alcohol Use Disorder is determined by the extent to which the individual meets the established criteria. This can range from mild to moderate to severe. The National Health Survey estimates that around 9% of men in the UK and 3% of UK women show signs of AUD (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001). This means that consuming alcohol became so important, or at times the most significant factor in their life, such that the individuals with signs of Alcohol use disorder could not function without Alcohol.

Signs of alcohol use disorder reported by Babor, Higgins-Biddle, Saunders, and Monteiro (2001) concur with those in DSM-5 2013. However, Grant, et al. (2017) observed that there has been a rise in high-risk alcohol consumption behaviour in the United States from 65.4% to 72.7 % among women as compared to the reported increase from 49% to 69% among men within 12 months. The same increase of 65.4% to 72.7 % among women and 49% to 69% among men within 12 months was reported concerning Alcohol Use Disorder (AUD) in the same year. This means that almost all of those involved in alcohol consumption developed AUD. Leung, Britton and Bell (2016), in their study points out that children with family history of problematic alcohol use demonstrate more escalation of alcohol use, and more often develop AUD than children without family history of the said disorder. The study observes that family attributes and the risk of developing AUD is positively associated with family drinking habits., parenting styles, family culture, and

family socioeconomic status. This observation prompted a heightened interest in exploring the contribution of familial characteristics to the onset of AUD among recovering clients who were alcohol addicts before starting on the treatment and recovery from AUD. According to Carter, Brandon, and Goldman (2015), the U.S. surgeon general advocated for a strict policy towards youth alcohol consumption in Nevada, which prioritizes complete abstinence, harsh repercussions, and the unlawful nature of underage drinking.

According to a survey conducted by the American Medical Association in 2010, certain parents administered alcohol to their offspring despite undergoing surgical interventions. The study, observed that a quarter of children participated in a gathering where alcohol consumption by minors and parents was present. This implies that the phenomenon of minors consuming alcohol in the presence of their parents could be attributed to either the family's cultural norms or the style of parenting employed by the parents.

A research done by Ewing, et al. (2015) on effects of adults and peers on adolescents' illicit substance use found that improved family involvement into their children's activities was not a shielding factor from the use of illicit substance as compared to having an integral nuclear family. Furthermore, the researchers noted that participants who were living with both parents reported less use of alcohol and other drugs than those living under different arrangements. The study observed that participants who adhered to their family values used illicit substance less than those who had no value for their family principles. This means that consistent family system was important as compared to some reactive ones where family cohesion improved depending on the circumstances in the family system.

According to a study done by Fernandez-Hermida, Calafat, Becoña, Tsertsvadze, and Foxcroft (2022), within 30 years on the role of parenting styles in their off springs'

alcohol use and abuse, indicated that parenting with authority exhibits greater efficacy in mitigating alcohol consumption and misuse compared to alternative parenting styles. However, the study did not investigate the development of alcohol use disorder. The review demonstrates that neglectful parenting style on the other hand is the least protective style on alcohol consumption and misuse. On the other hand, as a contrasting viewpoint, for instance, among the Asian and Arabic cultures, the authoritarian parenting style is associated with more positive behaviours with reduced alcohol use and abuse.

Results from research conducted in five Western Cape Provinces of South Africa among farmworkers to investigate alcohol use patterns indicate that men use alcohol more than women. It was also observed that binge drinking was the norm during the weekend among men. When farm labourers were compared with other workers in the farms, results indicated that the labourers exhibited a higher propensity for engaging in excessive drinking behaviour in comparison to other employees (Gossage, 2014). In the same study, it was also reported that labours were younger than the other workers with an average of two years, less educated, and live in the less developed part of their region.

As indicated in Gossage (2014), low-income people misuse alcohol more than high-income people. These findings are in contradiction with Necho (2020) who reports a higher prevalence of AUD among HIV/AIDS patients in South Africa as compared to those in Uganda. Although African news (2023) ranks South Africa relatively higher in economic development as compared to Uganda the Alcohol use disorder is prevalently higher in South Africa compared to Uganda. According to Gossage (2014), African HIV/AIDS patients had greater rates of AUD than the overall population. The contradicting results creates a need to assess the correlation between socio-economic status and AUD among recovering clients. Results from a research by to Abdu-Raheem's (2013) exhibit that, there exists a significant association between inconsistent punitive

disciplinary measures and the development of AUD. Abdu-Raheem (2013) established that change of parents' marital status, different and unreliable caregivers are factors associated with unacceptable behaviours including alcohol use disorder. These findings were consistent with FST which assumes that in a dysfunctional family system, the parents and their offspring engage in repetitive and negative interactions which may contribute to alcohol use disorder implying that such interactions are based on miss conceptualised goals that motivate both parents and their offspring towards specific behaviours, either acceptable or unacceptable in the general society.

In Uganda, Kabwama (2016) investigated on better understanding of family culture and AUD. The study established that alcohol use among men was connected to manhood, societal liberation, and home accountabilities. However, among girls, it was linked to being disrespectful and rebellious to gender roles which were associated with social punishment. Kabwama (2016) also observed that as the age of participants' increase, the use and abuse of alcohol increases as well which might result in Alcohol use disorder development implying that the researcher attributes the increase of alcohol use and abuse to factors such as the decline in health or employability, and communally acceptance of alcohol use. This means that health and employability decline may place individuals in a lower socio-economic status that might be stressful hence increasing alcohol intake and subsequently AUD.

In Kenya Birech (2013) did an investigation on gender as one of the aspects of family culture associated with alcohol abuse among family heads within the Nandi community. The results indicate that punitive fiscal circumstances, change in cultural practices, breaking down of sacred and traditional morals played a major role in alcohol abuse and

AUD development among the family heads. This study assessed the relationship between socio-economic factors, family culture, and family alcohol use. Additionally, Hassan (2013) shows that family or parental alcohol tolerance often increases youths' uncontrolled alcohol usage in Nairobi County. The study found that adolescent drinking in and out of the house was affected by parental monitoring. However, much still needs to be done since most empirical studies have not interrogated the direct causal link between other family attributes on Alcohol use disorder amongst the recovering clients.

It is worth noting that, alcohol use disorder can be demonstrated by individuals' taking higher quantity of alcohol and for a longer time than planned and trying to reduce or stop the alcohol use unsuccessfully. It can also be proven by spending a lot of time in activities related to obtaining, using or recovering from alcohol related effects (Bergland, 2015).

In addition, he also reported that alcohol use disorder is also characterised by craving, poor performance in personal, social, and health responsibilities. AUD progresses to tolerance and withdrawal. Diagnostic and Statistical Manual of Mental Disorder (DSM-5) (2013) describes AUD as an alcohol use habit characterized by the manifestation of two or more of the behaviours indicated below when they occur within the same twelve months' period. The behaviours include; an individual consuming more alcohol than intended with unsuccessful attempts to stop or reduce the amount of use. The person experiencing craving continues to drink even when a failure in major responsibilities and obligations results in interpersonal problems, health problems, and dangerous behaviours. Tolerance and withdrawal symptoms are also characteristics of AUD. Children with a family history of Alcohol use disorder demonstrate more escalation of alcohol use, and more often they develop AUD than children without a family history of the said disorder (Leung, Britton, & Bell, 2016). These findings concur with Social Learning Theory and Family System Theory but contradicts the Choice Theory.

SLT and FST argue that behaviours are acquired through social interactions while CT maintains that behaviours are acquired by choice. The study assessed if Alcohol use disorder is a result of social interactions or personal choice. It has been demonstrated that neglectful parenting style is the least protective from alcohol use and abuse (Becoña, et al., 2011). However, (Abdu-Raheem, 2013) indicates a positive relationship between punitive inconsistent discipline and alcohol use disorder. This study assessed the role of family attributes on alcohol-use disorder among recovering clients in selected rehabilitation Centers in Nairobi county Kenya.

1.2 Statement of the Problem

Global data estimates that, 237 million men and 46 million women have alcohol use disorders (AUDs) (Kamenderi, 2022). Furthermore, studies revealed that 5.9 percent of deaths worldwide are Alcohol use disorder related (World Health Organization, WHO 2014). In addition, the National Hospital Insurance Fund's (NHIF) reported that between 2017- 2019 the organization spent Kenya shillings 65.3 million for alcohol-related treatments including the inpatient recovering clients' treatment bills. World Health Organization (WHO) 2018 reports that 4 percent of all deaths in Kenya in 2016 were alcohol abuse-related and most of them from Nairobi County. However, studies such as Kamenderi (2022) focussed on the status of alcohol use disorder and related elements among the civil servants in Kenya. Also Mwanza (2019) in kibera slums investigated the relationship between perceived ethical parenting styles and alcohol abuse among the youth in Kibera constituency. Mwanza (2019) reports that Nairobi County has the highest number of alcohol abusers at 18.4% of all alcohol abusers in Kenya. In addition, Feasibility study conducted during this study in selected Rehabilitation Centers in Nairobi county had reviewed that individuals suffering from alcohol use disorder ranged from nineteen years to fifty years both male and female. Findings from the feasibility study

conducted in selected Rehabilitation Centers around Nairobi indicated that most (62.5%) of the recovering clients had relapsed and only (37.5% were being rehabilitated for the first time. Relapse makes treatment of Alcohol use disorder very expensive, hence making prevention a more productive way of managing Alcohol disorder in Kenya. Despite these studies, there is still limited information on alcohol use disorder. Therefore, this study sought to investigate family attributes and alcohol use disorder in recovering clients in selected rehabilitation institutions in Nairobi County, Kenya.

1.3 Purpose of the study

The purpose of this study was to investigate family attributes on alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi County Kenya

1.4 Objectives of the Study

The study was guided by the following objectives:

- i. To find out the influence of family culture on alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi County, Kenya.
- ii. To examine the extent of family socio-economic status influence alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi County, Kenya.
- iii. To investigate the influence of parenting styles on alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi County, Kenya.
- iv. To assess the influence of family alcohol, use on alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi County, Kenya.

1.5 Research Hypotheses

The hypotheses of this study were:

Ho1. There is no statistical significant relationship between Family Culture and Alcohol Use Disorder among the recovering clients in selected rehabilitation Centers in Nairobi County Kenya

Ho2. There is no statistically significant relationship between Family Socio-economic Status and Alcohol Use Disorder among the recovering clients in selected Rehabilitation Centers in Nairobi county Kenya.

Ho3. There is no statistically significant relationship between parenting style and Alcohol Use Disorder among the recovering clients in Rehabilitation Centers in Nairobi county Kenya.

Ho4. There is no statistically significant relationship between Family Alcohol use and Alcohol Use Disorder among the recovering clients in selected Rehabilitation Centers in Nairobi County, Kenya.

1.6 Justification/ Significance of the Study

World Health Organization report indicates a causal relationship between harmful use of alcohol as demonstrated by Alcohol use disorder and a wide range of mental and behaviour disorders (WHO, 2018). The report further observes that 5.3% of all global deaths are associated with detrimental consumption of alcohol and to a greater degree due to its Psychoactive and dependency properties.

Kaur and Ajinkya (2014) report that children whose parents are suffering from Alcohol use disorder are more likely to experience conduct such as, major depressive and substance use disorders including alcohol use disorder. Having children with the above-mentioned disorder might make the family and society unhealthy. In addition, Kamende (2016) observes that Nairobi County has the highest occurrence of alcohol use in Kenya at (17.5%) which can develop to Alcohol use disorder. This might be as a result of Nairobi County being a central point for many businesses, advanced technology, decline of cultural value systems, and fast-evolving ways of life. Managing Alcohol use disorder is best if handled not only at a controlling level but also by preventing development of alcohol-taking behaviour at the family level. However, the treatment of addicts is

expensive due to the relapsing nature of Alcohol use disorder making it out of reach to most common Kenyan citizens.

Although the government institutions have developed policies and guidelines to control the abuse and harmful use of alcohol, alcohol-dependent persons are still seen in the society. Therefore, this study examined family attributes and alcohol use disorder in recovering clients in selected rehabilitation institutions in Nairobi County, Kenya. Thus, the study findings may contribute to the body of knowledge in that the researchers may use the information of this study as reference for future research in areas related to family attribute and alcohol use disorder. The study may be beneficial to the recovering clients because they may use the information to avoid relapse.

The study also may be useful to NACADA to enforce their sensitizations on issues concerning alcohol use disorder in work places schools and community at large. The finding may be useful to the ministry of health in developing more preventive as compared to curative policies. Through the ministry of health, the government may use the findings to formulate policies which may strengthen the counselling and mental health departments to offer psycho social support to the recovering clients and the affected members of the society. The findings may be beneficial to the community members who may offer social support to the recovering clients without criminalizing.

1.7 Scope of the Study

This study examined family attributes and alcohol use disorder in recovering clients in selected rehabilitation institutions in Nairobi County, Kenya. It was conducted in selected rehabilitation Centers in Nairobi County with a population of about 200 recovering clients in the month of June 2022. The population of recovering clients was used because they were believed to have met the criteria of alcohol use disorder. The study focused on the following variables: parenting styles, family culture, family

economic status, and family alcohol use. The research design utilized in this study was *ex post facto*.

The present investigation employed questionnaires and Focus Group Discussion (FGD) as data collection tools to obtain qualitative as well as quantitative information from the recovering clients. FGD was used to collect qualitative information from the recovering clients. The researcher used FGD because it gave room for discussions on the study objectives to generate participants' knowledge, interpretations, philosophies, and implications. It also allowed explorations for in-depth and detailed content after developing a working rapport with the participants which helped to sustain the FGD on developing new comprehensions that were relevant to the study objectives.

1.8 Limitations of the of the Study

The study did not encompass the entire alcohol recovering clients in the Country but only those in the list of NACADA accredited rehabilitation Centers in Nairobi County. The population of recovering clients in most of the sampled rehabilitation Centers during the study had relatively reduced due to the economic difficulties following the global COVID-19 health problem. Sample and population size reductions were expected to impair national representation accuracy. Most of rehabilitation Centers in Nairobi are private entities with different protocols which impeded the research work plan. Alcohol use disorder recovering clients either experience stigma from the society or they perceive some kind of stigmatization making some opt out of the research

1.9 Delimitations of the Study

The researcher limited the study to residential alcohol recovering clients and not any other recovering client to ensure consistency of the sampled participants. This study was guided by three interrelated theories, which are; the (FST), (FLT), and (CT) using *Ex post*

facto research design. Nairobi County population was used because it was more heterogeneous than homogenous as compared to most other County making the sampled respondents a reflection of the larger population. Data collection was done within the permitted timelines by National, Commission for Science, Technology and Innovation. The study employed a simple random sampling method to ensure that all potential respondents had a fair chance to be included in the sample.

1.10 Assumptions of the Study

The assumption was made by the researcher that

- i) The participants responded to all the items with honesty with no biases and sincerely participated in the study just for the study purposes without any other interest and the population in the rehabilitation Centers was heterogeneous.
- ii) It was also assumed that the respondents were cognizant and capable of deliberating on alcohol use disorder and willingly shared their personal experiences honestly during the FGD.

1.11 Operational Definition of Terminations

Alcohol Use Disorder: A behaviour where an individual consumes, with a preoccupation of alcohol despite the well-known problems associated with the behaviour.

Busaa: Alcoholic drink brewed from fermented grain flour.

Chang'aa: An alcoholic drink made by distilling then condensing alcoholic vapour.

Client: An in-patient individual in a rehabilitation center undergoing treatment and recovering from alcohol use disorder.

Family: Parents, siblings, and members of extended families before the respondent attained the age of 18 years.

Family Alcohol Use: A state where the family members of the respondents consume alcohol for personal reasons and the behaviour does no harm to him or her including their significant others.

Family Attributes: Parental socio-economic status, parenting styles, family cultural beliefs, parental level of education, and family abuse of alcohol.

Family Culture: It is the conduct, traditions, performs, and standards one's family has. The distinguishing factor that sets apart a particular family from all other families across the globe. It is a family distinctiveness, reliable practices, principles, and ideals that identifies a family.

Family Socio-economic Status: The term refers to the cumulative fiscal and sociological value of an individual's work experience, as well as their monetary and collective position in relation to others, whether as an individual or as part of a family unit.

Investigation: Process of collecting data to find out the facts about alcohol use disorder in order to determine what caused it.

Parenting Styles: These are psychological concepts that represent approaches and activities applied by parents when taking care of their children.



CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This section has several sub-topics guided by the study objectives. The sub-topics reviewed include; parenting styles, family culture, family social economic status, and Family Alcohol use behaviours. Theoretical framework, Conceptual framework as well as recap of literature reviewed are similarly tackled in this chapter.

2.2 Family Culture and Alcohol Use Disorder

Family culture involves all that is important to the family members and what makes a family different from others. Important factors in a family culture may include morals, religious values and opinions, emotional state, and duties among others. Such aspects when shared among a social group that is related, they become their family culture

(Pullen, 2017). Families have the responsibility of passing their culture onto future generations and helping them in understanding, appreciating, and seeing mistakes in their cultural settings as learning opportunities. In the US, Netherlands and Great Britain, it has been observed that cohabiters have more problems with alcohol use in contrast to the entire population (Joutsenniemi, et al., 2007).

In another report on family culture Tsampanli-Kitsara and Frrokaj (2016), revealed that sibling relationships develop negative emotions when one of the siblings gets into alcohol use and abuse. Destruction of sibling relationships by alcohol use might push the one using it into alcohol and similar issues such as AUD. Sibling relationships are generally both loving and conflicting, but the introduction of alcohol use reduces the warmth while conflict might increase. A sibling who does not abuse alcohol might experience isolation and rejection among other negative emotions much more from the parents. This leads them to develop a competitive relationship with the sibling using alcohol which worsens the conflict among them. Subsequently, alcohol use might increase, which results to worsened alcohol-related problems including Alcohol use disorder. This agrees with the family system theory which posits that individuals' behaviours are influenced by those of other family members. Additionally, the study argues that when a sibling or siblings get into Alcohol use disorder, others experience loss and mourn the loss of relationship they experienced before the development of the disorder. These findings are in agreement with Philip, Ford, Henry, Rasmus, and Allen (2016) who argues that trust in the social network made up of the nuclear and extended family members was safeguarding against AUD.

Researches have also revealed that most of the female population get into Alcohol use disorder after divorce and while experiencing isolation from the family member. Siblings

develop relationships among themselves before developing relationships with peers, the kind of relationship among siblings can determine how they manage challenges that confront them. This was established in a study conducted in the Department of Psychiatric Social Work, Central Institute of Psychiatry and Ranchi India (2018). The findings coincide with the Family System Theory that posits that individuals are best understood in the family setting. When a family member is subjectively or objectively isolated from the rest, he or she can no longer function normally. Relationships among family members remain a major aspect of a family culture.

Religion is an additional component of the culture of a family. The results of a study that was conducted in Mauritius on religious aspects connected to alcohol consumption and AUD Luczak, et al. (2014) demonstrate that participants who thought that their religion supported abstinence from alcohol and also called for a devotion to the faith, used less alcohol than those who did not feel that their religion supported abstinence from alcohol and also called for a devotion to the faith.

However, the findings of the study showed that participants whose religion emphasized abstinence and a devotion to their faith were more likely to develop alcohol use disorder if they used or abused alcohol at any point in their lives. The traditions and customs of the family are handed down from one generation to the next, and each new member is expected to uphold them. When behaviours are consistent with the requirements set out by the group, social learning theory proposes both positive and negative forms of discipline as appropriate responses. According to Luczak et al. (2014), abstinence from alcohol as a means of sustaining religious family culture may entail that the consumption of alcohol is not acceptable; this may result in either positive or negative punishment.

Some cultural practices have a preventative effect on underage drinking and alcohol abuse, according to research by Massawe, Ruheza, and Msambila (2022). This was

discovered to be strongly ingrained cultural beliefs such as rites of passage and other communal assemblies where traditional brews such as alcohol are of major relevance on things pertaining to the community. This approach affects the efficacy of measures that are intended to reduce reliance on alcohol. This is due to the fact that members of the community think that excessive consumption of traditional brew during communal occasions acts as a unifying force that promotes harmony, despite the fact that addiction and the related health risks are present. The aforementioned factors give the impression that there are no rules in place or that the laws that are in existence are insufficient to prevent underage drinking and abuse of alcohol during these community gatherings.

The significance of this recent study resulted relatively from the contradicting reports from different studies. Such studies include Massawe, Ruheza, and Msambila (2022), who indicates that family cultures in support of alcohol use during their traditional communal activities contribute positively to the development of AUD and Luczak, et al., (2014) who reported that family cultures that upheld abstinence from alcohol also contributes positively to the development of AUD.

In their 2018 research, Stephen and Odiemo looked at how the expression or repression of emotions might function as a sort of family culture. They investigated whether or not there was a correlation between the expression or suppression of emotions and alcohol use disorder in clients who were recuperating in rehabilitation institutions located in Kiambu. According to the research, there is a significant link between emotionally repressing oneself and AUD. There was a correlation between the observed expression or its suppression and the living situations of the family.

According to Susman (2022), individuals learn how to express or repress their emotions based on the cultural norms of their families. According to the findings of the study, any behaviour that is rewarded within the family is picked up, while any behaviour that is punished is avoided. The researcher investigated different types of living arrangements, such as nuclear families, single parents of either gender with children, grandparents raising their grandkids, and child-headed families, were investigated.

In Kenya, living arrangements as well as the prevalence of heavy episodic drinking (HED) were investigated. According to the findings, those in Kenya between the ages of 18 and 29 had the greatest HED. There was also found to be a favourable link between living arrangement and heavy episodic drinking as criterion for alcohol use disorder (Kendagor, et al., 2018). According to the findings of the study, participants who were previously married but later separated and living apart had three times the number of episodes of excessive drinking when compared to those who were married or living together as a couple. In the traditional context of Africa, it is assumed that individuals who enter into marriage will remain married to the person they married. It's possible that the significant percentage of participants with HED who were separated from their families did so as a defence mechanism against the cultural stigma linked with African cultural expectation.

According to research conducted in the Nandi community, the breakdown of religious values and traditional practices that controlled the abuse of alcohol has contributed to problematic drinking, including the development of alcohol use disorder (Kariuki, Misaro, Kabiru, & Birech, 2013). In addition, it was found that alcohol use disorder had destabilized marriages and the emotional wellbeing of the children which could result in a vicious cycle around alcohol. These findings are in agreement with those of Luczak et al. (2014), who found that participants whose religions advocated abstinence from

alcohol and also asked for a commitment to the religion, used less alcohol and few of them developed AUD. Luczak et al. (2014) also found that individuals who fingered that their religion advocated abstinence from alcohol and also called for a commitment to the religion, used less alcohol.

According to the findings of a study that was carried out in Kirinyaga County, Kenya, with the purpose of determining the connections and implications of female drinking habits on familial unity (Wangechi, 2016), it was found that the majority of the participants who consumed large amounts of alcohol on a regular basis were between the ages of 30 and 39. According to the survey, the high number of people who abuse alcohol may be traced back to stressful situations in families brought on by the pressures of maintaining a certain level of financial stability. In addition, research conducted in South Africa by Hoque and Ghuman (2012) found that a stressed familial environment was positively associated with alcohol use disorder

2.3 Family Socio-economic Status and Alcohol Use Disorder

Family Socio-economic Status (SES) is best understood when studied along the main three proportions which are, income, education levels, and occupation (Chen, Kong, Gao, & Mo, 2018). Family socio-economic status was studied using parental highest education level completed, participants' income before they developed Alcohol use disorder and the participant's highest level of education completed.

In a study that was carried out by the Centers for Disease Control and Prevention (2012), it was discovered that participants who did not have a high school certificate and who had a low income experienced the fewest instances of Heavy Episode Drinking (HED). The study was carried out in 48 states, and it involved 457,677 respondents. In addition to this, researchers found that there was a positive correlation between HED and household income. These findings concur with those that were reported by Calling, Ohlsson, Sundquist, Sundquist, and Kendler (2019).

A study was carried out on the role of education level, financial status, and neighbourhood as a measure of socio-economic status among the Swedish inpatient and outpatient clients with alcohol use disorder (Calling, Ohlsson, Sundquist, Sundquist, & Kendler, 2019). According to the findings of the study, participants who were experiencing or had previously suffered alcohol use disorder had low levels of education, poor incomes, and had spent their young adult lives in low-income neighbourhoods. According to DSM-5, having a HED is one of the features indicating that an individual is experiencing alcohol use disorder.

In a study to investigate the intergenerational effect of education on psycho active substance use in the United States, the findings indicated a negative correlation between parental education level and alcohol consumption (Deza, 2018). The findings singled out binge drinking which is one of the characteristics of alcohol use disorder. Young adults whose parents had low education were less likely to drink frequently but were more likely to drink heavily per occasion, a drinking pattern that may place more disadvantaged young adults at a greater health risk.

In an examination of the relationship between parental education and young adults drinking frequency and quantity per occasion, well (2018), young adults whose parents had low education were less likely to drink frequently but were more likely to drink heavily per occasion. A similar study on socioeconomic status and alcohol related problems was conducted among community – dwelling Japanese men by Murakami and Hashimoto (2019), it was realized that individuals having lower education levels are at an increased risk for both non-problematic alcohol consumption and alcohol-related problems in comparison to those with higher levels of education. The same study also looked at the role of income on alcohol abuse and reported a lower risk of non-problematic heavy drinking among community – dwelling Japanese men with a low

income. The results are in opposition to previous research that has indicated a direct association between reduced financial resources and the development of alcohol-related issues.

It is a common misconception that those with low levels of education are more likely to struggle with AUD. In a study conducted by Rosoff et al. (2019) on people of European Ancestry, it was found that there is an inverse correlation between educational achievement and binge drinking, which includes alcohol dependence. This belief has been debunked as a result of this study. On the other hand, a positive correlation was found between the level of education attained and the amount of times alcohol was consumed. According to Horsman (2018), who states that individuals who use alcohol and had completed higher education levels acquire alcohol use disorder less frequently than those with lower education levels, the finding on education levels and problematic alcohol use concurs with his findings.

Comparable findings were reported by Tsamparli-Kitsara and Frrokaj (2016) whose findings indicates that young offspring, aged 14 years in the low socio-economic status started using alcohol as they worked to support their family members living in poor socio-economic conditions. More related findings were obtained from an investigation conducted to examine the contribution of underage drinking to the development of Alcohol use disorder among Americans of African origin (Horsman, 2018). The study observed that participants who experienced teenage alcohol consumption but had completed Higher Education levels developed AUD less than those with lower education levels. Marital status was also observed to be a determinant because the married developed less Alcohol use disorder as compared to the unmarried. These findings are consistent with Probst, Parry, Wittchen, and Rehm (2018) and Calling, Ohlsson,

Sundquist, Sundquist, and Kendler (2019), who observe a negative relationship between Education level, income levels, neighbourhood and Alcohol use disorder.

Analogous verdicts were also reported in South Africa and Namibia, studies indicate that about 3% of the alcohol consumed is mainly home-made or illegally produced using unrecorded and potentially harmful components that might contribute to Alcohol use disorder (Ferreira-Borges, Parry, & Babor, 2017). Such studies further noted that the population in the low socio-economic status suffer more alcohol-related problems as compared to those in the high socio-economic standing.

A common observation was reported that when preparing for pregnancy, women within the middle-income class are less likely to consume alcohol as compared to those in the lower-income status (Lepper, et al., 2016). Women in the lower socio-economic class might use alcohol for different reasons which supersede the consequences of alcohol consumption during pregnancy.

An examination among 1950 youth in Tanzania, Francis (2015) indicates that college students had the highest HED followed by casual labourers who possessed a high school level of education or lower. This finding contradicts most observations which hold that higher education levels are associated with low alcohol use and UAD. Such a contradiction was reported by Katembu and Okunya (2018) who observed that participants with less than college-level education had the highest Alcohol use disorder prevalence. They were followed by participants with college education level while those with University education had the least Alcohol use disorder prevalence.

While concurring with those who observe that low socio-economic population experience more Alcohol use disorder, a survey conducted by Probst, Parry, Wittchen, and Rehm

(2018) reports that 60% of alcohol-related deaths are found among the low socio-economic population as compared to 15% of Alcohol-related deaths among the high socio-economic status population in South Africa. The measurement of socio-economic status entails the consideration of various factors, including but not limited to education level, individual or family income, family size, marital status, and occupation, as posited by Wangari (2017). Socio-economic status was operationalized as education level, individual, income, family size, housing status, neighbourhood status, marital status, and occupation.

Kenya particularly Nairobi County has been found to be among those countries with the highest number of alcohol abusers at 18.4%. WHO (2018), reports that 4 percent of the overall fatalities in Kenya in 2016 were alcohol abuse-related. The reported increase in alcohol use and related problems has been attributed to improved socio-economic status as a result of devolution. Wangui, Mariene, and Wamalwa (2017) approves the above report by observing low consumption of alcohol among the low SES population but more negative effects including Alcohol use disorder. These findings concur with those from an investigation carried out in Eastleigh, Nairobi County Kenya, which indicates that problematic alcohol consumption and AUD were more prevalent among single, unemployed young male who were born in Eastleigh having married parents and high family income (Korio & Nyavanga, 2019). The unemployed young males were in the low SES though their parents had high family income.

Apart from the urban population like in Nairobi County, in Nandi community alcohol addiction and AUD are linked to poverty. (Kariuki, Misaro, Kabiru, & Birech, 2013). The Poor SES was associated with distilling of *chang'aa* and brewing of *busaa* as a source of family income which in return makes alcohol too available for the family members in

such communities including the under age. These observations concur with Mungai and Midigo (2019) in their exploration in Murang'a County where sixty-five percent of the population that use alcohol have been established to experience Alcohol use disorder. There is a correlation between AUD and familial culture. The presence of certain family cultural practices, such as the domestic production of alcohol, the consumption of alcohol by the father figure, and the cohabitation with someone in the family affected by AUD, have been identified as potential contributing factors to the onset of alcohol use and the development of AUD. Participants' perceptions were also reported as factors related to Alcohol use disorder.

2.4 Parenting Styles and Alcohol Use Disorder

Parenting styles have been grouped into four major categories (Achwal & Prakash, 2021), categorized as follows: Permissive, authoritarian, authoritative, and neglectful parenting styles. It is evident that different parenting styles result in different behaviours in children. The researcher assessed the link between AUD and parenting styles. Martínez-Loredo, et al. (2015) observes that different parenting styles could either protect adolescents from alcohol use and abuse or influence them to negative alcohol-related behaviours. The finding of the study reports that adolescents who had a perception that their parents are neglectful are susceptible to AUD within two years of the study. The research revealed that adolescents who perceived their parents as oblivious necessitated extra care to mitigate the risk of developing AUD.

As indicated in Calafat, García, Juan, Becoña, and Fernández-Hermida (2014) inadequate parenthood is an important susceptibility factor for substance use among adolescents. Martínez-Loredo, et al. (2015), in the study further postulates that the Spanish adolescents who perceived their parents as neglectful at age 12 indicated that they developed Alcohol use disorder at age 14 years. In contrast, the style of parenting that is authoritarian is defined by a lack of parental affection and harshness, yet having high expectations and

demands from their children results to lower alcohol use. Indulgent parenting style normally does not give feedback to their children and when they do it is mainly negative. When mistakes occur, children are yelled at and receive corporal punishment.

It is a controlling parenting style and children are not allowed independence. This makes such children good at following rules but low in self-discipline. According to Hoffmann and Bahr, (2014) the findings establishes that low self-discipline might contribute to such individuals being influenced to use or abuse alcohol and eventually develop Alcohol use disorder. Norway, like other European Countries, including the United Kingdom, has developed a culture of binge drinking among male where 25% of the male normally drink 10 or more units of alcohol (Courtney & Polich, 2009).

Parental influence on their offspring can determine how much the young adults are socialized into binge drinking by the peers. An early and productive relationship between parents and their offspring can determine the level of diffusion of the intoxication culture among peers (Pedersen & Soest, 2013). Parents have a responsibility to establish healthy relationships with their children before the latter are 13 years old. A culture develops if it is accepted by the individuals being cultured. It can therefore be assumed that parents with a productive relationship with their offspring have a better chance to socialize them into their alcohol-related behaviours either into use, abuse, or alcohol-free culture. Such an assumption needs to be researched to prove a possible constructive behaviour in parenting styles to save countries like Kenya from the economic and social burden of Alcohol use disorder.

A positive relationship between positive family relationships and low alcohol use or abuse has also been realised. Researches observe that there are personal factors that influence an individual into abusing alcohol. Such factors include; gender roles, age, low

self-esteem, sensation seeking, and alcohol knowledge among others. Youth are generally under the control of their parents or guardians. Parents and guardians have a responsibility to socialize their youth into their respectful gender roles and ensure that they learn those roles productively (Ramsoomar, 2015).

Negative socialization or non-productive parental practices at a young age are factors to the individual's self-esteem development. When young adults and youth develop low self-esteem, they might seek personal sensation in addiction or AUD. Parents, siblings, and extended family members have a responsibility to promote and sustain their offspring's sense of well-being. Majority of the youth experiencing low sense of well-being can also develop low self-esteem. Setting and developing life goals requires parental involvement, supervision, and a positive relationship between the youth and parents or guardians.

In a study by Bratek, et al. (2013), it was argued that Alcohol use disorder in a family is influenced by both genetic and behaviours among family members. This is in agreement with the FST that states, individuals' behaviours are best understood when observed in light of their interaction with family members (Johnson & Ray, 2016). In families where parents are non- alcoholic but use a permissive parenting style, they make very little demands on their children and also have little expectation from them. According to Berge (2016), children brought up in a permissive parenting style, have to set their own limits whether they are productive or counter-productive. The parenting style characterized by permissiveness may exert an impact on the alcohol consumption patterns of children, including the abuse of alcohol and the onset of AUD. Parents have the responsibility to instil a sense of wrong or right in their children including use, misuse or abuse of alcohol which might develop into alcohol use disorder. In this respect authoritarian parenting style has been reported to be undesirable and not meaningfully correlated to drug

dependency, including AUD, as observed in Kawempe Division Kampala Uganda (Nkurunungi, 2019).

More on the relationship between parenting styles and AUD was reported in the NACADA report (2011), which observed that about 50% of the individuals who abuse alcohol were between 10 and 19 years old. The point in life at which individuals begin to consume and abuse alcohol is a determinant in the possibility of developing AUD. Individuals who undergo initiation into alcohol consumption during their early years exhibit a higher propensity to develop AUD compared to those who commence alcohol abuse during adulthood. (Aiken, et al., 2018).

Children and adolescents are expected to be under the parents' or guardians' authority and getting into alcohol use or abuse and eventually, Alcohol use disorder might be related with parenting style and other family attributes practices. Alcohol use disorder can also be acquired if, either alcohol is too accessible at home, or modelling the parents' and other family members' behaviours are done, or if parenting style allows alcohol use. Socialization is a continuous process, both directly and indirectly. Families have the responsibility to socialize their members into the appropriate gender roles alongside other behaviours.

A confirmation of the findings by Aiken, et al. (2018) on age of the initiation into alcohol as a factor in the development of Alcohol use disorder was reported by (Njoki, 2013). The researcher reports that younger students who abused alcohol did it more frequently in a week than the older students. It was further observed that thirty percent (30%) of the respondents who abuse alcohol in school were influenced by having too much pocket money. Students get pocket money mainly from their parents and this might be part of parenting practices that parents engaged in. Parents have a responsibility to meet the productive needs of their offspring while the latter should be accountable to their parents.

To have too much pocket money is an indication that the parent or guardians do not supervise or understand the needs of their offspring.

Alcohol use disorder is dangerous to families, individuals, and society as a whole. Families have the greatest role in controlling development and progression of Alcohol use disorder among their youth and other family members. This makes it important to establish the specific family characteristics that contribute or can control the development of Alcohol use disorder among family members. It is observed that parents need to understand the activities their children are involved in during the leisure time. Further, they should get involved in the children's life by knowing their friends and having some common friends with their children to increase the time spent together. Research recommends that parents and guardians need to establish rules and ensure they are adhered to by all family members (Masaba, 2017).

A study conducted in the school of Business, Kimathi University College of Technology, Githui (2011), reported that parental figures will act as exemplars for their offspring. This agreed with the virtue ethics, parents impact values to their children directly or indirectly within the environment in which they are interacting thus behaviour is learned through the process of observational learning (Mclead & Evans, 2023). This is in line with Bandura's Social Learning Theory. The study further reports that taking a proactive position in the life of an offspring by engaging discussions about alcohol but also the consequences of its consumption including developing Alcohol Use Disorder, might keep the offspring away from alcohol consumption and totally from developing Alcohol Use Disorder. Odhiambo, Sifuna, and Kombo (2020) in their investigation observed an unproductive association between parents and their girls as a reason that contributes to illicit substance misuse including alcohol. The study continues to state that giving them

a lot of pocket money without a spending philosophy play a main role in alcohol consumption, abuse and finally onset of AUD.

Additional influence of different parenting activities was observed in Mukuru informal settlement, Nairobi Kenya. It was realised that parents who take time to constructively control and supervise their offspring reduce their possibility of getting into alcohol abuse when they are still young. Such children develop a positive attachment to their parents and both have a lot to share and discuss. The attachment and parental positive control strengthen the efficiency of parental socialization free from alcohol abuse (Chweya & Auya, 2014).

In South Eastern University Maithya and Cheloti (2021), in their study indicates that monitoring and supervising the friends' children kept by parents played a key role in preventing drug and substance abuse by the children. The study also recommends the setting of rules to be followed by the children and the monitoring of the social commitment and relationships the children kept. In Kenya, there is an unproductive association between parents and their girls as a factor that contributes to illicit substance abuse including alcohol. Giving daughters a lot of pocket money without a spending philosophy play a main role in alcohol consumption, abuse and finally development of AUD (Odhiambo, Sifuna, & Kombo, 2020).

Lack of monitoring of daughters by parents' leisure time activities such as the programs they watch and the content they read also contribute to development of AUD. The results concurs with the finding in (Mwanja & Njagi, 2017), who reports that parenting styles considerably envisage illicit substance misuse among students. Kimani (2019) found a significant link between parenting techniques and youth alcohol misuse in Kibera informal community, Kenya.

Alcohol use disorder affects rural households in Mbeti – Northward, Embu County, Kenya, according to Njeru (2015). Most respondents are 20–35-year-old recovering clients. Individuals' within that age bracket are too young to have taken alcohol and developed Alcohol use disorder. This might be an indication that the respondents started accessing alcohol before the legal age of alcohol use in Kenya or the parents could have had a hand in the development of alcohol use behaviour. The study further indicates that a majority of respondents (62%) grew up in a nuclear family. Permissive type of parenting allows offspring to have their way irrespective of the consequences. These findings are in contradiction with other researches that reports, children who grow up in single-parent families abuse alcohol more. Therefore, it is imperative to examine the correlation between AUD and various methods of parenting. Parenting socializing practices to be assessed included, family rules and consequences, parental supervision and monitoring, family members' relationship, and participants' attitudes.

It was partly in response to conflicting reports on parenting styles and alcohol use disorder by different studies that this study was conducted. Some of the contradicting reports on parenting styles and alcohol use disorder includes; Kimani (2019), who reported an important affiliation between parenting styles and alcohol abuse among the young population, (Berge, 2016), who, reports that parenting styles were of minimal significance in the use of alcohol and the development of AUD and (Hoffmann & Bahr, 2014) who established low self-discipline as an influence to use or abuse alcohol and eventually develop Alcohol use disorder.

2.5 Family Alcohol Use and Alcohol Use Disorder influences

Longitudinal predictors of young adolescent binge drinking have been linked with an emphasis on possible parental influences in studies such as that carried out by Pedersen and Soest (2013). Such studies indicate a link between parental and their offspring in light of alcohol consumption and related behaviours including Alcohol use disorder

development at the age of 28 years. The purported positive correlation can be attributed to the phenomenon of offspring emulating their parents' alcohol consumption patterns or the absence of effective parental supervision. Learning theory such as Classical conditioning, argues that all behaviours associated with rewarding stimuli can be acquired (Cherry & Gans, 2023).

An intoxicated individual has little inhibitions and might look happier and less stressed, making the experience look rewarding and worth experimenting by the adolescents. However, not all observed behaviour is learned. Choice theory by Glasser (2000) on the other hand posits that human beings make choices that help them to meet their specific need but not just observe and model after other peoples' behaviours. Parental monitoring and support for their adolescents determine the offspring's alcohol use, abuse and development of alcohol use disorder. The report continue to argue that parental Alcohol use disorder is more influential than parental monitoring and support behaviours (Pedersen & Soest, 2013). This creates need for a study to establish the actual effects on both parental monitoring as captured in parenting styles and alcohol use as captured in family alcohol use and their offspring's alcohol use behaviours including Alcohol use disorder.

A longitudinal study conducted in Norway with 2558 participants indicate a culture of Binge drinking (Pedersen & Soest, 2013). The respondents were followed from their mid-teenage years to when they attained their late twenties. The results further indicate that parental binge drinking was an indication that their children are also likely to have the same alcohol problem. Parent monitoring of their teenage children was less influential as compared to the parents' Binge drinking behaviour. The parents could talk about the effects of Binge drinking with their offspring but the effect was minimal.

Parents' frequency of alcohol consumption was also related to the offspring's frequency of alcohol use. A high frequency of alcohol consumption develops alcohol tolerance which evenly might develop and Alcohol use disorder (Pedersen & Soest, 2013). These findings are different from a study conducted in public schools in Chicago with 1373 participants. The results indicate that parental cross-sectional and longitudinal monitoring and children's alcohol-specific communication can be the main determinant of alcohol use among 28 years old teenagers.

Research indicates that the level and frequency of alcohol consumption among parents has a significant impact on the alcohol consumption patterns, misuse, and development of alcohol use disorders among their offspring. Bratek et al. (2013) reported that individuals who consume alcohol are more prone to have experienced parental separation during their upbringing. Bratek, et al. (2013) further reports that alcoholic persons grew up with alcoholic parents who were less caring for them when young. Due to their Alcohol use disorder, these parents were less dependable, helpful, and supportive. Reality Therapy holds that normal individuals always work to achieve the genetically coded needs which are survival, freedom, fun, power, love, and belonging (Glasser, 2017).

Bratek et al. (2013) conducted a study which observed that individuals with alcohol dependence are more likely to have been raised by parents who themselves struggle with alcoholism and exhibit lower levels of parental care during their formative years. They continue to report that children's absenteeism from school contributes to their development of AUD as they try to deal with the pain of isolation from their school-mates and friends. A qualitative study by Desai, Ruitter, Magan, Reddy, and Mercken (2020), to investigate how out-of-school youth's social networks influence alcohol use show that family members who are similar in age either sibling or members of their extended family support each other in alcohol use through financing and social support.

This result is consistent with the findings of Brown (2013), who posited that the conduct people exhibit is influenced by their familial ties and interactions. The finding also concurs with Social Learning Theory as cited in the study Mcleod and Evans (2023), SLT holds that all behaviours that are observed are acquired with time and Alcohol use disorder is no exception. The results concur with those of a study done among 25 Grade 9 learners in Western Cape, South Africa. The study observes that parental use of alcohol at home contributed to their daughters' alcohol use (Hlomani-Nyawasha, Meyer-Weitz, & Egbe, 2020). Parents are expected to be role models and authority figures for their children. This means that when they take alcohol at home, their daughters might understand it to be an accepted behaviour, and with time they might develop the same behaviour as well.

There seem to be a positive relationship between parental comfort of drinking from home and alcohol intake, binge drinking, drunk driving, and being driven by a drunk driver. This is consistent with a study that found an association between apparent parental tolerance for alcohol, comfort of consuming in the house, alcohol consuming, and alcohol-related outcomes (Lauckner, et al., 2020).

In Kenya, basic education is compulsory and children's major roles are connected to schoolwork. When they are out of school, they are idle and this pushes them deeper into alcohol abuse and dependency. A study by Wangui, Mariene, and Wamalwa (2017), reports that family Alcohol use disorder negatively influences the children's school attendance, motivation to learning, and discipline. Alcohol-dependent parents' offspring would miss school either due to a lack of resources or moral support. Absenteeism would result in poor academic performances which discourage learners, making them to suffer from psychological pain, social isolation, and other negative emotions. According to Masaba (2017) reports that individuals who abused alcohol are between 22 and 27 years

and that eighty percent (80%) of the respondents who abused alcohol have a family history of AUD. It was also reported that some parents allow the company of their children to bars and other alcohol selling places. The children are directly or indirectly being introduced to alcohol use and abuse. The young offspring might get the impression that it is acceptable to use alcohol.

This is supported by the finding that 18% of the respondents who abuse alcohol were introduced by their parents. The vast majority of individuals who exhibit addiction to alcohol learn the drinking behaviour from the family. Fathers with an alcohol problem and especially Alcohol use disorder will most likely have children who will develop alcohol use disorder in their adulthood (Githui, 2011) . Offspring can develop alcohol problem and Alcohol use disorder either through modelling their father's alcohol behaviours or out of a perception that abuse of alcohol is a way of life. These findings concur with other results such as (Masaba, 2017).

2.6 Theoretical Framework

This research was informed by three interconnected theoretical frameworks, the family system theory, social learning theories, and choice theory. Family system theory was used to explain the effect of the relationship and interaction among family members. It also helped to develop an understanding of behaviours that are transmitted through generations and form the family culture. On the other hand, Social Learning Theory was used to create an understanding of behaviours that are acquired through observation.

2.6.1 Family System Theory.

The families undergo both normative and non-normative transitions that result in diverse levels of pressure impacting all individuals within the family unit. According to Corey (2016), people are understood when observed in the context of relationships.

Understanding individuals, is best done by assessing how such individuals interact with all family members.

Alcohol use disorder is a behaviour that individuals might use to express dysfunctionality within a family. Like other problems in the family, AUD may be indicative of the functioning of the family unit, rather than solely attributable to a person's maladjustment. Family System Theory argues that every member of a family is connected to living systems and any change in one section of the system reverberates throughout all sections in the system. The living system is the basic agent. This makes it important to evaluate the relationship between different behaviours within family system and the development of Alcohol use disorder.

Family System Theory holds the assumption that in a dysfunctional family system, parents and their offspring engage in repetitive and negative interactions based on miss-conceptualized goals that motivate both the parents and their offspring. Society expects parents to take the leadership role in family while their offspring directly or indirectly learn from them. Where parents are alcohol dependent, their children can learn the behaviour directly or indirectly.

In cases where parents' goals for their offspring are not compatible with the offspring's personal goals, the interaction might be counterproductive, resulting in frustration and distress. A review of Satir (1983) by Corey (2016) records that family members take different defensive stances to cope with distress. Such stances include; blaming— family members who blame others normally avoid taking responsibility for the situations. The interaction between family members gets worse and such an individual can turn to alcohol as a way of managing the stress. Other family members when stressed might engage in irrelevant behaviours. They get into patterns that will distract them from the stress, hoping the pain and stress will just fade away.

2.6.2 Social Learning Theory

It was first proposed by Bandura (1986). It combines both Classical Conditioning by Ivan Pavlov and Operant by B.F. Skinner (McLeod, 2023). Classical conditioning contends that Reflex behaviours are acquired through the association of an unconditioned stimulus with a neutral stimulus for a length of time (Cherry & Gans, 2023).

In operant conditioning, behaviours are acquired as a result of organisms manipulating their environment to receive a reward or reinforcement. Alcohol use disorder is a product of behaviour that is acquired. Agreeing to Social Learning Theory, individuals tend to model more on people who are similar in some way. This is dependent on whether the observed behaviour is appraised as rewarding or not. Individuals experience both internal or external reinforcement and at times both forms of reinforcement including vicarious reinforcement. The present investigation aims to evaluate the correlation between the three types of reinforcement and AUD.

Bandura (1986) extended the Social Learning Theory through the development of the Social Cognitive Theory. Bandura's social cognitive theory posits that an individual's level of self-efficacy determines their willingness to engage in a given task or situation. Specifically, the theory suggests that a person's confidence in their ability to effectively manage a situation is a key factor in their decision to participate in it. Persons experiencing Alcohol use disorder might have encouraged alcohol consumption with the expectation that they can manage the effect of the alcohol situation. Relapse can be explained using Social Cognitive Theory's self-efficiency context. Individuals experiencing high self-efficiency have higher possibilities to engage in difficult tasks, with an expectation of mastering and managing the difficult task such as managing and controlling Alcohol use disorder. Social Cognitive Learning Theory argues that individuals model after others depending on the motivation, past reinforcements, promises, and vicarious reinforcements. Social cognitive learning theory argues that

learning or change of behaviour depends not only on observation but also on the internal reward which includes pride, satisfaction, and a sense of accomplishment.

2.6.3 Choice Theory

Glasser (2001, 2005) argues that every person is born with five genetically programmed essentials that motivate individuals throughout their lives. These genetically programmed essentials are, survival or self-preservation, love and belonging, power or inner control, freedom or independence and fun or enjoyment. Healthy and functioning individuals engage in different actions in pursuit of these essentials. Different characteristics of alcohol use disorder may be sustained as a way of meeting these genetically programmed essentials.

According to Choice Theory individuals including the alcohol recovering clients' behaviours are generated from within making individuals' the author of their destiny. Every behaviour is a product of the individual's thinking, feeling, action and physiology. Individuals' actions including alcohol use which is the foundation of alcohol use disorder development is aimed at attaining a specific need or feeling. Unfortunately, the unintended physiologies occur resulting to alcohol use disorder.

Choice Theory explained alcohol use disorder as a product of the interaction between thinking, feeling, action and physiology in an effort to meet the genetically programmed essentials as opposed to the social learning theory and family system theory which explains alcohol use disorder as an acquired behaviour from the environment.

2.7 Conceptual Frame Work

The conceptual framework identifies family attributes as independent variable and Alcohol use disorder as the dependent variable that is influenced by independent variables. Family attributes are indicated by family alcohol use, family culture, family socio-economic status, and parenting styles. Family attributes are assumed to directly or indirectly contribute to the development of alcohol use disorder in various ways. For

example, the use of alcohol by different family members might be acquired by younger members through learning or as a response to the psychological pains of living in a dysfunctional family.

Family Socio-economic status might contribute to the development of AUD either as a way of managing stress which results from unmet family financial obligations or as a way of spending unbudgeted for resources including time. Different parenting styles result in different personalities, which respond to issues differently including alcohol use and the development of AUD. However, these family attributes will be assessed. Extraneous variables can also influence the dependent variable but they are controlled through sampling.

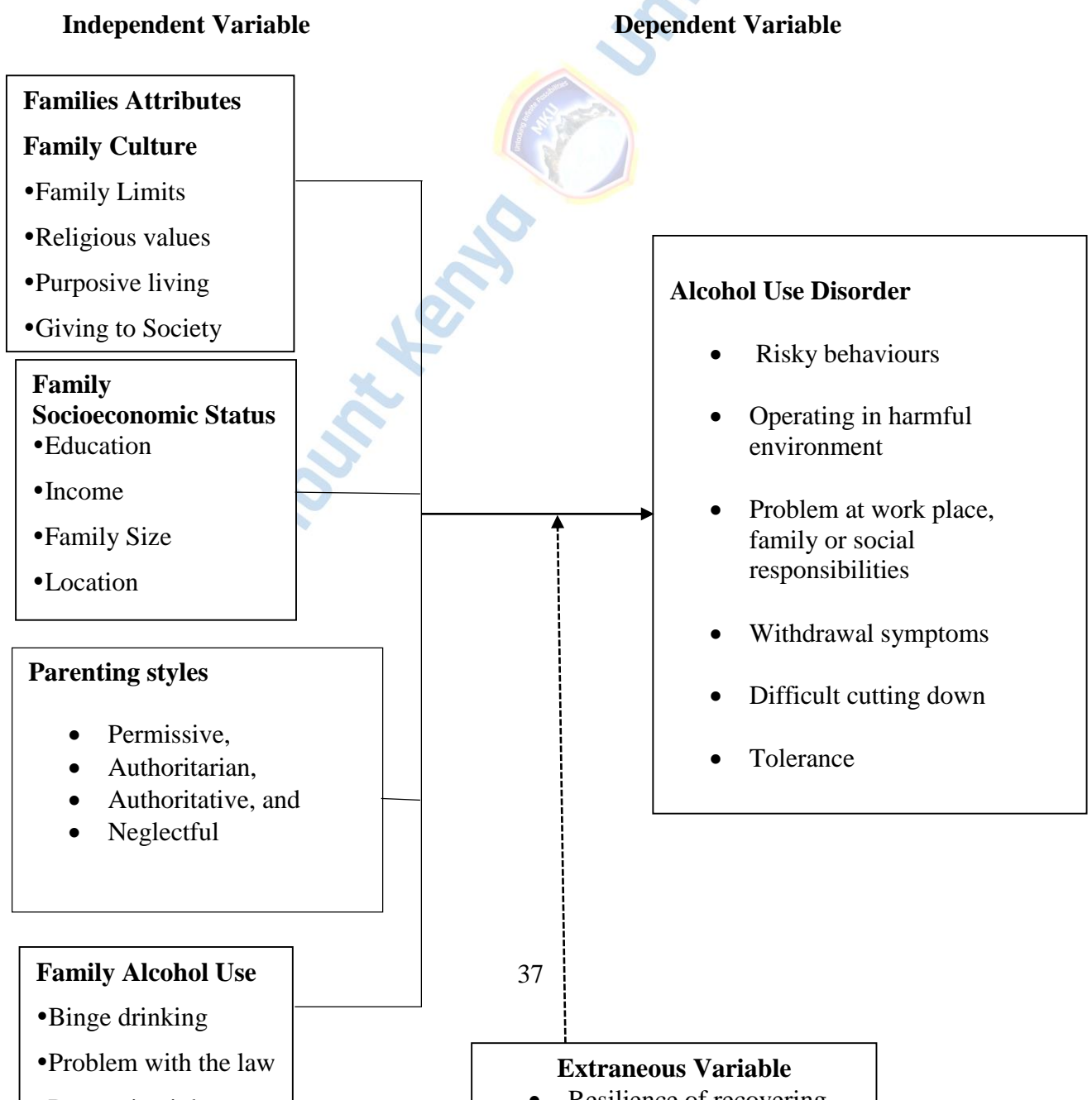


Figure 1: Relationship between Families' Attributes and Alcohol Use Disorder

Source: Researcher, 2024.

2.8. Recap of the Literature Review

A study by Wangui, Mariene, and Wamalwa (2017), observes a low consumption among the low Social Economic Status (SES) population but more negative effects including Alcohol use disorder, while Kariuki, Misaro, Kabiru, and Birech (2013), and observes that poor socio-economic status plays a major role on alcohol abuse and in development of alcohol use disorder. The two studies provide contradicting results, and this study seeks to address. Odhiambo, Sifuna, and Kombo (2020) in their study, observes an unproductive link between parents and their girls as a feature that contributes to drug abuse including alcohol use disorder.

The study continues to report that giving daughters a lot of pocket money without a spending philosophy play a main role in alcohol use, abuse and finally alcohol use disorder. The study did not identify the parenting style or SES that is likely to be associated with this kind of behaviour. This study assessed the relationship between alcohol use disorder family culture, parenting styles, family alcohol use and also the SES. It has been observed that fathers with an alcohol problem and especially alcohol use disorder will most likely have children who will develop alcohol use disorder in their

adulthood (Githui, 2011). These observations have not brought out the living arrangement involved, whether it is a single parent or a nuclear family. An investigation by Katembu and Odiemo (2017), reports a positive correlation between suppression of emotions and AUD among recovering clients in rehabilitation Centers in Kiambu County. The study did not investigate other aspects of family culture such as family religious' values and opinions on alcohol use and AUD, which was investigated. A positive correlation between marital status and AUD was reported by (Kendagor, et al., 2018). The study also examines the correlation between participants' marital status and AUD but ignores the effect of parents' marital status on the participants. alcohol use disorder is a consequence of the effects of past experiences including the living arrangements of the participants. Kimani (2013) observes that thirty percent (30%) of the respondents who abuse alcohol in school are influenced by having too much pocket money. The study had not investigated the link between different parenting styles and their children's spending philosophy, neither has it examined the effect of family or individual's income on alcohol use disorder. A positive relationship between stressful family environment and Alcohol use disorder was also reported (Hoque & Ghuman, 2012). Stressful family environment is a product of different factors and behaviours among the family members such as, the parenting styles, family culture, family social economic status or family alcohol use. Njeru (2015) in her study indicates that majority of the respondents (62%) grew up in a nuclear family. However, the study does not explain other family dynamics that influence the behaviours of its members. Individuals acquire behaviour from both their physical environment and the perceived environment. The study dwelt with the physical family environment but the researcher in this study will assess both the physical and perceived family environment (Njeru, 2015). Kimani (2013) indicates that sixty percent (60%) of all students who abused alcohol and participated in the study had a history of alcohol abuse

and dependency in their family. The consumption of alcohol in Kenya is not illegal other than illicit brews but alcohol use disorder is counterproductive in Kenya. Individuals with a familial background of alcohol abuse ought not to be stigmatized or neglected in terms of their potential development of AUD. The existing study wishes to assess the family attributes that might be contributing to the development of AUD with a purpose of reducing alcohol use disorder in the community.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains the research design that was used, target population, sample size, and sampling procedures. It also explains the data collecting instruments and procedures, techniques, validity and reliability of research instruments and data analysis as well as the research process and the ethical considerations.

3.2 Research Design

The research design employed in the study was *Ex post facto*. The aforementioned approach was deemed most suitable due to the fact that the variables of parenting and alcohol use disorder had already manifested, thereby precluding any control by the researcher. This design was appropriate because it allowed the study of possible relationships between existing situations by looking back in time for possible contributing factors. This research design allowed the researcher to explain alcohol use disorder as a result of antecedent conditions and discover how independent variables affect dependent variables. The study examined existing conditions using *ex post facto* research design to find possible links.

3.3 Location of the Study

This research was carried out in designated rehabilitation facilities located in Nairobi County, Kenya. Its coordinates are 1.28 degrees north latitude and 36.82 degrees east

longitude. It is about 1684 Meters above sea level, covering an area of about 69491 km² and holding a population of about 3.2 million persons distributed in seventeen Sub Counties (Britannica, 2019). NACADA accredited rehabilitation Centers are in four main categories which include; Outpatient Rehabilitation or treatment Centers, Inpatient Rehabilitation or treatment Centers, Residential Rehabilitation or treatment Centers, and Recovery housing. The researcher collected data from Inpatients Rehabilitation or treatment Centers and Residential Rehabilitation or treatment Centers. In Inpatients Rehabilitation or treatment Centers, clients are admitted to a hospital for about one month with thorough and intense programmed medical care while in Residential Rehabilitation or treatment Centers, clients are given rigorous and extremely controlled attention in a non-Hospital well-managed venue.

3.4 Target Population

This study's target population was 187 recovering alcoholics made up of 161 Male and 26 females in Nairobi County.

Rehabilitation Centers	Male population	Female population
Sapta	8	2
Asumbi	10	1
Chiromo Lane	20	5
Eden	11	2
Precision	28	0
The retreat	28	10
Bustani Treatment Centre	20	2
Nairobi Addiction Centers	15	1
Living Hope Couns. Centers	10	0
Silwan Fountain Treatment & Recovery Centers	8	0

Eden Halfway House	10	0
Mariakani Villa	1	1
Total	161	26

Table 1 *Target Population of the Recovering Clients in the Rehabilitation Centers in Nairobi County*

Source: (2024): Admission records from a feasibility study in selected rehabilitation Centers in Nairobi county Kenya

3.5 Sampling procedures and Techniques:

The researcher visited NACADA accredited rehabilitation Centers in Nairobi County. Using the list retrieved from the NACADA website, the researcher was able to identify the Centers. The researcher used purposive sampling to sample the rehabilitation Centers. From the list by NACADA, the researcher was able to select seven rehabilitation Centers as indicated in Table 2. To determine the sample size from the selected rehabilitation Centers, the researcher used a sampling table developed by Krejcie and Morgan (1970). Stratified sampling was used to divide the population into two groups based on gender. On the other hand, the study used systematic sampling where the researcher used the admission list for males and females as the sampling frame and was able to pick the Kth number of each gender. A sample size of 118 respondents were selected as indicated in table 2. The FGD had 6-8 participants in every sampled Centers. Purposive sampling method was used to develop lists of could be respondents, good at sharing their opinions and experiences. Aspects of gender, age, socio-economic status and religion were factored. This was done in consultation with the specific Centers' chief counsellor.

3.6 Sample Size

Table 2 Sample Size for the Study

Rehabilitation Centers	Males population	Sample size	Female population	Sample size
Sapta	8	8	2	2
Precision Rehabilitation and Counselling home	28	24	0	0
Eden Half way House	20	19	2	2
Bustani Treatment Centre	15	14	2	2
Living Hope Counselling Centre	8	8	1	1
The retreat	15	14	10	9
Nairobi Addiction Centre	15	14	2	2
Total	109	100	19	18

Source: Author, 2024.

Researcher used the Krejcie and Morgan sampling table as indicated in Table 2 above.

The table was developed using the formula

$S = \frac{\chi^2 N P (I-P)}{d^2 (N-1) + \chi^2 P (I-P)}$. Where; S is the required sample size,

χ^2_i is the table value of chi-square for 1 degree of freedom at the desired confidence level of (3.841), N is the population size,

P is the population proportion, and d is the degree of accuracy expressed as a proportion (05) (KENPRO, 2012).

3.7 Research Instruments

The methodology employed for data collection involved the utilization of questionnaires and structured Focus Group Discussions (FGDs). The FGDs helped in gathering in-depth information about the participant's perspectives, opinions, insights, and attitudes on

family alcohol use, socio-economic status, culture, and parenting styles in relation to the development of AUD.

Questionnaires were organized in six sections. All the statements in section one to section five were stated on a 5-point Likert scale, 5-Strongly Agreed, 4-Agree, 3-Not sure, 2-Disagreed and 1- Strongly Disagreed. The first section contained items to obtain the biographic data of the respondents. Items in the second section were used to obtain data on family culture. The third section contained items to measure socio-economic status while the fourth section was designed to gather data on different parenting styles. The fifth section was designed to gather data on family alcohol use. The sixth section contained items to obtain information on the level of AUD of the respondents which were adopted from the DSM-5. The statements in this section were stated on a 5-point Likert scale, 5-Very few times, 4-, Few times 3-Sometimes, 2-Most of the times and 1- Always.

3.8 Piloting of the Research Instruments

The main goal of piloting in any study is to identify any unexpected challenge such as unclear items and unnecessary insertions or items that might have been omitted in the data collecting tools (Viechtbauer, et al., 2015). Additionally, it helps to establish the human and financial resources that will be required to conduct the full study, to evaluate the planned data analysis procedures, and detect any challenge associated with the projected study methods (Teijlingen & Hundley, 2001). To determine the pilot study sample size, the researcher used the sample size rule of the thumb that states, thirty (30) participants are representative enough for a study (Whitehead, Julious, Cooper, & Campbell , 2015). The pilot study was conducted in selected NACADA accredited rehabilitation Centers in Kiambu County, Kenya. Kiambu County was selected because the population resembles that in Nairobi County in the Heterogeneous nature. The Rehabilitations Centers in Kiambu include; New Hope Rehabilitation Centers, Genesis

Sober Community, Sober Living and Recovery Community-based Org, Eden Village Rehab Centers, Nueva Esperanza Treatment and Rehabilitation, Jorgs Trust, The Raphaelites, Teens Challenge-Female rehab among others as in Appendix 1. The County has twenty-two NACADA accredited rehabilitation Centers (NACADA, 2022).

The researcher purposively sampled two rehabilitation Centers that had both male and female clients and which had not been included in the main study. Using the rule of the thumb, as indicated by Whitehead, Julious, Cooper, and Campbell (2015), forty (40) participants were selected. The researcher collected data from the two Centers. The collected data was coded and keyed into SPSS computer software Version 25. To establish the internal consistency of the tools, split-half reliability was used. The research tools were divided into two halves using odd and even numbers for each construct. The Cronbach's alpha coefficient was employed as a means of assessing the reliability of the variables. The researcher obtained a Cronbach's alpha coefficient of 0.79. According to Leech, Barrett and Morgan (2014), piloting is used to check whether the research instruments were well understood. The researchers noted that a value of 0.90 was deemed to be good, while a value of 0.80 was considered to be acceptable, and a value of 0.70 was regarded as adequate.

3.8.1 The Validity of the Questionnaires

The attainment of a representative sample was facilitated through the utilization of stratified sampling and simple random sampling techniques. Construct Validity of the present study was the degree to which the data collection tools are relevant to the hypothesis of the study. Content validity of the research instrument was acquired by ensuring they were relevant to the objectives of the study and consulting supervisors along with other psychology research specialists about study objectives.

3.8.2. Reliability of the Research Instrument

Pilot research was done among recovering clients in chosen rehabilitation Centers in Kiambu County who were similar to the sampled respondents to ensure instrument reliability. To establish the internal consistency of the tools, split-half reliability was used. The research instruments were partitioned into two equal parts by utilizing both even and odd numbers for every construct. A correlation coefficient was run between the two halves of the instrument using Spearman-brown formula, then split-half reliability was calculated.

A reliability coefficient threshold of 0.7 or higher was deemed acceptable. Sampled respondents were residential clients, making their environment and responses consistent and reliable. To increase reliability, the researcher reviewed the items to ensure that they had a good performance. Participant error was managed by ensuring that the tools were responded to when the respondents were stable and subjectively secure to control the biases. The researcher adhered to the work schedule and research ethics in order to mitigate potential errors and biases in the investigation process.

3.9 Data Collection Procedures

Mount Kenya University provided the researcher with a letter of introduction, which was presented to the National Commission for Science, Technology, and Innovation (NACOSTI) in order to obtain a research permit that would allow access to the field for data collection. The researcher got the relevant authorizations to conduct the study in different areas of jurisdiction. The researcher was prepared that in case the spread of the COVID-19 persisted up to the time of the studies fieldwork, questionnaires to were to be distributed to the sampled respondents as Google forms through a specific identified member of staff in the rehabilitation Centers.

Qualitative data was to be collected on zoom through FGD. FGDs were responded to in group setting where common guidelines were given and understood by the respondents. However, the COVID- 19 positivity rate declined and the researcher, by utilizing the assistance of research assistant physically distributed the questionnaire to the rehabilitation Centers. The researcher and the research assistant still observed the COVID-19 management protocols when conducting the FGDs as planned and agreed with the administration of the specific rehabilitation Centers.

3.10 Data Analysis

The researcher gathered data of both quantitative and qualitative nature. The content analysis method was employed to analyse the qualitative data which categories into the following themes, Problem with the law, violence, irresponsibility, interpersonal relationship among family members, and giving to the society among others as per research objective. This involved transcribing the information collected during the FGD both verbal and non-verbal, developing code path using the developed codes according to research objectives, scrutinized and developed meaning of the collected qualitative data and then Created validity and reliability through agreement between reports.

The quantitative data collected was analysed using descriptive and inferential statistics. Inferential statistics tested hypotheses whereas descriptive statistics measured central tendency and variance. Chi-square statistics and Pearson's correlation test (Pearson's r) were employed to test the research hypotheses. It also allows a researcher to investigate the significance of relationships between independent and dependent variables. The data analysis was conducted using version 25 of the Statistical Package for the Social Sciences (SPSS).

Table 3 *Data analysis Tools*

Serial No.	Hypothesis	Independent variable	Dependent variable	Statistic used
Ho1	There is no statistically significant relationship between family culture and alcohol Use Disorder among recovering clients selected rehabilitation Centers in Nairobi county Kenya	Family Attributes.	Alcohol use disorder	Chi square and Pearson correlation
HO2	There is no statistically significant relationship between Family Socioeconomic Status and alcohol Use Disorder among the recovering clients in. selected rehabilitation Centers in Nairobi county Kenya	Family Attributes.	Alcohol Use Disorder	Chi square and Pearson's correlation test (Pearson's r)
HO3	There is no statistically significant relationship between parenting style and alcohol Use Disorder among the recovering clients in. selected rehabilitation Centers in Nairobi county Kenya	Family Attributes.	Alcohol Use Disorder	Chi square and Pearson's correlation test (Pearson's r)

HO 4	There is no statistically significant relationship between Family alcohol use and alcohol Use Disorder among the recovering clients	Family Attributes.	alcohol Use Disorder	Chi-square and Pearson's correlation test (Pearson's r)
------	---	--------------------	----------------------	---

Source: Author, 2024.

3.11 Ethical Considerations

To maintain the fundamental ethical principles during the study, the researcher ensured vigilance on participants' management, data collection procedures, and accurate reporting. This was best achieved by assuring participants of confidentiality on the information given, ensuring participants give informed consent, giving information on voluntary participation, and avoiding any form of physical or psychological harm. During data collecting activities the researcher was accompanied by a counselling psychologist whose role was to prepare participants for data collecting activities and debriefing them after the data collection.

However, if any respondent re-experienced misgivings or any other undesirable outcome during and after responding to the items the developed psychosocial support plan in Appendix 2 was to be applied. The objectives of the psychosocial support plan were to help the respondents convalesce from any interruption either physical, emotional or otherwise.

Sampling of participants was done by the standard recruitment procedures and impressed on the research assistants the need to maintain the ethical standards. During and after the study, information and data concerning the study was stored safely and accessibly for proper use in the future. To sustain the ethical research goal of creating new knowledge while preserving the dignity and welfare of the respondents, the researcher undertook any possible risk reduction strategy including piloting the tools and receiving responses from

sampled participants. The psychological security of the respondents was a concern to the researcher. Any information that could identify a participant was avoided and instead, codes were used. Finally, the researcher was consistent in seeking supervision from professional experts including the study supervisors to control infringements.



CHAPTER FOUR: RESEARCH FINDINGS ANALYSIS AND PRESENTATION

4.1 Introduction

This chapter contains research presentations analysis, interpretations and discussions of the gathered information from respondents. The chapter has been structured into two separate parts. The initial segment comprises of demographic data pertaining to the respondents, which includes gender, the age at which the respondents started using alcohol, and their living arrangement. The second section contains presentation of results organized according to research objective.

4.1.1 Response Rate of the Respondents

As indicated in Table 4, the study reveals the distribution of the respondents' responses

Table 4 *Response Rate of the Respondents*

Rehabilitation Centers	Questionnaire administered	Questionnaires returned	%
Sapta	10	4	3.4
Precision Rehabilitation and Counselling home	33	22	18.6
Eden Half way House	21	12	10.2
Bustani Treatment Centre	15	5	4.2
Living Hope Counselling Centre	9	2	1.7
The retreat	14	5	4.2
Nairobi Addiction Centers	16	11	9.3
Total	118	61	51.6

Source: Author, 2024.

Out of the seven rehabilitation Centers, the researcher administered 118 questionnaires. A half of the respondents filled and returned the questionnaires. The study found that 61 (51.69%) of the respondents in both genders had returned the filled questionnaires as indicated in Table 4. As indicated in Mugenda (2009), the researchers confirmed that a response rate of 50% was adequate and that of 60% was good while that of 70% was very good. This study got a response rate of 51.6% which was adequate for this study.

4.1.2 Demographic Data

The present investigation incorporated details about demographics such as gender, age, educational attainment, and income of the participants as indicated in Figures 2,

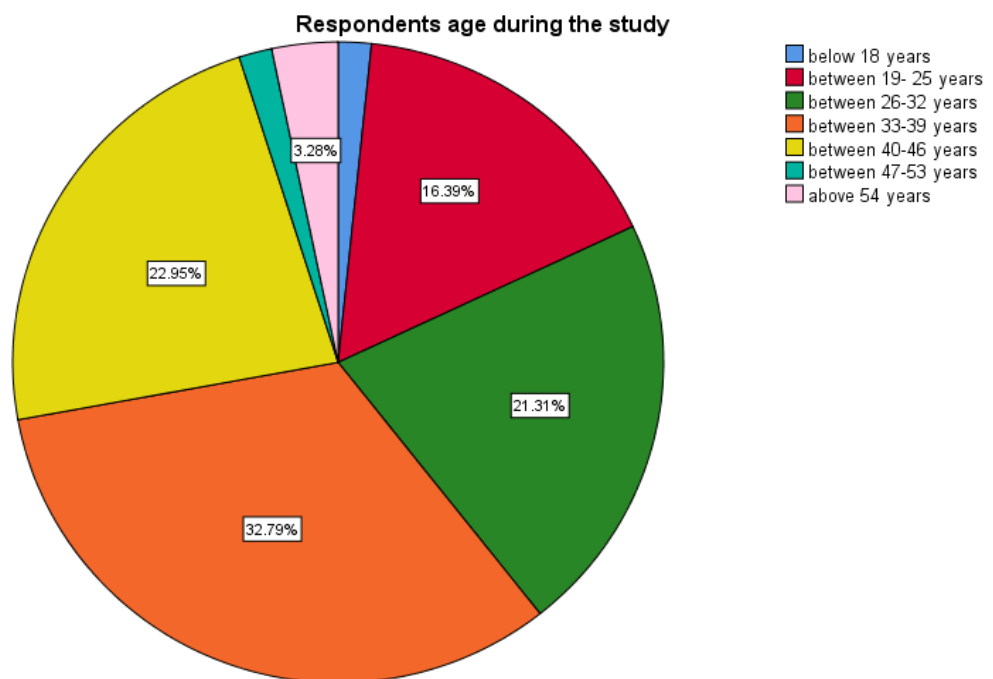


Figure 2 : Diagrammatic representation of respondents' age during the data collection

An analysis of respondents age during the data collection period for this study as captured in figure 2 above indicated that (32.79%) of the respondents were between thirty-three and thirty-nine years of age (33-39years). This age group of respondents between thirty-

three and thirty-nine years of age (33-39years) is said to be the most productive and energetic part of the Kenyan population. It is a concern to the society when they have suffered AUD which is a difficult condition to treat. Secondly, (22.95%) consisted of respondents who were between forty and forty-six years of age (40-46 years). The thirdly (21.31%) was between the age of twenty-six and thirty-two years (26-32 years). The fourth group was between nineteen and twenty-five years of age (19-25 years). Lastly (3.28%) were aged above fifty-four years of age. The smallest percentage of the respondents (3.28%) was shared between respondents' age between forty-seven and fifty-three (47-53years) and those aged below eighteen years. These results agree with (Wangeci, 2016), who indicates that most of the participants who consumed high amounts of alcohol regularly were aged between 30 – 39 years. This study also examined the age at which respondents started using alcohol and the findings recorded in figure 3. The age at which respondents started using alcohol has been associated with the development of alcohol use disorder.

The researcher analysed the age of the respondents at which they started using alcohol and alcohol use disorder as shown in Table 5

Table 5 *Age at which the respondents started using alcohol and alcohol use disorder*

	< 10 yrs.	11-17yrs	18- 24yrs	25-31yrs	32-38 yrs.
Male N	8	16	26	4	1
%	14.5	29.1	47.3	7.3	1.8
Female N	1	1	4		
%	16.7	16.7	66.7		

Source: Author, 2024.

The observation done in this study communicates that most of the recovering client's respondents were male totalling to 55 (90%) while the female clients were totalling to 6(10%). This is consistent with Kabwama's (2016) research, which indicates that the

consumption of alcohol among Ugandan males is linked to notions of masculinity, social freedom, and domestic responsibilities, leading many men to engage in alcohol use and subsequently develop alcohol use disorder. Nonetheless, the present investigation did not evaluate the underlying factors that contribute to the higher prevalence of alcohol consumption among men in Kenya, which may subsequently lead to the development of AUD.

In this study, the researcher also observed that most of the respondents started using alcohol between 18 and 24 years of age totalling to 26 (47.3%) male and 4 (66.7%) female. This is followed by those who started using alcohol between 11 and 17 years of age 16 (29.1%) being male and 1 (16.7%) being female. A small number started using alcohol before attaining 10 years with 8 (14.5% being male and 1 (16.7%) being female. Only 4 (7.3%) of the male respondents and 1 (16.7%) of the female respondents reported having their first drink between the ages of 25 and 31 and finally 1 (1.8%) male started using alcohol when he was between 32 and 38 years of age.

These findings seem to differ with Mohler-kuo (2015) as cited in Arya (2021) who reports that introduction to alcohol use in childhood is likely to be a risk factor in use, abuse during teenage and throughout their life. In the present study a small number 8 (14.5%) male and 1 (16.7%) female started using alcohol below 10 years of age or in childhood, hence rendering the age of first drinking to be a relatively insignificant risk factor in the progression of AUD. These findings seem to concur with Berge (2016) who observes that children being allowed to take alcohol at home and even being served alcohol were not linked to experiencing alcohol problems in adulthood. Arya (2021) observes that alcohol in form of beer was recorded among the highest consumed beverage in the world coming next after water and tea, with (40%) of college students partaking in hefty periodic alcohol use. This implies that individuals were consuming a minimum of five alcoholic beverages

for males and four alcoholic beverages for females during a single episode of alcohol consumption. According to the findings of the present investigation, a total of 26 (47.3%) male and 4 (66.7%) female participants-initiated alcohol consumption during the age range of 18 to 24 years, which is commonly associated with the typical college-going population in Kenya? The two observations pertaining to alcohol consumption among adolescents exhibit a degree of similarity.

Table 6 *Living arrangement for the respondents before they were 18 years old*

		grandparents only	parents only	father and siblings only	nuclear family	Mother and siblings only
Male	N	1	13	4	35	1
	%	1.9	24.1	7.4	64.8	1.9
Female	N	none	2	None	2	2
	%		33.3		33.3	33.3

Source: Author, 2024.

The present investigation examined the domiciliary conditions of convalescent patients in designated rehabilitation facilities within Nairobi County prior to attaining the age of 18. The data presented in Table 6 reveals that a significant proportion of the respondents, comprising 35 (64.8%) males and 2 (33.3%) females, resided with their immediate family members. On the other hand, 13 (24.1%) male and 2 (33.3%) female lived with their parents only. Most of the respondents grew up with both parents with an exception of 4 (7.4%) male who grew up with father and sibling only. Similarly, 1 (1.9%) male and 2(33.3%) female grew up with their mother and sibling only. The researcher also observed that 1 (1.9%) male was brought up by the grandmother.

The present study's results are inconsistent with those of a prior study conducted in Jamaica, which aimed to explore the correlation between alcohol consumption patterns

among secondary school students and their family structure (Oshi, 2018). The study identifies both single family organisation and married family organisation to be positively and significantly connected with generational use of alcohol. According to the study, it was observed that learners who grew up in either single family arrangement or married family arrangement were more probable to develop alcohol use behaviour in their era as related to learners from other family arrangements.

However, Oshi (2018) observes that there were more learners (63.0%) who grew up in a single-family arrangement that developed alcohol use behaviour as compared to those (62.1%) who grew up in a married family arrangement. The findings indicated that most (64.8%) of the recovering clients grew up in a nuclear family as compared to single family arrangement consisting of (7.4%) living with father and siblings only and (1.9%) living with mother and siblings only. These findings diverge from Bratek (2013) who concludes that recovering clients are less likely to have been brought up by complete families but most often by separated parents.

The present study's results corroborate those of a prior investigation conducted in Eastleigh, Nairobi County, Kenya, which demonstrated a higher incidence of problematic consumption of alcohol and alcohol use disorder among young males who were born in Eastleigh and had married parents (Korio, 2019). The aforementioned results are in alignment with the outcomes of a study conducted on 139 university students in their adolescence, which aimed to investigate the influence of living conditions on the prevalence of problematic alcohol consumption (Roemer, 2014). The research notes that individuals residing with both parents reported instances of binge drinking and alcohol-related issues.

4.2 The impact of family culture on alcohol use disorder among individuals undergoing rehabilitation in selected Centers located in Nairobi City County.

Table 7 reveals the descriptive data on father's relationship with their sibling.

Table 7 *Father's relationship with their off springs*

		SD		D		Not sure		A		SA	
		N	%	N	%	N	%	N	%	N	%
Coping strategies	M	13	25	9	17.3	12	23.1	10	19.2	8	15.4
	F	1	25	0	00	0	0.0	1	25	2	50
Spending philosophy	M	19	36.5	10	19.2	11	21.2	1	1.9	11	21.2
	F	1	25	1	25	1	25	1	25	00	00
Emphasized size	M	22	43	17	33.3	4	7.4	3	5.9	5	9.8
	F	1	25	2	50	0	0.0	0	0	1	25
Express feelings	M	16	30	10	19.2	7	13.5	12	23.1	7	13.5
	F	1	25	1	25	0.0	0.0	00	00	2	50
Depend d	M	13	25	25	48.1	6	11.5	7	13.5	1	1.9
	F	0	0	2	50	0.0	0.0	1	25	1	25
Reward	M	20	39.2	12	23.5	5	9.8	5	9.8	9	17.5
	F	1	25	1	25	1	25	1	25	0	0
	M	13	24.5	33	62.3	2	3.8	2	3.8	3	5.7
Com mitment	F	1	25	1	25	1	25	1	25	0	0

Source: Author, 2024.

Key; SD for Strongly Disagreed, D for disagreed, NOT SURE for Neither agreed nor disagreed, A for Agreed, SA for Strongly Agreed, Coping for he discussed with them different coping strategies in different situation, Spending philosophy for he trained them on how to spend money, Emphasized for, he emphasized on productive use of time, Express feelings for he allowed them to express their feelings, Depend for they word

depend on their father in times of trouble, Reward for he rewarded their positive behaviours either with kind words or otherwise, Commitment for he was committed to ensure they did not miss school.

Fathers' relationship with their children and AUD in recovering clients in selected rehabilitation Centers in Nairobi county Kenya was investigated and the findings of the study are presented in Table 7. The results showed that 10 (19.2%) and 8 (15.4%) of the male and 1 (25%) and 2(50%) of the female gender disagreed that their fathers discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges. However, about half of the participants in both genders, male 29(55.9%) and females 2(50%) disagreed that they were trained on how to spend money while 16(30%) and 10(19.2%) of the male gender and 1(25%) and 1(25%) of the female gender disagreed that they were allowed to express their feelings. This implied that fathers were not free with their children and vis versa.

As indicated in Table 7, 25(48.1%) of the males and 2(50%) of the females strongly disagreed that the children depended on their fathers whenever they incurred some trouble. The study also affirmed that, more male 13(24.5%) and 33(62.3%) than female 1(25%) and 1(25%) disagreed that their fathers were committed in ensuring that they don't miss school. This is an indication that the fathers were unavailable for them in times of need. The study further found that 20(39.2%) and 12(23.5%) males and 1(25%) and 1(25%) females were never rewarded for every positive behaviour. However, Table 8 on the other hand contains the statistics on mothers' relationships with her offspring and alcohol use disorder.

Table 8 *Mother's relationship with her off springs and alcohol use disorder*

		SD		D		NOT SURE		A		SA		Total	
		N	%	N	%	N	%	N	%	N	%	N	%
coping strategies .	M	12	22.6	24	15.1	6	11.3	3	5.7	8	15.1	53	100
	F	2	33.3	1	16.7	0	0	2	33.3	1	16.7	6	100
Spending philosophy	M	14	26.4	23	43.4	6	11.3	1	1.9	9	17	53	100
	F	3	50	0	0	0	0	1	16.7	2	33.3	6	100
Emphasize	M	14	27.5	24	47.1	7	13.7	1	2.0	5	9.8	51	100
	F	2	33.3	2	33.3	1	16.7	0	0	1	16.7	6	100
Express Feelings	M	17	31.5	19	35.2	6	11.1	2	3.7	10	18.5	54	100
	F	3	50	1	16.7	0	0.0	1	16.7	1	16.7	6	100
Depend	M	16	32.0	29	58.0	2	4.0	0	0.0	3	6.0	50	100
	F	3	50	2	33.3	0	0.0	1	16.7	0	0.0	6	100
Reward	M	17	31.5	22	40.7	10	18.5	1	1.9	4	7.4	54	100
	F	2	33	2	33.3	1	16.7	0	0.0	1	16.7	6	100
commitment	M	12	22.6	33	62.3	3	5.7	4	7.5	1	1.9	53	100
	F	3	50	1	16.7	0	0	1	16.7	1	16.7	6	100

Source: Author, 2024.

Key;

SD for Strongly disagreed, D for disagreed, NOT SURE for Neither agreed nor disagreed, A for Agreed, SA for Strongly agreed, Coping for she discussed with them different coping strategies in different situation, Spending philosophy for she trained them on how

to spend money, Express feelings for she allowed them to express their feelings, Depend for they word depend on their mother in times of trouble, Reward for she rewarded their positive behaviours either with kind words or otherwise, Commitment for she was committed to ensure they did not miss school.

In an exploration into the mothers' relationship with their offspring and AUD among recuperation patients in sampled rehabilitation Centers located in the Nairobi County, the results are recorded on table 8 above. The results revealed that 3 (5.7%) male, 2 (33.3%) female strongly agreed and 8 (15.1%) male, 1 (16.7%) female agreed that their mothers discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges. On the other hand, 12 (22.6.0%) male, 2 (33.3%) female agreed and 24 (45.3%) male and 1 (16.7%) female strongly disagreed that their mothers discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges. Respondents in this study are clients recovering from alcohol use disorder in rehabilitation Centers.

A majority 36 (67.9%) male and half (50%) female report that their mothers never discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges. This is an indication that the discussion with their mothers which could have been a protective factor against the development of AUD was never done. The results approved with the observation in NIAAA in USA (2021) which indicate that individuals brought up by parents who discuss issues with them developed schemes of resolving problems which in return shield against emotional dysfunction that repeatedly leads to problematic alcohol use including development of AUD.

In an additional examination into the mothers' association with their offspring and AUD among recovering clients in sampled rehabilitation Centers located within Nairobi County, the outcomes were also documented on table 8 above. They showed that 1 (1.9%) male, 1 (16.7%) female strongly agreed and 9 (17%) male, 2 (33.3%) female agreed that their mother trained them on how to use money. On the other hand, 14 (26.4%) male, 3 (50%) female disagreed and 23 (43.4%) strongly disagreed that their mothers trained them on how to use money. A majority 37 (67.8%) male and half (50%) female of the respondents' reports that their mothers never trained them on how to use money which was an indication that training on money philosophy could have been a shield against the development of AUD.

In a scrutiny interested in the mothers' relationship with their offspring and AUD among recovering clients in sampled rehabilitation Centers located within Nairobi County, the conclusions as documented on table 8 above indicated that, 1 (2%) male and no female strongly agreed. Similarly, 5 (9.8%) male, 1 (16.7%) female agreed that their mothers emphasized on productive use of time while on the contrary 14 (27.5%) male, 2 (33.3%) female disagreed and 24 (47.1%) male 2 (33.3%) strongly disagreed that their mothers emphasized on productive use of time. It is well understood that respondents in this study were clients recovering from alcohol use disorder in the sampled rehabilitation Centers. It is observed that majority 38 (74.8%) male and more than half (66.6%) female report that their mothers never emphasize on productive use of time. This was an indication that the mothers' emphases on productive use of time could have been a shielding aspect against the development of AUD unfortunately it was never done. The aforementioned observations pertaining to family culture and its impact on the development of AUD have prompted the necessity for further investigations into additional factors that contribute to the onset of AUD within society.

Table 9 contains information on the sibling's relationships and gender.

Table 9 *Sibling's Relationship and Gender*

		SD		D		N/S		A		SA		Total	
		N	%	N	%	N	%	N	%	N	%	N	%
Coping	MF	13	26.5	9	18.4	16	32.7	5	10.	6	12.2	49	100
		3	60	0	0	0	0	0	00	2	40	5	100
Spending philosophy	M	11	22.4	6	12.2	14	28.6	6	12.2	12	24.5	49	100
	F	3	60	0	0	0	0	0	16.7	2	40	5	100
Emphasize	M	11	23.4	7	14.9	15	31.9	4	8.5	10	21.3	47	100
	F	3	60	0	0.0	1	20	0	0.0	1	20	5	100
Express feelings	M	12	25.0	16	33.3	10	20.8	4	8.3	6	12.5	48	100
	F	4	80.0	0	0.0	1	20.0	0	0.0	0	0.0	5	100
Depend	M	16	32.7	16	32.7	9	18.4	4	8.2	4	8.2	49	100
	F	3	60.0	0	0.0	1	20.0	0	0.0	1	20	5	100
Reward	M	14	28.6	18	36.7	6	12.2	5	10.2	6	12.2	49	100
	F	2	40.0	0	0.0	2	40	1	20.0	0	0.0	5	100
Commitment	M	13	26.5	15	30.6	15	30.6	3	6.1	3	6.1	49	100
	F	2	40	0	0	2	40	0	0.0	1	20	5	100

Source: Author, 2024.

Key;

SD for Strongly disagreed, D for disagreed, NOT SURE-Neither agreed nor disagreed, A for Agreed, SA for Strongly agreed, coping for they discussed with them different coping strategies in different situation, spending philosophy for they trained them on how to spend money, Express feelings for they allowed them to express their feelings, depend for they word depend on their siblings in times of trouble, Reward for they rewarded their positive behaviours either with kind words or otherwise, Commitment for they were committed to ensure the respondents did not miss school

To understand the role of sibling relationship as part of the family culture and AUD among recovering clients in sampled rehabilitation Centers located within Nairobi County, an analysis of sibling relationship was conducted and captured in Table 9 above. The results indicated that 5 (10.2%) males, no female strongly agreed, 6 (12.2%) male and 2 (40%) female agreed that their siblings discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges. On the other hand, 13 (26.5%) male, 3(60%) female disagreed, 9 (18.4%) male and no female strongly disagreed that their siblings discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges.

In summary more respondents 22 (44.9%) male, 3 (60%) female disagreed that their siblings discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges as compared to 11 (22.4%) male and 2 (40%) female who agreed. More investigations on the role of sibling association as part of the family culture and AUD mong recovering clients in sampled rehabilitation Centers in Nairobi County was conducted and captured in Table 9 above. The outcomes disclosed that 6 (12.2%) males, no female strongly agreed, 12 (24.5%) male, and 2 (40%) females agreed that their siblings trained them on how to spend money.

On the other hand, 11 (24.4%) male, 3 (60%) female disagreed and 6 (12.2%) male and no female strongly disagreed that their siblings trained them on how to spend money. According to these observations, sibling training on how to spend money was not a factor in the development of alcohol use disorder. However, it is worth noting that a relatively large number of respondents¹⁴ (28.6%) were not sure of the role of their siblings in training them on how to spend money. This confirms that the role of parents on training

their children cannot be passed to their siblings. An additional investigation on the role of sibling connotation as part of the family culture and AUD among recovering clients in sampled rehabilitation Centers located within Nairobi County was conducted. Findings of an analysis demonstrating express of feeling are also recorded in Table 9 above. The study unveiled that 4 (8.3%) males, no female strongly agreed and 6 (12.5%) male, and no female agreed that their siblings allowed them to express their feelings. On the other hand, 12 (25%) male, 4 (80%) female disagreed and 16 (33.3%) male and no female strongly disagreed that their siblings allowed them to express their feelings.

In summary more respondents 28 (58.3%) male and (80%) female disagreed that their siblings allowed them to express their feelings. These findings indicate a relationship among the siblings that was not good, though the study did not investigate whether the specific siblings were users or non-users. To further explore the part played by siblings' association as part of the family culture and alcohol use disorder among recovering clients in sampled rehabilitation Centers located within Nairobi County, an analysis on dependability of siblings was conducted and the verdicts documented in Table 9 above. The conclusions unveiled that 4 (8.3%) males, no female strongly agreed and 4 (8.3%) male, and 1 (20%) female agreed that they could depend on their siblings for help in times of trouble. Furthermore 16 (32.7%) male, 3 (60%) female agreed, 16 (32.7%) male and no female strongly agreed that they could depend on their siblings for help in times of trouble. In summary, more respondents 32 (65.4%) male and 3 (60%) female disagreed that they could depend on their siblings for help in times of trouble.

Alcohol use disorder develops from specific human behaviours. To develop an understanding on the role of sibling interactions as part of the family culture and alcohol use disorder among recovering clients, the present study entailed an inquiry into the

dynamics of sibling relationships, with the results being documented in Table 9 as presented. The conclusions unveiled that 5 (10.2%) male, 1 (20%) female strongly disagreed, 6 (12.2%) males, and no female agreed that their siblings rewarded their positive behaviours either with kind words or otherwise. On the other hand, 14 (28.6%) male, 2 (40%) female disagreed and 18 (36.7%) male and no female strongly disagreed that their siblings rewarded their positive behaviours either with kind words or otherwise.

In summary more respondents 32 (65.3%) male and fewer respondents (40%) female disagreed that their siblings rewarded their positive behaviours either with kind words or otherwise. From the findings, the study revealed that the family members (fathers, mothers and siblings) of the recovering clients missed productive use of time indicating that they could never spend quality time together. This was in line with the results from the focus group discussion where one of the male respondents was quoted saying “*in my family, there we never had a planned family time. Family time happened only after closing school and before school openings where our father gives us lectures on what he expects of all of us*”. The respondent added “*my best experience about this time was that we were given some money to use after he was done expressing his opinion but with very little care about others.*”

This was seconded by a female respondent in the same focus group who said “*in my family we have never had any planned family time.*” This concurs with the report in a study by Li (2023), that children's wellbeing increases with the amount of time parents spend with them. In particular, the amount of time that the father and mother spent with their kids during school and during their free time had a favourable impact on the kids' academics and general well-being. This implies that lack of quality family time result to poor family members' cohesion with one another. According to family system theory people particularly those recovering from AUD are understood when observed in the

context of relationships by assessing how such individuals interact with all family members. The study showed that the recovering clients from AUD were never trained by their family members on how to spend money. Romo and Vangelisti (2014) corroborated these findings, reporting that 93% of participants said their parents were never honest about the family saving, spending, and income.

This disclosure could offer valuable perspectives on how kids learn about money and the financial savvy they carry into adulthood. This means that deficiency in understanding about finances (money) would increase the AUD'S. However, one of the focus group respondents retaliated that, *“my parents kept their financial affairs secret, so no one helped to prepare me for any potential risks in the future that’s how I ended up becoming AUD patient”*. This study indicated that the family members are never available for the AUD recovering clients and they could not depend on them whenever they got into trouble.

Table 10 reveals information on family member’s emotional support and gender for the recovering clients

Table 10 *Family Members 'Emotional Support and Gender for the Recovering clients*

		SD		D		NOT SURE		A		SA		Total	
		N	%	N	%	N	%	N	%	N	%	N	%
Father discussed	M	11	25.0	10	22.7	7	15.9	9	20.5	7	15.9	44	100
	F	0	0.0	1	25.0	0	0.0	1	25	2	50	4	100

Mother discussed	M	15	31.3	20	41.7	5	10.4	6	12.5	2	4.2	48	100
	F	1	20.0	2	40.0	2	40	0	0.0	0	0.0	5	100
Older sibling discussed	M	7	17.9	9	23.1	14	35.9	7	17.9	2	5.1	39	100
	F	2	50.0	1	25.0	0	0	1	25.0	0	0.0	4	100

Source: Author, 2024.

Key;

This key helped to understand the table above. SD for Strongly disagreed, D for disagreed, NOT SURE for Neither agreed nor disagreed, A for Agreed, SA for Strongly agree, Father discussed for father took time to discuss their emotional experiences, Mother discussed for mother took time to discuss their emotional experiences and Older sibling discussed for older sibling took time to discuss their emotional experiences

An investigation of family members' emotional support to the recovering client was conducted, and the results recorded in table 10 above. Evaluations on father's emotional support to the recovering client indicated that 9 (20.9%) male, 1 (25%) female strongly disagreed and 7 (15.9%) male, and 2 (50%) females disagreed. However, 11 (25.6%) males, no female agreed and 10 (22.7%) male, and 1 (25%) female strongly agreed that their father took time to discuss their emotional experiences such as when they were hurting, stressed, happy, or anxious among others. In general, the findings indicate that 21 (47.7 %) male and 1 (25%) female agreed that their father took time to discuss with them their emotional experiences as compared to 16 (36.4%) male and 3 (75%) female who disagreed that their father took time to discuss with them their emotional experiences.

An assessment on the mother's emotive provision with the recovering client showed that, 6 (12.5%) males, no female strongly disagreed and 2 (4.2%) male, no female disagreed.

However, 15 (31.3%) male, 1 (20%) female agreed and 20 (41.7%) male, 2 (40%) female strongly agreed that their mothers took time to discuss their emotional involvements such as when they were hurting, stressed, happy, and anxious among others. In general, the findings indicated that 35 (73 %) male and 3 (60%) female agreed that their mothers took time to deliberate with them their emotional experiences. This is in comparison to 8 (16.7%) male and no female who disagreed that their mother took time to deliberate with them their emotional experiences. The aforementioned results suggest that psychological assistance from parents does not serve as a safeguard against the onset of AUD.

Older sibling emotive provision to the recovering client was examined and the results indicate that, 7 (17.9%) male, 1 (25%) female strongly disagreed and 2 (5.1%) males, no female disagreed. However, 7 (17.9%) male, 2 (50%) female agreed and 9 (23.1%) male, 1 (25%) female strongly agreed that their older sibling took time to discuss their emotional involvements such as when they were hurting, stressed, happy, and anxious among others. An overall valuation indicates that 16 (41.0 %) male and 3 (75%) female agreed that their older sibling took time to deliberate with them their emotional experiences as compared to 9 (22.6%) male and 1 (25%) female who disagreed that their older sibling took time to deliberate with them their emotional experience. The finding in this study shows that 14 (35.9%) of the respondents did not have older siblings ruling out the development of AUD as a result of modelling. According to these findings, the provision of emotional support by the family is not a protective factor to the development of AUD.

The present study corroborated the assertions made by Githui (2011) regarding the association between weakened social institutions and problematic alcohol use, including AUD. This includes families inculcating moral apprehensions among members of their society and especially the youth. The study also noted that the social institutions and

especially the family had lost their authority over their youth hence exposing them to irresponsible use of alcohol and eventually the development of AUD. This is further confirmed by the large percentage (14.75%) of respondents who started using alcohol below the age of ten years. The aforementioned results necessitate further research to explore additional variables that may potentially contribute to the onset of AUD, such as individual decision-making processes as posited by the Choice Theory.

Table 11 contain descriptive statistics on family culture and alcohol use disorder among the recovering clients in selected rehabilitation Centers within Nairobi county.

Table 11 *Family Culture and Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers located within Nairobi County*

Family culture	Chi-square	df	Asymptotic Significance	Pearson's r value	Approximate significance
Mother instilling family value	3.64	16	.457	.104	.468
Mothers' Emotional support	1.354	16	.864	.014	.924
Adherence to family values	4.691	16	.321	.047	.740
Encouragement to be productive member of	6.969	16	.138	.252	0.78

Significance level of .05. Source: Author, 2024.

An analysis on family culture and alcohol use disorder was conducted and the findings recorded in Table 11 above. The chi square outcome of 3.64 yielded a P value of .457, surpassing the predetermined significance level of .05. This finding suggests that there is no causal relationship between maternal transmission of family values and the development of alcohol use disorder. This meant that mothers instilling family values did not influence the development of alcohol use disorder. An analysis of correlation coefficient for the Pearson product moment analysis was performed, and the findings demonstrated. $r(60) = .104 < .468$. This designates there was a positive Pearson product moment correlation coefficient (PPMCC) between mothers instilling family values and development of AUD among the recovering clients in selected rehabilitation Centers located within Nairobi County.

The observed positive relationship preordained that as mothers' instilling of family values increased, alcohol use disorder increased. These observations elucidate the influence of an individual's decision-making or other intrinsic factors in the onset of alcohol use disorder. The present study's results are in contrast with Pullen's (2017) observations, which suggest that a family culture is comprised of significant elements such as moral principles, religious beliefs, emotional disposition, and responsibilities, among others. Pullen posits that when these elements are shared among a group of individuals who are related, they collectively form the family culture.

Mothers have a responsibility of instilling family values that eventually develop to be the specific family's culture. However, the positive PPMCC between mothers' instilling family values and development of AUD among the recovering clients in selected rehabilitation Centers located within Nairobi County, Kenya indicates the role of gender identity in alcohol use and the development of AUD. As indicated in Table 10 above, most of the respondents started using alcohol between 18 and 24 years of age totalling to 26

(47.3%) male and 4 (66.7%) female. At this age, individuals are considered to be adults and most of them working to detach from the parental control. This explained the positive PPMCC between mothers instilling family values and development of AUD. It demonstrates that as the mothers instilling of family values increased the development of AUD among the recovering clients in selected rehabilitation Centers located within Nairobi County increased.

The investigation examined the correlation between family culture and AUD, with a particular focus on the role of maternal emotional support. The results of this analysis have been documented in Table 11. The chi square analysis yielded a result of 1.354, with a corresponding P value of .864. This value exceeds the predetermined significance level of .05, indicating that there is no statistically significant association between the level of emotional support provided by mothers and the development of AUD. This implies that maternal emotional support did not have a significant impact on the progression of alcohol use disorder.

The study found that among the recovering clients in selected rehabilitation Centers located within Nairobi County, there was a positive correlation between mothers' emotional support and the development of alcohol use disorder, as indicated by the PPMCC ($r(60) = .014 > .924$). The positive relationship communicated that as mothers' emotional support increased alcohol use disorder among the participants recovering clients in the selected increased. These results are confirmed by the participants' responses as captured in Table 11 above where majority 38 (74.6%) male and 4 (66.6%) female agreed that their mothers allowed them to express their feelings and give them emotional support. The results also concur with the recovery village (2022) report which shows that (70%) the recovering clients from AUD in rehabilitation Centers relapse somewhere within the first year of rehabilitation and only nearly to (35.9%) of all alcohol

use disorder recovering clients recover and keep their sobriety. This reality means that sobriety through rehabilitations is a very expensive undertaking due to the high relapse rate. It is recommendable that families develop an alcohol use abstinence culture to keep their family members free from alcohol use and obviously free from alcohol use disorder and other alcohol related social problems.

An analysis of respondents' adherence to family values as an indicator of family culture and alcohol use disorder was conducted and the outcomes documented in table 10 above. The obtained chi square results of $\chi^2 (16) = 4.691$ indicated that the p value of .321 exceeded the predetermined significance level of .05. This suggests that there is no statistically significant association between adherence to family values and the development of AUD. This preordained that adherence to family values was not a factor of influence in the development of alcohol use disorder. A PPMCC ($r (60) = -.047 > .740$) indicate a negative correlation coefficient between adherence to family values and development of AUD among the recovering clients in selected rehabilitation Centers located within Nairobi County. The negative PPMCC between adherence to family values and development of alcohol use disorder among the recovering clients in selected rehabilitation Centers in Nairobi County communicate that when the adherence to family values increased, the development of alcohol use disorder decreased. The present study's results are consistent with those of Ewing et al. (2015), who similarly noted that individuals who upheld their family values exhibited lower rates of alcohol and drug use in comparison to those who did not prioritize their family values.

An analysis of the level of encouragement to be a productive member of the society as another pointer of family culture and alcohol use disorder was conducted and the findings documented in Table 10 above. The results of a chi square test show that $\chi^2 (16) = 6.969$,

$p = .138$ which indicates that the level of significance is exceeded. $.05$ demonstrates that there is not a statistically significant connection between being encouraged to be a useful member of society and the development of an AUD. This predicted that encouragement to be a productive member of the society had no role in the development of alcohol use disorder. Likewise, the PPMCC ($r(60) = .252 > .078$) indicates that there was a positive relationship between encouragement to be a productive member of the society and development of AUD among recovering clients in selected rehabilitation Centers located within Nairobi County. These findings indicate that as encouragement to be a productive member of the society increases the development of AUD increased. According to Choice theory, it is important for individuals to be a productive member of the society as this would generate a good sense of belonging and love which is a basic genetically code need.

However, stigma could hinder the recovering clients to join broader societal framework and contribute to its productivity as a functional member. This concurs with Obiol (2021) who in his in depth study among twenty-two (22) respondents recovering from alcohol use disorder observes that respondents avoided responsibility as one strategy of managing stigma from the society. Other strategies used by the respondents to manage the effect of stigma as reported in Obiol (2021) include; avoidance, ignoring, or denying the effect of stigma. The researcher also used a chi square test as indicated in Table 12 to test the hypothesis that there was no relationship between family culture and alcohol use disorder

Table 12 *Chi-Square test Results for Family Culture and AUD*

	Value	df	Asymptotic significance (2-sided)
Pearson Chi-square	5.333	4	.255

Significance level of .05. Source: Author, 2024.

In order to assess the null hypothesis proposing that there exists no statistically significant correlation between Family culture and AUD among recuperating clients in designated

rehabilitation Centers located in Nairobi County, a chi-square test was employed to determine whether a relationship exists between Family culture and AUD among the aforementioned recuperating clients. Table 12 above presents the recorded Chi-square tests. A chi-square tests results $\chi^2 (4) = 5.333, p = .255$. the chi (5.333) was greater than asymptotic value (.255) indicating that there was statistical significant relationship between family culture and alcohol use disorder among the recovering clients in selected rehabilitation Centers located within Nairobi County. Based on the chi-square analysis, the researcher rejected the null hypothesis. The results indicate that there is significant association between family culture and the onset of AUD in individuals undergoing recovery at specific rehabilitation facilities. However, literature has communicated that family culture influences the use and misuse of alcohol (Sudhinaraset, Wigglesworth, & Takeuchi, 2016). The population of Nairobi County exhibits heterogeneity, and it is imperative to examine the impact of diverse cultures on the emergence of alcohol use disorder within the community.

4.3 Influence of Family Socio-economic Status on Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers located within Nairobi County.

Family SES is best understood when studied along the three main proportions; education levels, income, and occupation. Family socio-economic status was studied using; respondents' highest education level completed, respondents' income before they developed Alcohol use disorder, and the parental highest education level completed. The researcher used figure 3 to demonstrate the diagrammatic representation of the respondents' highest education level completed.

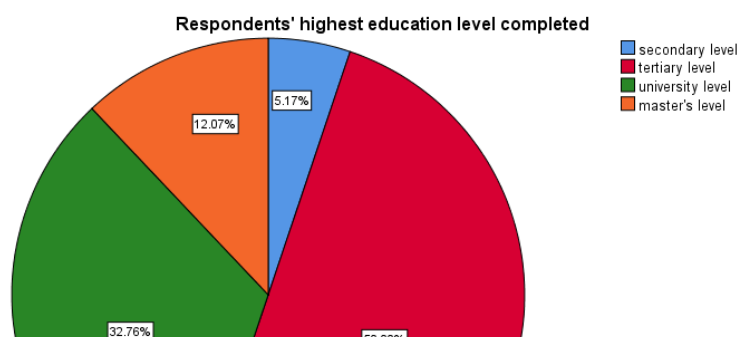


Figure 3:

Diagrammatic representation of the respondents' highest education level completed

Education level is one of the indicators of SES in the society (Chen, Kong, Gao, & Mo, 2018). The respondents' highest level of education was examined and captured in Figure 4 above. Half 30 (50%) of the respondents' highest completed education level was tertiary. In the current post-secondary education placement, tertiary level institutions normally admit learners who score below fifty-five percent (55%) or (C+) in their Kenya Certificate of Secondary education (KCSE). The results align with the research conducted by Murakami and Hashimoto (2019), which suggests that individuals with lower levels of education are more susceptible to developing non-problematic excessive alcohol consumption and issues with drinking in comparison to those with higher levels of education.

A smaller group of respondents 19 (32.76%) had completed University level of education. This was followed by a group of 8 (12.07%) respondents who had completed Master's level. The smallest group of respondents 4(5.17%) had completed secondary level of education. These observations are in contradiction with Gitatui, Kimani, Muniu, & Okube (2019), who observes that persons, who have completed higher education levels with good earning, ingest more alcohol per session and use alcohol more frequent in a week. He also notes that higher education institutions acted as a major alcohol use and abuse

socialization agent. This observation concurs with the current finding that most of the respondents (49.18%) as recorded in figure 3 above started using alcohol between eighteen and twenty-four years (18-24 years) which is normally the post-secondary age.

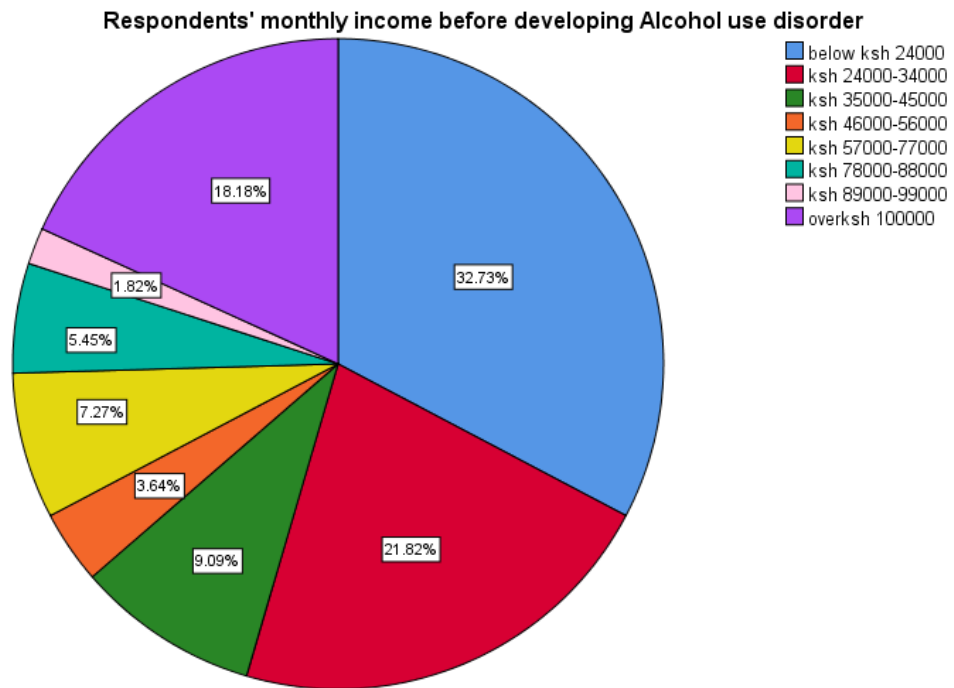


Figure 4: Diagrammatic representation of the respondents' highest education level completed

Findings on the respondent's income before they developed Alcohol use disorder was recorded in Figure 4 above. The investigation established that most of the respondents (32.73%) were earning below Twenty-four thousand Kenya shillings (<24,000) before they developed alcohol use disorder. These findings contradict Gitatui, Kimani, Muniu, & Okube (2019) who reports that persons who have completed higher education levels with good earning, ingest more alcohol per session and use alcohol more frequent in a week. The presence of this paradoxical phenomenon has led to the perception that income may not be a decisive element in the onset of alcohol misuse and the emergence of AUD. The second group was earning between Kenya shillings forty-six thousand and fifty-six thousand before developing alcohol use disorder. This was followed by the third group

(18.8%) that was earning over one hundred thousand Kenya shillings per month. Which is in concurrence with the study by (Gitatui, Kimani, Muniu, & Okube, 2019). The existing divergent findings have necessitated further research to examine the impact of income on the emergence of AUD within the community.

Table 13 *Living Arrangements and Respondents' Highest level of Education Completed*

	PL		SL		TL		UD		MD		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
grandparents only	0	0.0	0	0.0	1	100	0	0.0	0	0.0	1	100
parents only	2	18.2	1	9.1	6	54.5	0	0	2	18.2	11	100
father and siblings	2	50.0	0	0.0	1	25.0	1	25.0	0	0.0	4	100
nuclear family	4	11.8	7	20.6	14	41.2	7	20.6	2	5.9	34	100
mother and siblings	0	0.0	1	33.3	2	66.7	0	0.0	0	0.0	3	100

Source: Author, 2024.

Key: PL-Primary Level, SL-Secondary Level, TL-Tertiary Level, UD -University degree and MD - Master's degree

The information collected and captured in table 13 above, shows that the only participant living with the grandparents had completed the tertiary level. The study also observed that, participant who were living with parents only 2 (18.2%) had primary, 1 (9.1%) had secondary, 6(54.5%) had the tertiary and 2(18.2%) had the Masters as their highest education levels completed. The highest education level for participants living with fathers and siblings was also studied, 2 (50%) had primary, 1 (25%) had tertiary, and 1 (25%) had university as their highest education levels completed. Participants living with their nuclear family was also explored. The findings indicated that, 4 (11.8%) had primary education, 7 (20.7%) had secondary, 14 (41.2%) had tertiary education, 7 (20.7%) had

university, and 2 (5.9%) had Masters as the highest levels of education completed. When investigating the education level of participants who lived with mothers and siblings only before they were 18 years, it was observed that, 1 (33.3%) had completed secondary 1 and 2 (66.7%) had tertiary levels respectively.

Regardless of their living situation, the present study notes that the majority of participants had attained a tertiary level of education as their highest finished levels of learning. The current finding approves the observation in a research conducted among community –dwelling Japanese men (Murakami & Hashimoto, 2019). It found that people with lower education levels had an increased likelihood of both excessive alcohol consumptions that did not lead to problems and issues with drinking when compared to people with higher education levels. The current findings also concur with the observations made by Calling, Ohlsson, Sundquist, Sundquist, & Kendler (2019) who observes that participants who experienced alcohol use disorder had low education levels, low income, and lived in the low-income neighbourhood during their adulthood. In contrary, Rosoff D. B., et al. (2019), reports that individuals who used alcohol and had completed higher education levels develop health problems including alcohol use disorder less as compared to those with lower education levels. However, the focus group discussion noted that. *“the students pursuing degrees in engineering and medicine took more alcohol compared to those taking other courses because they attributed it to stressful demands of the courses they were undertaking”*.

According to Lasserre (2021), SES, a medium or low level of education were independent risk factors for developing AUD, compared to a high level of education. This implies that education level could not necessarily be the cause of AUD but the stressful events attributed to either low or high levels of education. According to choice theory, Glasser (2001, 2005) argues that every person is born with five genetically

programmed essentials that motivate individuals throughout their lives. Such essentials as survival or self-preservation, love and belonging, power or inner control, freedom or independence and fun or enjoyment may interfere with an individual's choice thus throwing them into AUD

Table 14 *Living arrangements and respondents' monthly income in Kenyan shillings, before developing AUD*

	GP		PO		F&S		NF		M&S		%
	N	%	N	%	N	%	N	%	N	%	
<Ksh. 24,000	0	0.0	6	46.2	2	50	8	23.5	2	66.7	18
25,000-34,000	0	0.0	2	15.4	1	25	9	26.5	0	0.0	12
35,000-45,000	1	100	1	7.7	0	0.0	3	8.8	0	0.0	5
46,000-56,000	0	0.0	0.0	0.0	0	0.0	2	5.9	0	0.0	2
57,000-77,000	0	0.0	0.0	0.0	1	25	3	8.8	0	0.0	4
78,000-88,000	0	0.0	1	7.7	0	0.0	2	5.9	0	0.0	3
89,000-99,000	0	0.0	0	0.0	0	0.0	1	2.9	0	0.0	1
> 100,000	0	0.0	3	23.1	0	0.0	6	17.6	1	33.3	10
Total	1	100	13	100	4	100	34	100	3	100	55

Source: Author, 2024.

Key:

Key: GP for grandparent PO for parents only F&S for father and siblings NF for nuclear family, M&S for mother and sibling

The findings on the investigation on participants' income before they developed AUD and their living arrangement before age 18 years was captured on Table 14 above. Results

indicate that most of the respondents 34 (61.8%) lived with their nuclear family before they attained 18 years of age. 13(23.6%) lived with their parents only, 4 (7.3%) lived with father and sibling, 3 (5.5%) lived with mother and sibling and 1 (1.8%) lived with the grandparents. The findings of this study are in agreement with those of Njeru (2015), who found that the majority of respondents who were clients of an alcohol recovery program had grown up in a nuclear family setting 62% of the time. The majority of rehabilitation Centers situated in Nairobi are under private ownership, with the recuperating clientele bearing the expenses of their treatment while under institutional care. This creates a need for an investigation on the role of treatment cost on clients' population in the rehabilitation Centers. An investigation on participant's income before developing alcohol use disorder is captured in table 13 above. The table indicates that most of them 18 (32.7%) were earning less than twenty-four thousand Kenya shillings (<Ksh.24000 pm) per month, 12 (21.8%) were earning between twenty-five and thirty-four thousand Kenya shillings per month (Ksh 25,000-34,000).

Similarly, 5 (9.1%) were earning between Kenya shilling thirty-five and forty-five thousand per month (Ksh. 35,000-45,000), 2 (3.6%) were earning between forty-six thousand and fifty-six thousand per month (Ksh 46,000-56,000), while 4 (7.2%) were earning between Kenya shillings fifty-seven thousand and seventy-seven thousand per month (Ksh57,000-77,000 pm). Additionally, 3 (5.5%) were earning between seventy-eight thousand and eighty-eight thousand Kenya shillings (Ksh. 78,000-88000pm), 1 (1.8%) earning between Kenya shillings eighty-nine thousand and ninety-nine thousand (Ksh89,000-99,000), and 10 (18.1%) were earning more than one hundred thousand Kenya shillings.

Table 15 Respondents' living arrangements before they were 18 years old and living structures for the recovering clients.

	GP		PO		F&S		NF		M&S	
	N	%	N	%	N	%	N	%	N	%
Semi-permanent family house	1	10	2	25	0	0.0	6	26.1	0	0.0
Permanent(blocks/stones) family owned	0	0.0	3	37.5	0	0.0	6	26.1	1	50.0
Gated family owned residence	0	0.0	1	12.5	0	0.0	9	39.1	0	0.0
Gated and Guarded community family owned	0	0.0	1	12.5	1	100	0	0.0	1	50.0
Gated and Guarded Family owned residence	0	0.0	1	12.5	0	0.0	2	8.7	0	0.0
Total	1	100	8	100	1	100	23	100	2	100

Source: Author, 2024.

Key: GP for grandparent PO for parents only F&S for father and siblings NF for nuclear family, M&S for mother and sibling

An investigation on the respondents living arrangements and the dwelling structures as an indication of the parents' SES is captured in table 15 above. Results review that 9 (25.7%) of the respondents lived in a semi-permanent family house which is a characteristic of low social economic neighbourhood. 10 (28.6%) lived in permanent block family owned house, 10 (28.6%) lived in gated family owned residence, 3 (8.6%) lived in gated and guarded family owned residence, and 3 (8.6%) lived in gated and guarded family owned residence. These finding indicate that most of the respondents 29

(82.9%) grew up in a low to medium social economic neighbourhood while 6 (17.1%) of the respondents grew up in the higher social economic neighbourhood.

Table 16 Respondents' age at which they started alcohol use and the highest level of Education completed by the recovering clients

	PL		SL		TL		UL		ML		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
<10 years	0	0.0	1	20.0	3	60.0	0	0.0	1	20.0	5	100
11-17years	2	11.8	5	29.4	8	47.1	1	5.9	1	5.9	17	100
18-24 years	6	22.6	3	11.3	11	40.7	5	18.5	2	7.4	27	100
25-31years	1	25.0	0	0.0	2	50.0	1	25.0	0	0.0	4	100
32-38years	0	0.0	0	0.0	0	0.0	1	100	0	0.0	1	100

Source: Author, 2024.

Key: PL-Primary Level, SL-Secondary Level, TL-Tertiary Level, UD -University degree and MD - Master's degree

A study was conducted to examine the correlation between the age at which individuals initiate alcohol consumption and their level of educational attainment. The findings of this investigation have been presented in Table 16. Results indicate that 5(29.4%) of those who started using alcohol ages between 10-11years attained secondary level of education. In addition, 8(47.1%) had attained tertiary level of education. The study also found that 1(5.9) attained masters level. This means that the earlier an individual starts the use of alcohol the lower the level of education. These findings approved Schmengler (2022), who observes that young adults with lower education got involved in increased alcohol use which was likely to generate into problematic alcohol use. The results of this study also agreed with the views of Soundararajan (2017), who posits that those who

initiate alcohol consumption at a younger age are at a higher risk of developing persistent and excessive alcohol consumption patterns in their adult years, ultimately leading to AUD.

However, the study displayed that 11(40.7%) of those started using alcohol between the age 18-24 years attain tertiary level of education while 5(18.5%) attained university level. The study found that out of those who started using alcohol at ages 25-31years 2(50%) had attained tertiary level while 1(25%) and 1(25%) had attained primary and university levels respectively. Only 1(100%) who started taking alcohol between 32-38years had attained university level. In line with SES Lasserre et al (2022) reports that a medium or low level of education were independent risk factors for developing AUD, compared to a high level of education.



Table 17 shows the distribution of the respondents' age at which they started alcohol use and their economic status

Table 17 Respondents' age at which they started alcohol use and their income before they got into AUD.

	<10yrs.		11-17yrs		18-24		25-31		32-38yrs		
	N	%	N	%	N	%	N	%	N	%	
Below Ksh. 24,000	3	42.9	6	37.5	9	33.3	0	0.0	0	0.0	18
Ksh. 25,000-34,000	2	28.6	2	12.5	7	25.9	1	25.0	0	0.0	10
Ksh. 35,000-45,000	0	0	1	6.3	2	7.4	2	50.0	0	0.0	5
Ksh.46,000-54,000	0	0	2	12.5	0	0.0	0	0.0	0	0.0	2
Ksh. 55,000-77,000	0	0	1	6.3	2	7.4	1	25.0	0	0.0	4
Ksh. 78,000-88,000	0	0	1	6.3	1	3.7	0	0.0	1	100	3
Ksh. 89,000-99,000	0	0	0	0.0	1	3.7	0	0.0	0	0.0	1
Above Ksh. 100,000	2	28.6	3	18.8	5	18.5	0	0.0	0	0.0	10
Total	7	100	16	100	27	100	4	100	1	100	55

Source: Author, 2024.

The objective is to determine the correlation between an individual's income and the age at which they begin consuming alcohol as recorded on table 17 above, results designated that 18 (32.7%) earned less than Kenya shilling twenty-four thousand (<Ksh. 24,000). 10 (18.2%) earned between Kenya shilling twenty-five thousand and thirty-four thousand (Ksh. 25,000-34,000), 5 (9.0%) earned between thirty-five thousand and forty-five thousand (Ksh. 35, 000-45, 000). 2 (3.6%) earned between forty-six thousand and fifty-four thousand Kenya shillings (Ksh. 46, 000-54, 000), 4 (7.3%) earned between Kenya shilling fifty-five thousand and seventy-seven thousand. 3 (5.5%) earned between Kenya shillings seventy-eight thousand and eighty-eight thousand (Ksh. 78,000-88,000), 1 (Percentage?) earned between Kenya shillings eighty-nine thousand and ninety-nine thousand and 10 (18.1 %) earned above Kenya shillings one hundred thousand.

In a survey completed in July 2022 to establish the poverty level in Kenya, the finding recognized that about 17% of the population in Kenya was living below the poverty line of (Ksh. 224.79) per day which is equivalent to Kenya shilling six thousand seven hundred and forty-four (Ksh 6,744) per month (Kamer, 2022). The current study results designate that the lowest earned amount was below Kenya shilling twenty-four thousand (<ksh24, 000) by (32.7%) of the respondents which is in the low SES but not necessarily in the poverty level.

These finding are confirmed by information from the FGD that found out individuals with low income turned to alcohol use when the amount earned was not enough to meet their entire financial obligation. This agrees with choice theory that theorizes that individuals' behaviours are guided by the five genetically coded needs. Turning to alcohol according to choice theory is a cognitive way to meet their survival need. The location is populated

by the users and those experiencing AUD resulting to modelling on the use of alcohol and eventually developing AUD.

Table 18 shows the respondents' age at which they started alcohol use and the highest level of education by their father.

Table 18 Respondents' age at which they started alcohol use and the highest level of Education completed by their father

	PL		SL		TL		UD		MD		DD		TL	%
	N	%	N	%	N	%	N	%	N	%	N	%		
< 10 years	1	16.7	1	16.7	1	16.7	2	33.3	1	16.7	0	0.0	6	100
11-17 years	0	0.0	3	18.8	3	18.8	3	18.8	5	31.3	2	12.5	16	100
18-24 years	2	8.3	1	4.2	13	54.2	5	20.8	1	4.2	2	8.3	24	100
25-31 years	2	50.0	1	25.0	1	25.0	0	0.0	0	0.0	0	0.0	4	100
Total	5	10.0	6	12.0	18	36.0	10	20.0	7	14.0	4	8.0	50	100

Source: Author, 2024.

Key:

PL-Primary Level, SL-Secondary Level, TL-Tertiary Level, UD-University degree, MD-Master's degree, DD-Doctoral degree

Table 17 above presents an inquiry into the correlation between the age at which participants commenced alcohol consumption and the educational attainment of their fathers. The data revealed that a total of 6 (12%) of the sample, initiated alcohol consumption prior to reaching the age of 10 years. Also, 1 (16.7%) of the fathers had completed primary level, another one-1(16.7%) had completed secondary level, and 1(16.7%) had completed tertiary level. Out of the total sample, 2(33.3%) had attained a university level education, while 1(16.7%) had a father who had completed a master's level education.

This study observes that 16 (32%) of the respondents started using alcohol between eleven and eighteen years (11-18) years. Out of the sixteen 3 (18.8%), their fathers had completed secondary level, the other 3 (18.8%), their father had completed tertiary level, and the other 3 (18.8%) had completed University level. Moreover, 5 (31.3%), their fathers had completed the masters level and 2 (12.5%) had completed doctoral level. It was also observed that 24 (48%) started using alcohol between age eighteen and twenty-four (18-24 years). Out of the twenty-four, 2 (8.3%), their fathers had completed the primary level, 1 (4.2%), his father had completed secondary level, and 13 (54.2%) had completed tertiary level.

Besides, 5 (20.8%) had completed university level 1 (4.2%) had completed the master's level and 2 (8.3%) had completed doctoral level. The smallest group of 4 (8%) started using alcohol between the age of twenty-five and thirty-one years. Out of the four, 2 (50%) their father had completed primary education level, 1 (25%), his father had completed secondary education level, and 1 (25%) had completed tertiary level. Based on the findings of the present study, it can be concluded that the paternal level of education attained has minimal impact on the onset of alcohol consumption among their children.

Table 19 below displays the statistics of the respondents' age at which they started alcohol use and the highest level of education completed by their mothers.

Table 19 Descriptive statistics of the respondents' age in years at which they started alcohol use and the highest level of Education completed by their mother

	PL		SL		TL		UD		MD		DD		TL
	N	%	N	%	N	%	N	%	N	%	N	%	N
< 10	0	0.0	1	20	3	60	0	0.0	1	20	0	0.0	5
11-17	2	11.8	5	29.4	8	47.1	1	5.9	1	5.9	0	0.0	17
18-24	6	22.2	3	11.1	11	40.7	5	18.5	2	7.4	0	0.0	27
25-	1	25.0	0	0.0	2	50.0	1	25.0	0	0.0	0	0.0	4
32-38	0	0.0	0	0.0	0	0.0	1	100	0	0.0	0	0.0	1
Total	9	16.7	9	16.7	24	44.4	8	14.8	4	7.4	0	0.0	54

Source: Author, 2024.

Key: PL-Primary Level, SL - Secondary Level, TL-Tertiary Level, UD -University degree, MD- Master's degree, DD-Doctoral degree.

The current investigation aimed to examine the correlation between the highest-level educational achievement attained by the participants' mothers and the ages at which their children-initiated alcohol consumption. Results indicate that 4 (8%) started using alcohol before they were 10 years. Out the four, 1 (20%) the mother's highest completed education level was secondary, 3 (60%) the mothers' highest completed education level was tertiary, and another 1 (20%) the mother's highest completed education level was master's degree.

The results similarly specify that 17 (31.5%) of the respondents started using alcohol at the age between eleven and seventeen years. Out of the 17 respondents, 2 (11.8%), their mother's highest completed education level was primary. Further, 5 (29.4%), their mothers' highest level of education completed was the secondary. Eight (47.1%) report that their mothers' highest completed education level was tertiary. It was likewise observed that 1 (5.9%) participant's mother highest completed education level was the university level and finally another 1 (15.9%) recounted that the mother's highest education level completed was the master's level. Half of the respondent 27 (50%) started using alcohol at the age between eighteen years and twenty-four years. Of the twenty-seven respondents, 6 (22.2%) designated that their mothers' highest education level completed was primary. Similarly, 3 (11.1%) report that their mothers' highest education level completed was the secondary. A significant proportion of 11 (40.7%), indicated that their mothers attained a tertiary level of education as their highest academic level. Furthermore, 5 (18.5%) indicated that their mothers attained a university-level education as their highest level of educational attainment. The minimum value of 2 (7.4%) indicates that the highest academic attainment achieved by the participants' mothers was at the level of a master's degree.

A small number 4 (8%) started using alcohol at the age between twenty-five and thirty-one. Out of the four, 1 (25%) reports that the highest education level completed by the mother was primary. Two out of the four people surveyed said that their mothers had completed at least some degree of tertiary education, whereas 1(25%) said that their mothers had completed at least some level of university education. A participant reported initiating alcohol consumption during the age range of 32 to 38 years, while their mother attained a university degree as her highest level of academic achievement.

Individuals in the low SES group had a higher prevalence of AUD than the high SES group (5.1% vs 4.6%). Low SES group had a higher proportion of current smokers (29.0% vs 15.2%) and those with ND (6.7% vs 3.0%). Those in the low SES group had higher prevalence of multi-morbidity (two or more chronic conditions) than the high SE. The researcher also conducted a chi square test to test the relationship between social economic status and alcohol use disorder among the recovering clients in the selected Centers in Nairobi County as indicated in Table 20.

Table 20 *Highest education level and Alcohol use disorder among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya*

Social status	Economic	Chi-square	df	Asymptotic Significance level	Approximate significance	Pearson's R value
Father's highest education level completed		28.48	16	.908	.690	-.062
Mother's highest education level completed		31.99	16	.010	.967	-.006
Respondents' highest education level completed		8.43	16	.751	.100	.233
Respondents' income before alcohol use disorder		18.05	16	.925	.214	.183

Significance level of .05 . Source: Author, 2024.

An analysis on social economic status was conducted and recorded in table 19 above. The obtained chi-square test statistic value of $\chi^2(16) = 28.48$, with a corresponding p-value

of .908, exceeded the predetermined alpha level of .05. This indicates that there existed a statistically significant association between the highest level of education completed by fathers and the development of AUD. This means that fathers' highest level of education completed influenced the development of AUD among the recovering clients.

An analysis of the PPMCC (r) as recorded in table 19 above, ($r(59) = -.062 < .690$) which indicates there was a negative relationship between the fathers' highest level of education completed and development of AUD among the recovering clients in selected rehabilitation Centers located within Nairobi County. PPMCC (r) of fathers' highest level of education completed and the offspring's progression of AUD indicates that if the fathers' highest level of education completed decreased the development of alcohol use disorder increased. On the contrary, if the fathers' highest level of education completed increased, the development of alcohol use disorder decreased. This study pertains to the impact of paternal education level on the emergence of AUD in their offspring, with a particular emphasis on male children.

An observation of mothers' highest level of education completed and the emergence of AUD was made and results recorded in Table 19 above. The chi results of 31.99 and asymptotic significance level P value of .010 ($\chi^2(16)31.99 =, p = .010$) show exhibited that a statistical significant association between mothers' highest academic level completed and the development of alcohol use disorder. This predestined that mothers' highest level of education completed predispose the recovering clients' development of alcohol use disorder. The findings of the study revealed that a negative correlation existed between the PPMCC (r) (PPMCC) and the level of education attained by mothers, with respect to alcohol use disorder. The indicated negative PPMCC (r) demonstrates that as the mothers' highest level of education completed increase AUD among the recovering clients in selected rehabilitation Centers located within Nairobi County decreased.

An increase in the highest level of education completed by the parents was most likely accompanied by more responsibilities outside the home hence reducing the amount of time spent with their children. This was echoed by responses from few respondents who reported taking a lot of alcohol at home when the parents were absent. These observations on parental highest level of education completed and their children alcohol consumption, misuse and emergence of AUD concur with those in (Wells & Östberg, 2018) who observes that the parent education level created an early life significance situation responsible for their children's dangerous alcohol use behaviours. The study concludes that adolescents whose parents had acquired low education levels drunk alcohol fewer times but drunk heavily in a drinking session.

An investigation on Respondents' highest education level and the emergence of AUD was conducted and the findings recorded in Table 19 above. The chi results of 8.43 and an asymptotic significance level (P) value of .751 ($\chi^2(1) = 8.43, p = .751$) was observed. This shows there was a statistical significant relationship between respondents' highest academic level and the emergence of AUD. This indicates that respondents' highest level of education completed did influence their development of alcohol use disorder. Results of an analysis of the PPMCC indicate a positive relationship between respondents' highest level of education completed and alcohol use disorder. The positive PPMCC (r) demonstrates that as the respondents' level of education completed increase the alcohol use disorder increased. Increased highest level of education completed was likely to be accompanied by increased income leaving the individuals with more money that can be used on alcohol. On the other hand, increased education level might come with increased responsibility in the society hence making the individual less popular among the locals,

resulting to alcohol as a way of managing their emotional issues which might eventually progress to alcohol abuse and develop into alcohol use disorder.

An analysis of respondents' income before developing (AUD) and the emergence of AUD was carried out and the results findings in Table 19 above. The chi results indicate 18.05 and an asymptotic significance Level (P) value of .925 ($\chi^2 (16)18.05 =, p = .925$). The observed Chi exceeds the asymptotic level of .925. This designate exhibited a statistically significant relationship between respondents' income before emergence of AUD among the recovering clients in selected rehabilitation Centers located within Nairobi County. This indicated that respondents' income before developing alcohol use disorder did influence the onset of AUD.

A positive Pearson product moment correlation coefficient between respondents' income before onset of AUD was also observed. This positive correlation demonstrated that as the respondents' income before onset of AUD increased. According to Collins (2016) an individual with higher SES may consume similar or greater amounts of alcohol compared with individuals with lower SES, the latter group seems to bear a disproportionate burden of negative alcohol-related consequences. Furthermore, the Lasserre et al (.2022) observes that individuals in the low SES group had a higher prevalence of AUD than the high SES group (5.1% vs 4.6%).

A chi square was conducted to test the hypothesis that there was no relationship between social economic status and alcohol use decoder among the recovering clients in the selected rehabilitation Centers in Nairobi as found in table 21

Table 21 *Chi-square test result for family socio-economic status and Alcohol Use Disorder among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya*

	Value	Df	Asymptotic significance(2-sided)
Pearson Chi-square	24.466	28	.657

Significance level of .05. Source: Author, 2024.

The second null hypothesis of the research that stated, there existed no statistically significant relationship between family socioeconomic status and AUD among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya was tested. The study utilized chi-square tests to evaluate the potential association between family socio-economic status and alcohol use disorder among individuals undergoing recovery in specific rehabilitation Centers located in Nairobi County. The Chi-square tests were recorded in table 20 above. A chi-square result indicates that the asymptotic significance (P value) of .657 which exhibited statistical significant relationship between family socio-economic status and AUD.

According to the chi-square findings, the null hypothesis was rejected. The findings indicate that the emergence of AUD was influenced by the family socio-economic status. The results were reinforced by Calling (2019) who noted that higher educational level, higher income and higher neighbourhood SES were all associated with a reduced risk for AUD for both males and females in all ages. Therefore, the study suggested for intensive psych education on the development of alcohol use disorder and more studies to establish the role of socio-economic factors in the emergence of AUD.

4.4 Influence of Parenting Styles on Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers located within Nairobi County.

As indicated in Table 22 the study presented descriptive statistics on the influence of parenting styles on alcohol use disorder in the selected rehabilitation Centers.

Table 22 Descriptive statistics (percentages and frequencies) of father's parenting styles and gender

		SD		D		NOT SURE		A		SA		Total	
		N	%	N	%	N	%	N	%	N	%	N	%
Rules	M	15	32.6	4	8.7	7	15.2	13	28.3	7	15.2	46	100
	F	2	4.0	1	2.0	0	0.0	0	0.0	2	4.0	5	10.0
warmth	M	19	42.2	10	22.2	7	15.6	6	13.3	3	6.7	45	100
	F	2	50.0	0	0.0	1	25.0	0	0.0	1	25.0	4	100
Nagged	M	14	30.4	7	15.2	6	13.0	11	23.9	8	17.4	46	100
	F	2	50.0	1	25.0	0	0.0	1	25.0	0	0.0	4	100
Punishment,	M	16	34.8	10	21.7	4	8.7	13	28.3	3	6.5	46	100
	F	1	25.5	1	25.0	0	0.0	2	50.0	0	0.0	4	100
Targets	M	16	36.4	15	34.1	7	15.9	3	6.8	3	6.8	44	100
	F	1	25.0	1	25.0	0	0.0	2	50.0	0	0.0	4	100
Opinions	M	5	11.1	9	20.0	9	20.0	16	35.6	6	13.3	45	100
	F	2	50.0	0	0.0	0	0.0	1	25.0	1	25.0	4	100
Modify	M	5	11.1	6	13.3	11	24.4	19	42.2	4	8.9	45	100
	F	1	25.0	1	25.0	0	0.0	1	25.0	1	25.0	4	100
Expectations	M	6	13.6	14	31.8	10	22.7	10	22.7	4	9.1	44	100
	F	1	25.0	0	0.0	0	0.0	3	75.0	0	0	4	100
Program	M	5	10.9	11	23.9	8	17.4	13	28.3	9	19.6	46	100
	F	1	25.0	1	25.0	0	0.0	0	0.0	2	50.0	4	100
Interaction	M	9	20.0	12	26.7	11	24.4	9	20.0	4	8.9	45	100
	F	2	50.0	0	0.0	0	0.0	2	50.0	0	0.0	4	100
Demands	M	9	20.0	2	4.4	9	20.0	19	42.2	6	13.3	45	100
	F	1	25.0	0	0.0	0	0.0	1	25.0	2	50.0	4	100
School	M	3	6.5	3	6.5	10	21.7	8	17.4	22	47.8	46	100
	F	1	25	0	0.0	0	0.0	1	25.0	2	50	4	100
activities													

Source: Author,2024.

Key; SD for Strongly disagreed, D for disagreed, Not Sure for Neither agreed nor disagreed, A for Agreed, SA for Strongly agree, Rules for father had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken, Nagged for father nagged, yelled and demanded discipline from

respondents more than he encouraged, listened or praised them, Warmth for he did not show respondents warmth or friendliness, love or encouraging feelings, punishment for father used physical punishment, such as canning and gave no choices, options or room for negotiation it was always his way, targets for he was never involved in respondents academic work meeting their personal targets and emotional development, opinions for father never explained or gave them an opportunity to give their opinion when making family rules, modify for father was able to modify and adjust their relationship according to the circumstance in relation to needs at the moment and punished accordingly, Expectations for there were very few family rules or the expected principles of conduct, and the few rules that were set were changeable, program for father never made program or plans to be followed when he was absent, Interaction for respondents had limited interaction with their father because he was either too busy with work, problems or he had nothing to share with them, Demands for father had very few expectations or demands for behaviour from respondents and siblings and offered very little supervision, School activities, for father was never interested in the respondents school work, school activities and missed all or most the school events and Cared for father neither cared nor responded to respondents feeling or emotions.

The relationship between fathers' different parenting styles and AUD was assessed and findings recorded in table 22 above. The findings indicate that 15 (32.6%) male, 2 (40%) female respondents strongly disagreed and 4 (8.7%) male, 1 (20%) female disagreed that their fathers had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken. Furthermore, 13 (28.3%) male, no female agreed and 7 (15.2%) male, 2 (40%) female strongly agreed that their fathers had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken.

Looking at other characteristics of authoritarian parenting style, 19 (42.2%) male 2 (50%) female strongly disagreed and 10 (22.2%) male, no female disagreed. On the other hand, 6 (13.3%) male, no female agreed and 3 (6.7%) male, 1 (25%) female strongly agreed that their fathers nagged, yelled and demanded discipline from them more than he encouraged, listened or praised them. This study also looked into punishment and it was observed that 16 (34.8%) male, 1 (25%) female strongly disagreed and 10 (21.7%) male, 1 (25%) female disagreed, while 13 (28.3%) male, 2 (50%) female and 3 (6.55%) male and no female strongly agreed that their father used physical punishment, such as canning and gave no choices, options or room for negotiation for it was always his way. The researcher in this study also looked at the relationship between the respondents and their father.

It was observed that 19 (42.2%) male, 2 (50%) female strongly disagreed and 10 (22.2%) male, no female disagreed while 6 (13.3%) male, no female agreed and 3 (6.7%) male, 1 (25%) female strongly agreed that their father did not show them warmth or friendliness, love or encouraging feelings. This finding show that most of the respondents were not brought up by an authoritarian father though they developed Alcohol use disorder

In this study, neglectful parenting style has been operationalized, as the parents were never involved in the children's academic work, their efforts to meet their personal targets, and emotional development. Parents had limited interaction with their children because they were either too busy with their work, problems or they had nothing to share with them. Moreover, parents had very few expectations or demands for behaviour from the children and offering very little supervision.

This study aimed to examine the impact of fathers' neglectful parenting style on the emergence of AUD. Martinez -Lorendo (2016) observed that neglectful parenting is a significant factor for developing AUD as such parenting is characterised by low warmth

and low control. These findings corroborate the current findings as presented in Table 21 that 16 (36.4%) male, 1 (25%) female strongly disagreed and 15 (34.1%) male, 1 (25%) female disagreed, on the other hand 3 (6.8%) male, 2 (50%) female agreed and 3 (6.8%) male, 2 (50%) female strongly agreed that their father was never involved in their academic work, to meet their personal targets and emotional development. This implies that their fathers' failure to be involved in their academic development could have led to development of the AUD. Nevertheless, Alegre (2011) highlighted that parents might be undemanding, detached, indifferent, and insensitive to their children.

An investigation on the fathers' response to their offspring's feelings, the findings show that 1 (2.2%) male, 1 (25%) female strongly disagreed and 7 (15.2%) male, no female disagreed on the other hand 11 (23.9%) male, 2 (50%) no female agreed and 15 (32.6%) male, 2 (50%) female strongly agreed that their fathers neither cared nor responded to their feelings or emotions.

An exploration on the father's interaction with his children was conducted. The findings indicate that 9 (20%) male, 2 (50%) female strongly disagreed and 12 (26.7%), no female disagreed whereas 11 (24.4%) male, no female agreed, likewise 9 (20%) male, 2 (50%) female strongly agreed that their fathers had limited interaction with them because he was either too busy with his work, with problems or had nothing to share with them. This means that Children of neglectful parents' exhibit lack self-control, have low self-esteem, are less competent than their peers and they may find themselves searching for love in all the wrong places (Santrock, 2005).

An examination on father's expectations or demands for behaviour from the children and supervision, the findings indicates that 6 (13.6%) male, 1 (25%) female strongly disagreed and 14 (31.8%) male, no female. Although 10 (22.7%) male 3 (75%) female

agreed and 4 (9.1%) male and no female strongly agreed that their father had very few expectations or demands for behaviour from them and offered very little supervision.

The findings indicate that a majority of the male respondents, comprising 20(45.5%), expressed disagreement with the given assertion, thereby suggesting that their fathers had set certain behavioural expectations and provided oversight. Contrarily, 75% of the female participants concurred with the statement that their fathers had minimal expectations or demands regarding their behaviours and provided inadequate supervision. The findings of the present study contradict Fernandez-Hermida, Calafat, Becoña, Tsertsvadze, & Foxcroft (2022), who demonstrates that neglectful parenting style was the least protective from alcohol use and abuse. These observations bring out the issue of gender identity where the male parent is more concerned with the male children and less concerned with the opposite gender.

Authoritative parenting style has been operationalized as, parents show warmth or friendliness, love or encouraging feelings, listening to their children's opinions and choices. This is in order to upgrade their freedom and thinking, set limits and responsibilities with an understanding of the penalties or consequences of their behaviour. Characteristics of authoritative parenting style such as showing warmth, love and encouraging feelings were studied, the findings show that, 19 (42.2%) male 2 (50%) female strongly disagreed and 10 (22.2%) male, and no female disagreed, while 6 (13.3%) male no female agreed and 3 (6.7%) male, 1 (25%) female strongly agreed that their fathers did not show them warmth or friendliness, love or encouraging feelings. Most of the male respondents 29 (64.4%) indicated that their fathers showed them warmth or friendliness, love or encouraging feelings. This is a characteristic of Authoritative parenting style, meaning they were brought up by an authoritative father though they

developed AUD. A negative association between an authoritative parenting style and high episodic drinking has also been demonstrated in regard to alcohol misuse (Mathialagan & Teng, 2017).

The present study also investigated the relationship between paternal authoritative parenting style and AUD. Verdicts conversed that 5 (11.1%) male, 2 (50%) female strongly disagreed and 9 (20%) males, no female disagreed. However, 16 (35.6%) male, 1 (25%) female agreed and 6 (13.3%) male, 1 (25%) female strongly agreed that their father listened to their opinions and choices to upgrade their freedom and thinking, he also set limits and responsibilities with an understanding of the penalties or consequences of their behaviour. A summary of these findings indicate 22 (48.9%) male respondents were brought up by an authoritative father. The statement appears to be in contrast with the research conducted by Fernandez-Hermida, Calafat, Becoña, Tsertsvadze, & Foxcroft (2022), which suggests that the authoritative parenting style is the most effective in preventing alcohol use, abuse, and the emergence of AUD. In the recent study, permissive parenting style has been operationalized as, parents never making programs or plans to be followed when were was absent, parents being too caring, prizing, cherishing, valuing their children's opinions on major family decisions.

Permissive parenting style and the development of AUD was evaluated. Findings indicated that 5 (10.9%) male ,1 (25%) female strongly disagreed and 11 (23.9%) male ,1 (25%) female disagreed while 13 (28.3%) male, no female agreed and 9 (19.6%), 2 (50%) female strongly agreed that their father never made program or plans to be followed when he was absent. A closer look at the results showed that more male participants 22 (47.9%) were brought up by permissive father as compared to 16 (34.8) male participants that were not brought up by a permissive father.

A study by Ceka (2016) revealed that parents loved their children and that is why they gave them space to do what they want to do. They preferred spoiling their children than denying them whatever they needed. They believed denying their children some things meant they didn't love them. These findings reinforced the current finding from the focus group discussion where one of the members said “. However, “I always got my way whenever I was left free. I could find myself getting into alcohol to kill boredom because the alcohol was available and my parents did not stop me from taking”

This could usher them into AUD.

The study also presented information on the parenting styles in order to ascertain whether it had any effects on alcohol use disorder as indicated in Table 23.

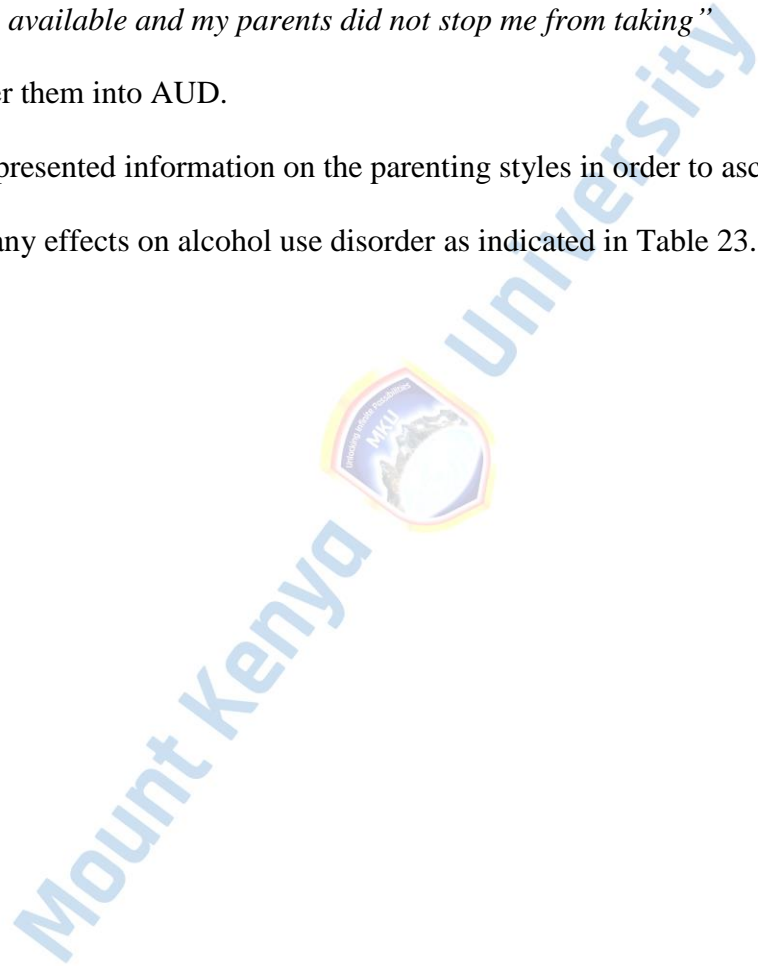


Table 23 Descriptive statistics (percentages and frequencies) of mother's parenting styles and gender

SD		D		N/S		A		SA		Total	
N	%	N	%	N	%	N	%	N	%	N	%

Rules	M	13	27.3	5	10.4	4	8.3	14	29.2	12	25.0	48	100
	F	1	20	2	40.0	2	40	0	0.0	0	0.0	5	100
Warmth	M	21	42.0	19	38.0	5	10.0	4	8.0	1	2.0	50	100
	F	3	60.0	0	0.0	1	20.0	1	20.0	0	0.0	5	100
Punishment	M	14	28.6	11	22.4	7	14.3	13	26.5	4	8.2	49	100
	F	1	20.0	2	40.0	0	0.0	1	20.0	1	20	5	100
Choices	M	16	32.7	8	16.3	11	22.4	7	14.3	7	14.3	49	100
	F	1	20.0	2	40.0	0	0.0	1	20.0	1	20.0	5	100
Presumed	M	15	31.3	11	22.9	7	14.6	12	25.0	3	6.3	48	100
	F	2	40.0	1	20.0	0	0.0	2	40.0	0	0.0	5	100
Targets	M	20	40.8	16	32.7	5	10.2	5	10.2	3	6.1	49	100
	F	2	40.0	1	20.0	1	20.0	1	20.0	0	0.0	5	100
Appreciated	M	4	8.2	3	6.1	10	20.4	13	26.5	19	38.8	49	100
	F	1	20.0	0	0.0	1	20.0	1	20.0	2	40.0	5	100
Opinions	M	3	6.1	6	12.2	9	18.4	15	30.6	16	32.7	49	100
	F	0	0.0	1	20.0	1	20.0	1	20.0	2	40.0	5	100
Caring	M	3	6.1	5	10.2	12	24.5	13	26.5	16	32.7	49	100
	F	1	20.0	1	20.0	1	20.0	1	20.0	1	20.0	5	100

Source: Author, 2024.

Key;

SD for Strongly disagreed, D for disagreed, NOT SURE for Neither agreed nor disagreed, A for Agreed, SA for Strongly agreed , Rules for mother had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken, Punishment for mother used physical punishment, such as canning and gave no choices, options or room for negotiation it was always her way, Warmth for she did not show respondents warmth or friendliness, love or encouraging feelings. Targets for she was never involved in respondents' academic work meeting their personal targets and emotional development, cared for mother neither cared nor responded to respondents feeling or emotions, Opinions for mother never explained or gave them an opportunity to give their opinion when making family rules, Choice for their mothers never allowed them to make choices, instead they chose items for them Appreciated for that their

mothers appreciated and had fun being with them. She was happy with their little or big determinations and achievement and communicated the same through different kinds such as physical contacts, laughter, nice voice tones, playful teasing, facial expressions, and encouragement among others. Presumed for their mothers never explained reasons to avoid definite behaviours but presumed they should just know.

The relationship between mothers' parenting style and AUD was studied and the findings recorded in table 23 above. The findings indicate that 13 (27.3%) male, 1 (20%) female respondents strongly disagreed and 5 (10.4%) male, 2 (40%) female disagreed that their mothers had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken. Similarly, 14 (29.2%) male, no female agreed and 12 (25%) male, no female strongly agreed that their mothers had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken. In summary, more male respondents 26 (54.2%) informed the researcher that they were brought up by an authoritarian mother while a smaller proportion of female participants 3(60%) reported not having been raised by an authoritarian mother.

Looking at other characteristics of authoritarian parenting style, observations indicate that 14 (28.6%) male ,1 (20%) female strongly disagreed and 11 (22.4%) male, 2 (40%) female disagreed while 13 (26.5%) male,1(20%) female agreed and 4(8.2%) male ,1 (20%) female strongly agreed that their mothers used physical punishment, such as canning and gave no choices, options or room for negotiation it was always their way. Most of the male respondent 25 (51.4%) specified that their mothers were not authoritarian parents. These findings have found out that 27 (50%) of the respondents started using alcohol between the age 18-24 years, at this age, an individual is considered

to be an adult in Kenya, making canning or other forms of physical punishment inappropriate.

Findings from the focus group discussion as revealed by one of the respondents that *“my parents were so strict to the extent that when I reached 18 years I started indulging into the forbidden items such as alcohol particularly when the source of rules or authority was absent. I felt grown enough not to be coerced to do the forbidden things”*.

Another respondent said

“My mother was very strict and I never touched alcohol One Christmas holiday we went to the rural home and she left me there.

I took alcohol until I would not manage myself.”

The relationship between the respondents and their mothers was of interest in this study. It was observed that 21(42.0%) male 3 (60%) female strongly disagreed and 19 (38.0%) male, no female disagreed while 4 (8.0%) male, 1 (20%) female agreed and 1 (2.0%) male, no female strongly agreed that their mother did not show them warmth or friendliness, love or encouraging feelings. According to Ceka (2016) 32 of the youth brought up be the authoritarian parents abused alcohol. These findings show that most of the respondents 40 (80%) male and 3 (60%) female were not brought up by an authoritarian mother though they developed alcohol use disorder. The findings create a need for a study to examine on other factors apart from parenting styles that could be contributing factors to the emergence of AUD. The present study also assessed the role of neglectful parenting style in the development of alcohol use disorder. The results as documented in table 22 above show that 20 (40.8%) male, 2 (40%) female strongly disagreed and 16 (32.7%) male, 1 (20%) female disagreed. On the other hand, 5 (10.2%) male, 1 (20%) female agreed and 3 (6.1%) male, no female strongly agreed that their mothers were never involved in their academic work, to meet their personal targets and

emotional development. These findings give a connotation that most of the male respondents 36 (73.5%) disagreed with the statement and so their mothers were involved in their academic work, to meet their personal targets and emotional development. This indicated that the mother was not neglectful to the majority of respondents though they developed alcohol use disorder.

Neglectful parenting style is also characterized by the parent being too caring, prizing and cherishing their children' opinions at the expense of responsibility. Findings indicate that 3 (6.1%) male, 1 (20%) female strongly disagreed and 5 (10.2%) male, 1 (20%) female disagreed on the other hand 13 (26.5%) male, 1(20%) female agreed and 16 (32.7%) male, 1 (20%) female strongly agreed that their mothers were too caring, prizing, cherishing and valued their opinions on major family decisions.

Consolidated results designate that majority 29 (59.2%) agreed that their mothers were too caring, prizing, cherishing, and valued my opinions on major family decisions, confirming that neglectful parenting style is a probable reason in the emergence of AUD. These findings coincide with Martinez (2016) who observes that different parenting styles could either protect adolescents from alcohol use, abuse or other negative alcohol-related behaviours including AUD. Martinez (2016) notes that adolescents who perceived their parents as neglectful had a higher likelihood of onset of AUD within a two-year timeframe, according to the study. This study also scrutinised the authoritative characteristic of mothers and the development of AUD among recovering clients in selected rehabilitation Centers located within Nairobi County. Verdicts conversed that 3 (6.1%) males, no female strongly disagreed and 6 (12.2%) male, 1 (20%) female disagreed, however 15 (35.6%) male, 1 (20%) female agreed and 16 (32.7%) male, 2 (40%) female strongly agreed that their mothers listened to their opinions and choices to

upgrade their freedom and thinking, they also set limits and responsibilities with an understanding of the penalties or consequences of their behaviour.

A summary of these findings indicate 31 (68.3%) male and 3 (60%) female respondents were brought up by an authoritative mother. The statement appears to be in contrast with the research conducted by Fernandez-Hermida, Calafat, Becoña, Tsertsvadze, and Foxcroft (2022), which suggests that the authoritative parenting style is the most effective in preventing consumption of alcohol, abuse, and the onset of AUD. An exploration on the mothers' behaviour towards their offspring's decision making was conducted, the verdicts indicate that 16 (32.7%) male, 1 (20%) female strongly disagreed and 8 (16.3%) male, 2 (40%) female disagreed. However, 7 (14.3%) male, 1 (20%) female agreed and 7 (14.3%) male, 1 (20%) female strongly agreed that their mothers never allowed them to make choices, instead they chose items for them. An authoritative mother will allow the children to make choices but guide them to what is applicable in the circumstance. These findings indicate that most of the male participants 24 (49 %) were actually allowed to make their choices as compared to 14 (28.6%) who reported that they were not allowed to make their choices.

This was an indication that they were brought up by authoritative mothers though they developed alcohol use disorder. Parental appreciation of their offspring's little or big determinations and achievement and communicated the same through different kinds such as physical contacts, laughter, nice voice tones, playful teasing, facial expressions, encouragement among others are characteristics of authoritative parenting style. An investigation of the same was conducted in this study and the results indicate that 4 (8.2%) male, 1 (20%) female strongly disagreed and 3 (6.1%) males, no female disagreed with the statement, however 13 (26.5%) male, 1 (20%) female agreed and 19 (38.8%) male, 2 (40%) female strongly agreed that their mothers appreciated and had fun being with them.

She was happy with their little or big determinations and achievement and communicated the same through different kinds such as physical contacts, laughter, nice voice tones, playful teasing, facial expressions, and encouragement among others.

Another characteristic of an authoritative mother includes explaining reasons towards definite behaviours such as alcohol use among others, an investigation on the same indicated that 15 (31.2%) male, 2 (40%) female strongly disagreed and 11 (16.3%) male, 1 (20%) female disagreed. Conversely, 12 (25%) male, 2 (40%) female agreed and 3 (6.3%) male, no female strongly agreed that their mothers never explained reasons to avoid definite behaviours but presumed they should just know. More participants 26 (47.5%) male and 3 (60%) female specified that their mothers explained reasons to avoid definite behaviours and did not presume that they should just know. A smaller number of 14 (31.3%) male and 2(40%) females agreed that their mothers never explained reasons to avoid definite behaviours but presumed they should just know. The aforementioned results serve to corroborate the notion that the authoritative parenting style does not function as a safeguard against the onset of AUD. However, these findings necessitate further research to explore the protective and risk factors associated with the onset of AUD within society. During an investigation on the influence of different parenting style on offspring's psychoactive substance use including alcohol use Berge (2016), results indicates that self-reporting of the participants was more accurate as compared to reports from the parents. The study also reports that parenting styles were of minimal significance in the use of alcohol and onset of AUD.

Table 24 *Relationship between parenting styles and alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi county Kenya*

Parenting styles	Chi	df	Asymptotic Significance level	Pearson's R value
Neglectful	6.133	16	.048	.273

Authoritative	6.122	16	.124	.190	.214
Authoritarian	5.668	16	.933	.225	.012
Permissive	3.922	16	.955	.417	-.008

Significance level of .05. Source: Author, 2024.

In order to investigate the impact of different parenting styles on the progression of AUD, a chi square analysis was performed and the outcomes are documented in Table 24. The statistical analysis of the data using chi-square test ($\chi^2 (16) = 3.922, p = .417$) indicated that there was a significant association between a permissive parenting approach and AUD among the recovering clients who were selected from rehabilitation Centers located in Nairobi County. The aforementioned implies that the permissive parenting style has an impact on the progression of AUD in individuals undergoing rehabilitation in specific Centers within Nairobi County. The study conducted a thorough examination of the PPMCC and found evidence of a negative correlation between permissive parenting styles and alcohol use disorder among individuals undergoing recovery in specific rehabilitation facilities located in Nairobi County. The findings suggest a negative correlation between permissive parenting style and AUD, indicating that an increase in the former is associated with a decrease in the latter.

An observation of the Authoritarian parenting style was carried out and findings were as recorded in table 24 above. The chi-square test yielded the following results: $\chi^2 (16) = 5.668, p = .225$. The asymptotic significance level exceeded the predetermined significance level of 0.05. The findings indicate a statistically significant correlation between the parenting style characterized by authoritarianism and the occurrence of AUD. This means that authoritarian parenting style had not influenced the progression of AUD among recovering clients in selected rehabilitation Centers located in Nairobi County. PPMCC (r) was also calculated and results were $(59) = .012 > .933$ which indicated there was a positive PPMCC between authoritarian parenting styles and alcohol

use disorder among recovering clients in selected rehabilitation Centers located within Nairobi County. The results indicated a positive relationship demonstrating that as the characteristics of authoritarian parenting style increased the alcohol use disorder among recovering clients in selected rehabilitation Centers located within Nairobi County increased.

An analysis of authoritative parenting style was also conducted and the finding recorded in table 23 above, the chi results $\chi^2 (16) = 6.122, p = .190$, Asymptotic Significance level was higher than the significance level 0.05. The findings indicate a statistically significant correlation between the parenting style characterized by high levels of control and support, namely authoritative parenting, and the presence of alcohol use disorder. The findings suggest that there was a significant impact of authoritative parenting style on the emergence of AUD in individuals undergoing rehabilitation in selected Centers within Nairobi County. The PPMCC revealed a positive correlation between authoritative parenting styles and AUD among individuals undergoing rehabilitation in selected Centers within Nairobi County.

An analysis of neglectful parenting style was conducted and the conclusion documented in table 23 above. The chi results $\chi^2 (16) = 6.133, p = .189$ exhibited a statistical significant relationship between neglectful parenting style and AUD because the obtained asymptotic significance level was higher than the significance level 0.05. This meant that neglectful parenting style had influence on the development of AUD. The PPMCC indicated there was a positive relationship between neglectful parenting styles and AUD among recovering clients in selected rehabilitation Centers located in Nairobi County. The correlation was positive implying that as neglectful parenting increased, alcohol use disorder also increased. Therefore, the study concludes that neglectful parenting style

would have influenced the emergence of AUD among the recovering clients in selected rehabilitation Centers located in Nairobi County to some extent.

The study also conducted a chi square to test the relationship between parenting styles and AUD of the recovering clients as indicated in Table 25

Table 25 *Pearson Chi-square results for parenting styles and AUD among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya*

	Value	df	Asymptotic significance(2-sided)
Pearson Chi-square	2.949	4	.566

Level of confidence 0.05 Source: Author, 2022.

In order to examine the third hypothesis, which posited that there exists no statistically significant correlation between parenting styles and AUD among recovering clients in selected rehabilitation Centers located in Nairobi County, a Chi-square measurement was conducted and the findings are presented in Table 25. The Chi-square test results in SPSS indicated an asymptotic significance level of 0.566 for the two variables, which exceeded the significance value of 0.05. The findings indicate there was statistically significant correlation between parenting styles and AUD among the recovering clients in selected rehabilitation Centers located in Nairobi County. Consequently, the researcher therefore was able to reject the null hypothesis.

4.5 Influence of Family Alcohol Use on Alcohol Use Disorder among Recovering Clients in selected rehabilitation Centers in Nairobi county Kenya

Offspring of parents who abuse alcohol are at an increased risk for experiencing abnormal outcomes during their childhood, adolescence, and adulthood. The aforementioned factors encompass escalated health care utilization, mental and psychological perturbations, behavioural anomalies, cognitive impairments, and alcohol intake, as stated by Hutchinson (2014).

Family alcohol use and Gender for the recovering clients in selected rehabilitation Centers located within Nairobi County was investigated and the observation captured in Table 26.

Table 26 *Descriptive statistics on family alcohol use and Gender for the recovering clients in selected rehabilitation Centers located within Nairobi County.*

		NU		S U		RU		HU		BD		Tota l	
		N	%	N	%	N	%	N	%	N	%	N	%
Father	M	10	23.8	10	23.8	12	28.6	6	14.3	4	9.5	42	100
	F	1	25.0	1	25.0	2	50	0	0.0	0	0	4	100
Mother	M	35	76.1	5	10.9	5	10.9	0	0.0	1	2.2	46	100
	F	3	60.0	0	0.0	1	20.0	1	20.0	0	0.0	5	100

older	M	10	25.6	11	28.2	9	23.1	4	10.3	5	12.8	39	100
brother	F	1	33.3	1	33.3	0	0.0	1	33.3	0	0.0	3	100
Older	M	22	75.9	6	20.7	1	3.4	0	0.0	0	0.0	29	100
sister	F	1	25.0	2	50.0	1	25.0	0	0.0	0	0.0	4	100

Source: Author, 2024.

Key

1. Non user (NU) – does not take alcohol at all, Social user (SU) – only takes alcohol in social functions, Regular user (RU)– takes alcohol once in a while, Heavy user (HU) – takes alcohol and gets dysfunctional, Binge drinker (BD) – takes a lot of alcohol at a time
 Father for at the time they started using alcohol, Mother for at the time they started using alcohol, older brother for at the time they started using alcohol, older sister for at the time they started using alcohol. The key above helps in understanding the table 26 above

An investigation on family alcohol use for the recovering clients in selected rehabilitation Centers located within Nairobi County, the findings indicate that there was an alcohol user in every family represented by the respondent. These findings concur with Kimani (2013) who reports that sixty percent (60%) of all students who abused alcohol and participated in the study had a history of alcohol abuse and dependency in their family.

An examination was conducted on the respondents' fathers' alcohol use at the time they started using alcohol. The results show that 10 (23.8%) male ,1 (25%) female started using alcohol when their fathers were non-users, 10 (23.8%) male, 1 (25%) female started using alcohol when their fathers were already social users. 12 (28.6%) male, 2 (50%) female started using alcohol when their fathers were already a regular user, 6 (14,3%)

male and no female, started using alcohol when their fathers were already heavy users and 4 (9.5%) and no female started using alcohol when the father was already a binge drinker. Most of respondents 12 (28.6%) started using alcohol when the fathers were regular alcohol users.

The present study's results align with those of a prior investigation carried out in Muranga County (Mungai 2019), which demonstrated that paternal alcohol consumption and the presence of a family member with AUD were associated with increased alcohol use and the onset of AUD. Ninety percent (90%) of the respondents were of the male gender making gender identity a most likely factor to influence alcohol consumption among the sons through modelling and subsequently the development of AUD. This was confirmed by the small number 5 (10.9%) male, 1 (20%) female who started using alcohol when their mothers were already regular users.

An examination on the respondents' mothers' alcohol use at the time they started using alcohol, outcomes displayed that the highest number of respondents 35 (76.1%) male, 3 (60%) female started using alcohol when their mothers were non-users. As indicated above, a small number of respondents 5 (10.9%) male, no female started using alcohol when their mothers were already social users, 5 (10.9%) male, 1 (20%) female started using alcohol when their mothers were already regular users. Besides, 1 (20%) female and no male, started using alcohol when the mother was already a heavy user, and 1 (2.2%) and no female started using alcohol when the mother was already a binge drinker. Research has shown that children who have a familial background of AUD exhibit a greater propensity for increased alcohol consumption and a higher likelihood of developing the disorder compared to their counterparts without such a family history (Leung, Britton, & Bell, 2016).

A consideration on the respondents' older brother alcohol use at the time they started using alcohol, results demonstrated that 10 (25.6%) male, 1 (33.3%) female started using alcohol when their older brothers were non-users, 11 (28.2%) male, 1 (33.3%) female started using alcohol when their older brothers were previously social users. Further, 9 (23.1%) male, no female started using alcohol when their older brother was already a regular user, 4 (10.3%) male and 1 (33.3%) female, started using alcohol when the older brother was already a heavy user and 5 (12.8%) male and no female started using alcohol when the older brothers were already binge drinkers.

A consideration on the respondents' older sisters' alcohol use at the time they started using alcohol, results demonstrated that 22 (75.9%) male, 1 (25%) female started using alcohol when their older sisters were alcohol non-users., Similarly, 6 (20.7%) male, 2 (50%) female started using alcohol when their older sisters were previously social users, 1 (3.4%) male, 1 (25%) female started using alcohol when their older sisters were already regular users. The study indicates that no participant started using alcohol when their older sister was either a heavy user or a binge user. However, from the focus group discussion one of the respondents was quoted saying that,

“I started using alcohol as I observed my brother taking it. I associated it with being a grown up. Since I wanted everyone in the family to respect me as an adult, I had to start so that I can feel like one”

this implies that when a significant member of the family is using alcohol, the others might feel it is okay, family members might continue with the use to remain in the company of the significant family member.

The findings in the existing study concur with those reported in (Pedersen & Soest, 2013). The said findings indicate a positive relationship between parental alcohol use and their offspring in light of alcohol consumption and related behaviours including AUD

development at the age of 28 years. The results of the present investigation are in concurrence with those reported by Kirsimarja (2019). The present study aimed to examine the variability in the incidence of intellectual and behavioural syndromes over an extended period among offspring of parents with no history of alcohol-related issues, parents with limited alcohol-related complications, and parents with severe alcohol-related complications. Additionally, the study explored the association between maternal and paternal alcohol misuse and the risk of disorders in their offspring. The findings communicated a positive relationship between parental alcohol misuse irrespective of the severity of the misuse and their offspring's risk of developing intellectual and interactive syndromes.

Findings of the current study also concur with those by Solis (2012) as reported in Mosel (2022), who observes that adolescents and young adults whose mothers experience problematic alcohol use were more likely to alcohol abuse and develop AUD. The study also observes that fifty to sixty percent (50-60%) AUD onset is accounted for by the individual's genetic composition. Gender identity was reported to be a reason in offspring's alcohol consumption and the emergence of AUD. Conferring to the findings, 35 (76.1%) of the male participants and 3 (60%) of the female participants started using alcohol when their mothers were non-alcohol users as compared to 10 (23.8%) of the male participants and 1 (25%) female participants who started using alcohol when their fathers were non-alcohol users. An investigation on the development of AUD and family non-alcohol consumption behaviour, results indicate that 83 (48.3%) responses out of the total 172 (100%), responses from the participants indicate that they started using alcohol when the parents and older siblings were not using alcohol.

Nevertheless, the present investigation diverges from Pedersen and Soest's (2013) findings regarding the impact of parental excessive drinking on the emergence of AUD

in children. The current study report that most, 36 (20%) of all the 172 (100%) responses from the participants who reported that they started using alcohol when there were alcohol social users in their family. This is in comparison to the least, 10 (5.8%) of all the responses from of the participants who indicated that they started using alcohol when there were binge drinkers in their family.

These findings on the family's alcohol use status when the participants started using alcohol approves Cherry & Gans (2023) learning theory such as classical conditioning which contends that all behaviours associated with rewarding stimuli can be acquired. Alcohol social use is mainly associated with happier and less stressful environment with little inhibitions if any. An intoxicated family member might look happier and less stressed with little inhibitions, making the experience look rewarding and worth experimenting with other younger family members.

Social learning theory as cited in McLeod (2016), holds that all behaviours that are presented and observed repeatedly are acquired with time. This explains the relatively high number of responses, 31(18%) from the participants who indicated that they started using alcohol when there were regular alcohol users in the family. This implies that when a significant member of the family is using alcohol, the others might feel it is okay and thus family members might continue with the use to remain in the company of the significant family member.

Nevertheless, not all observed behaviours are learned. Choice theory by Glasser (2000) posits that human beings make choices that help them to meet their specific need but not just observe and copy or model after other peoples' behaviours. This explains the very high numbers, 10 (23.8%) male, 1 (25%) female participants who started using alcohol when their fathers were non-alcohol users and 35 (76.1%) male, 3(60%) female participants who started using alcohol when their mothers were non- alcohol users. These

finding generate the need for a study to investigate the role of individual choices in emergence of AUD.

From the focus group discussion, the study found that alcohol consumption and eventually AUD can be as a result of a coping mechanism. Nadkarni et al. (2013) reported the use of alcohol as a coping mechanism, which resulted in the emergence of alcohol use disorder (AUD). The authors noted that individuals consumed alcohol as a strategy to cope with psychosocial stress and to obtain unanticipated revenue. However, one of the respondents was quoted saying

“I started drinking when my only brother was jailed for two years. I could not forget that day and I always had night mares of what had happened. I therefore began drinking in order to deal with his absence and other associated stress.” A male respondent aged 38years.

This implies that the stress emanating from other events may also lead to AUD. For instance, the report from discussion group noted that Alcohol use disorder is associate with financial misappropriation, problem with the Law domestic violence among others. Children growing with a significant member of the family experiencing alcohol use disorder might be bullied and labelled by peers on the account of their family member alcohol use disorder. Thus making them turn to alcohol use and eventually develop AUD.

The chi square test in Table 27 reveals the relationship between family alcohol use and alcohol use disorder among the recovering clients in Nairobi county, Kenya

Table 27 Relationship between Family Alcohol Use and Alcohol Use Disorder among Recovering Clients in Selected Rehabilitation Centers in Nairobi County

Family alcohol use	chi	df	Asymptotic Significance	Approximate significance	Person's R value
Father	.460	16	.977	.833	-.032

Mother	6.993	16	.136	.467	-109
Older brother	.920	16	.922	.883	-026
Older sister	3.321	16	.506	.368	-.159

Significance level of 0.05 Source: Author,2024.

The analysis of Fathers' alcohol use was conducted and the chi results $\chi^2 (16) = .460, p = .977$ documented in table 27 above. The obtained chi-square results ($\chi^2 (16) = .460, p = .977$) indicate a lack of statistical significance in the association between the alcohol consumption of fathers and the occurrence of AUD in recovering clients from selected rehabilitation Centers located within Nairobi County. This means that Fathers' alcohol use had no effect on alcohol use of the participants nor the development of alcohol use disorder. A calculation of PPMCC indicates that there was a negative relationship between Fathers' alcohol use and the development of AUD. This meant that if the father's alcohol use increased the recovering client alcohol use disorder decreased.

The analysis of mothers' alcohol use was carried out and the findings recorded in table 27 above. The statistical analysis of the chi results ($\chi^2 (16) = 6.993, p = .136$) exhibited is a significant association between the alcohol consumption of mothers and the AUD of clients undergoing rehabilitation in selected Centers located in Nairobi County. The findings suggest that there was significant association between the alcohol consumption of mothers and the onset of AUD in individuals undergoing recovery. The PPMCC revealed a negative correlation between maternal alcohol consumption and the onset of AUD. The findings suggest an inverse relationship between the AUD of recovering clients in selected Centers located within Nairobi County and the alcohol consumption of their mothers. Specifically, an increase in maternal alcohol use was associated with a decrease in the AUD of the recovering clients.

The analysis of older brothers' alcohol use was carried out and the findings recorded in table 27 above. The chi results $\chi^2(16) = .920, p = .922$) exhibited no statistical significant relationship between' older brothers' alcohol consumption and AUD of the participants in selected Centers. This means that older brothers' alcohol use did not affect the emergence of AUD of the recovering clients. The PPMCC indicates that there was a negative PMCC between older brothers' alcohol use and the development of alcohol use disorder among recovering clients in selected rehabilitation Centers. The negative PPMCC results means that when their older brothers' alcohol uses increased AUD among recovering clients in selected Centers decreased.

An analysis of older sisters' alcohol use was also carried out and the findings recorded in table 27 above. The chi results $\chi^2 (16) = 3.321 p = .506$) exhibited a statistical significant relationship between older sisters' alcohol consumption and emergence of AUD among the recovering clients in selected Centers. This means that older sisters' alcohol use affects the development of AUD. However, the PPMCC (r) indicates that there was a negative PPMCC between older sisters' alcohol consumption and the emergence of AUD. This means that when the older sisters' alcohol use increased, AUD among the recovering clients in selected rehabilitation Centers in Nairobi county Kenya decreased.

To test the fourth hypothesis which stated that there was no statistical significant relationship between Family Alcohol use and AUD among the recovering clients in selected rehabilitation Centers located with Nairobi County, a Chi-square measurements was computed using the Chi-square tests. The chi square test as indicated in Table 28 was conducted to test the null hypothesis that, stated that there was no relationship between for family alcohol use and AUD among the Recovering Clients in selected rehabilitation Centers in Nairobi county Kenya.

Table 28 *Chi-square tests Results for Family Alcohol Use and AUD among the Recovering Clients in selected rehabilitation Centers in Nairobi county Kenya*

	Value	Df	Asymptotic significance(2-sided)
Pearson Chi-square	5.333	4	.255

Level of confidence 0.05. Source: Author, 2024.

According to SPSS, Chi-square tests results recorded in Table 28 above, the P-values labelled as asymptotic significance of these two variables is 0.255. The obtained P-value exceeded the predetermined significance level of 0.05, suggesting the absence of a statistically significant association between family alcohol use and AUD among individuals undergoing rehabilitation in selected Centers. This implies that the researcher found sufficient evidence to reject the null hypothesis.

The present investigation also examined the DSM-5 criteria for AUD. The findings of the study suggest that the respondents, who were individuals in recovery, fulfilled the criteria outlined in the DSM-5. An investigation of the specific criteria and the respondents age was conducted. Table 27 contain the provided information on the amount of alcohol the respondents consumed and their ages during the study. According to DSM-5 AUD in United States among adults decrease in the middle age and especially so among the members of the population aged between 30 and 64 years of age. AUD was reported to be highest among persons aged between 18 and 29 years and lowest among the population above 65 years of age.

The distribution found in Table 29 indicates whether the respondents took large amount of alcohol than was intended or not.

Table 29 *They took larger amounts of alcohol than they intended*

	Vft		Ft		sometimes		Mot		Al		Total	%
	N	%	N	%	N	%	N	%	N	%	N	%
19-25	0	0.0	1	12.5	4	50	2	25.0	1	12.5	8	100
26-32	2	16.7	1	8.3	1	8.3	5	41.7	3	25	12	100
33-39	1	5.6	3	16.7	3	16.7	10	55.6	1	5.6	18	100

40-46	1	8.3	0	0.0	6	50.0	5	41.7	0	0.0	12	100
47-53	0	0.0	0	0.0	0	0.0	1	100	0	0.0	1	100
54>	0	0.0	0	0.0	2	100	0	0.0	0	0.0	2	100
Total	4	7.5	5	9.4	16	30.2	23	43.4	5	9.4	53	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, Al for always

Table 29 presents an examination of the correlation between the quantity of alcohol consumed and the age of the participants. The findings indicated that most 4(50%) of the respondents aged between nineteen and twenty-five years took larger amounts of alcohol than they intended sometimes. Subsequently, a total of two respondents, constituting 25% of the sample population aged between 19 and 25 years old, reported consuming alcohol in quantities exceeding their intended limits on a frequent basis.

It was observed that one respondent (12.5%) within the age range of nineteen to twenty-five years reported consistently consuming larger quantities of alcohol than initially intended. Among the participants aged 19 to 25 years, a minority of 1 (12.5%) reported consuming larger quantities of alcohol than they had intended on a few occasions, while none of the respondents in the same age group reported doing so very few times.

The youngest group of respondents was between twenty-six and thirty-two years of age which formed twenty-two point six percent (22.6%) of all the respondents. Among these respondents, most of them 5(41.7%) reported that they who took larger amounts of alcohol than they intended most of the times. The second group among the respondents aged between twenty-six and thirty-two years of age was 3(25%) testified that they who took larger amounts of alcohol than they intended always.

The third group among the respondents aged between twenty-six and thirty-two years of age was 2(16.7%) stated that they who took larger amounts of alcohol than they intended very few times. The smallest group among the respondents aged between twenty-six and thirty-two years of age was 1(8.3%) that stated that they who took larger amounts of alcohol than they intended few times and a similar number 1(8.3%) stated that they who took larger amounts of alcohol than they intended some times.

There was another group of respondents was between thirty-three and thirty-nine years of age which formed forty percent (40%) of all the respondents. Among these respondents, most of them 10(55.6%) conveyed that they who took larger amounts of alcohol than they intended most of the times. The second group among the respondents aged between thirty-three and thirty-nine years of age was 3(16.7%) who testified that they who took larger amounts of alcohol than they intended few times and a similar size 3(16.7%) respondents stated that they took larger amounts of alcohol than they intended sometimes. The smallest group among the respondents aged between thirty-three and thirty-nine years of age was 1(5.6%) that stated that he or she took larger amounts of alcohol than they intended very few times and a similar number that stated that he or she took larger amounts of alcohol than they intended always.

The fourth youngest group of respondents was aged between forty and forty-six years of age which made twenty-two point six percent (22.6%) of all the respondents. Among these respondents, most of them 6(50%) conveyed that they took larger amounts of alcohol than they intended sometimes. The second group of the respondents aged between forty and forty-six years of age were 5(41.7%) who attested that they who took larger amounts of alcohol than they intended most of the times. The smallest group among the

respondents aged between forty and forty-six years of age was 1(8.3%) that stated that he or she took larger amounts of alcohol than he or she intended very few times.

The group with the list number of respondents was aged between forty-seven and fifty-three years of age which formed two percent (2%) of all the respondents. Among these respondents, all conveyed that they who took larger amounts of alcohol than they intended most of the times. While the group with the most elderly respondents was more than fifty-four years of age which made four percent (4%) of all the respondents. Among these respondents all indicated that they who took larger amounts of alcohol than they intended sometimes.

Table 30 presented the distribution on the persistency desired to cut down or regulate alcohol use among the client in selected rehabilitation Centers.

Table 30 *They persistently desired to cut down or regulate alcohol use but still went back to alcohol*

	Vft		Ft		sometimes		Mot		A		Total	%
	N	%	N	%	N	%	N	%	N	%		
19-25	2	25.0%	0	0.0%	1	12.5%	4	50.0%	1	12.5%	8	100
26-32	1	8.3%	1	8.3%	2	16.7%	3	25.0%	5	41.7%	12	100
33-39	2	11.1%	0	0.0%	4	22.2%	9	50.0%	3	16.7%	18	100
40-46	0	0.0%	1	8.3%	1	8.3%	9	75.0%	1	8.3%	12	100
47-53	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	100%	1	100
54>	1	50.0%	0	0.0%	0	0.0%	1	50%	0	0.0	2	100
Total	6	11.3	2	3.8	8	15.1	26	49.1	11	20.8	53	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, Al for always

Table 30 captured information on respondent's persistent desired to cut down or regulate alcohol use though they still went back to drinking alcohol and their ages during the study.

The cohort of participants who were the most junior in age ranged from nineteen to twenty-five years old. Most of them 4(50%) reported that they persistently desired to cut down or regulate alcohol use but they still went back to drinking alcohol most of the time.

Among the respondents aged between nineteen and twenty-five years of age were 2 (25%). They testified that that they have persistent preference for reducing or controlling their alcohol consumption. but still went back to drinking alcohol very few times. A small number 1(12.5%) among the respondents aged between nineteen and twenty-five years of age stated that they have persistent preference for reducing or controlling their alcohol consumption. but still went back to drinking alcohol sometimes and a similar number 1(12.5%) informed that they have persistent preference for reducing or controlling their alcohol consumption but still went back to drinking alcohol always. It was also observed that most of the respondents 23(43.4%) irrespective of their age during the study determinedly desired to cut down or regulate alcohol use but still went back to drinking alcohol most of the time. secondly 16(30.2%) irrespective of their age during the study persistently desired to cut down or regulate alcohol use but still went back to drinking alcohol sometimes.

While others 4(7.5%) untiringly desired to cut down or regulate alcohol use but still went back to drinking alcohol very few times and 5(9.4%) persistently chosen to cut down or regulate alcohol use but still went back to drinking alcohol few times. Those who persistently desired to cut down or regulate alcohol use but still went back to drinking alcohol always were 5(9.4%) and mainly from the younger group of respondents.

The distribution table on Table 31 indicated percentages of the time they spent on alcohol

Table 31 *They spent most of their productive time on alcohol related activities*

	Vft		Ft		sometimes		Mot		A		Total	%
	N	%	N	%	N	%	N	%	N	%		
19-25	2	28.6	2	28.6	1	14.3	1	14.3	1	14.3	7	100
26-32	1	8.3	1	8.3	6	50	3	25.0	1	8.3	12	100
33-39	2	11.8	3	17.6	3	17.6	6	35.3	3	17.6	17	100
40-46	0	0.0	2	16.7	4	33.3	4	33.3	2	16.7	12	100
47-53	0	0.0	0	0.0	0	0.0	1	100	0	0.0	1	100
54>	1	50.0	0	0.0	0	0.0	1	50	0	0.0	2	100
Total	6	11.8	8	15.7	14	27.5	16	31.4	7	13.7	51	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, Al for always

One of the criteria for AUD, as outlined in the DSM-5, is the amount of could be productive time spent on problematic alcohol related activities. The present investigation revealed that a proportion of 28.6% (n=2) of participants within the age range of nineteen to twenty-five years reported infrequent engagement in activities related to alcohol consumption, such as procuring, consuming, or recuperating from its effects. A comparable proportion of 28.6% of the participants within the age range of nineteen to twenty-five years expended a noteworthy amount of time appealing in the acquisition of their substance of choice which was mainly alcohol, drinking it, or recovering from its effects on a few occasions. A smaller proportion of the respondents, specifically 14.3% of those aged 19-25, reported spending a significant amount of time engaging in activities related to alcohol consumption, such as obtaining it, drinking it, or recovering from its effects. Similarly, an equivalent percentage of participants in the same age group reported spending some time engaging in these activities. A single participant, constituting 14.3% of the sample, consistently allocated a significant amount of time towards procuring alcohol, consuming it, and recuperating from its impact.

The cohort of participants ranging from twenty-six to thirty-two years of age constituted the second most youthful demographic in the research. The study revealed that a majority of the respondents, specifically 50%, dedicated a significant amount of time to procuring, consuming, or recuperating from the effects of alcohol on occasion. Twenty-five percent of the aforementioned quantity dedicated a significant amount of time to procuring, consuming, or recuperating from the effects of alcohol. The study findings indicate that a minority of the respondents, specifically one individual representing 8.3% of the sample, within the age bracket of twenty-six to thirty-two years, reported spending a

significant amount of time engaging in activities related to alcohol consumption, such as acquiring alcohol, drinking, or recuperating from its effects, on a limited basis rather than frequently. The study revealed that a single respondent, constituting 8.3% of the sample, expended a significant amount of time procuring, consuming, or recuperating from the effects of alcohol on only a few occasions. A similar proportion (8.3%) dedicated a significant amount of time to the acquisition, consumption, or recuperation from the effects of alcohol on a limited number of occasions. One additional respondent, constituting 8.3% of the sample, within the age range of twenty-six to thirty-two, reported spending an important quantity of time engaging in activities related to alcohol consumption, such as procuring, consuming, or recuperating from its effects. The protracted engagement in activities aimed at acquiring alcohol, consuming it, or recuperating from its effects renders an individual with alcohol use disorder unproductive within the community.

The results of a study conducted at Washington University School of Medicine in St. Louis revealed that individuals with serious drinking disorders exhibited a significantly higher rate of absenteeism from work compared to those without the disorder, with the former group missing more than twice the number of workdays (Dryden, 2022). Upon analysing the survey data, the researchers discovered that people with an extreme addiction to alcohol indicated an average of 232 days of job skipped annually due to reasons such as illness, injury, or absenteeism. This figure is over two times the amount of days at work skipped by those who do not suffer from AUD.

A correlation has been reported in Kenya between AUD and decreased productivity. The study aimed to assess the prevalence of alcohol use disorder (AUD) and associated factors among public sector employees in Kenya. The findings revealed a growing issue of severe

AUD, leading to reduced workplace productivity and increased healthcare costs, as well as a high attrition rate among affected employees (Kamender, Muteti, Kimani, & Okioma, 2022).

The distribution found in Table 32 indicated the clients' desire or urge for alcohol when they were in an environment where they previously got alcohol from.

Table 32 They experienced an intense desire or urge for alcohol when they were in an environment where they previously got alcohol from

	Vft		Ft		sometimes		Mot		A		Total	%
	N	%	N	%	N	%	N	%	N	%		
19-25	1	12.5	1	12.5	3	37.5	0	0.0	3	37.5	8	100
26-32	1	8.3	1	8.3	4	33.3	4	33.3	2	16.7	12	100
33-39	1	5.6	2	11.1	3	16.7	7	38.9	5	27.8	18	100
40-46	2	16.7	1	8.3	3	25	5	41.7	1	8.3	12	100
47-53	0	0.0	0	0.0	0	0.0	0	0.0	1	100	1	100
54>	0	0.0	1	50.0	1	50.0	0	0.0	0	0.0	2	100
Total	5	9.4	6	11.3	14	26.4	16	30.2	12	22.6	53	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, Al for always

Another DSM-5 criteria for AUD that was examined was the experiencing of an intense desire or urge for alcohol when the alcohol recovering client were in an environment where they previously got alcohol from. Most of the respondents 16(30.2%) experienced an intense desire or urge for alcohol when they were in an environment where they previously got alcohol from most of the times.

When they were in a setting where they had previously gotten alcohol, the second biggest group 14(26.4%) expressed an acute need or yearning for alcohol. This was closely followed by 12 (22.6%) who always had an acute want or drive for alcohol when they were in a place where they had previously obtained alcohol. A smaller percentage of

respondents 6 (11.3%) reported that, when they were in a situation where they had previously obtained alcohol they experienced a severe desire for alcohol a few times. When they were in an atmosphere where they had previously gotten alcohol the fewest number of responders (5(9.4%) articulated a pressing urge for alcohol a few times.

An inquiry was done on respondents' ages throughout the research and their having an overwhelming need or urge for alcohol while they were in an environment where they previously obtained alcohol from with the results indicated in table 31 above. The study's results revealed that 3(37.5%) of respondents aged nineteen to twenty-five years old reported an overwhelming need or drive for alcohol when they were in a setting where they previously obtained alcohol sometimes. When they were in a place where they previously acquired alcohol from, a comparable proportion of 3(37.5%) of the respondents aged nineteen to twenty-five years old had an acute want or craving for alcohol always.

It was also shown that a lower number 1(12.5%) of respondents aged nineteen to twenty-five years old had an acute want or drive for alcohol when they were in a setting where they had previously obtained alcohol very few times. When they were in a place where they had previously obtained alcohol, an identical number of one (12.5%) of the respondents aged nineteen to twenty-five years old had a pressing desire for alcohol a few times. An investigation was conducted on respondents aged twenty-six to thirty-two years old, and their experiences with an acute want or drive for alcohol while they were in a place where they previously obtained alcohol. The findings revealed that 4(33.3%) of respondents aged twenty-six to thirty-two years old reported an overwhelming need or drive for alcohol when they were in a setting where they previously obtained alcohol sometimes.

When they were in a setting where they previously obtained alcohol most of the time, a comparable number 4(33.3%) of respondents aged twenty-six to thirty-two years old expressed a burning thirst for alcohol most of the times. A reduced number 2(16.7%) of the respondents aged between aged twenty-six to thirty-two years of age experienced an intense desire or urge for alcohol when they were in an environment where they previously got alcohol from always. It was discovered that 1(8.3%) of respondents aged twenty-six to thirty-two years old had an intense desire or urge for alcohol when they were in an environment where they had previously obtained alcohol only a few times, and another 1(8.3%) of respondents aged twenty-six to thirty-two years old had an intense desire or urge for alcohol when they were in an environment where they had previously obtained alcohol very few times.

An investigation was done on respondents aged thirty-three to thirty-nine years old and their experiences with an overwhelming need or drive for alcohol when they were in a place where they previously obtained alcohol. The data revealed that the majority 7(38.9%) of respondents aged thirty-three to thirty-nine years old reported an acute want or drive for alcohol when they were in a setting where they previously obtained alcohol the majority of the time. This was followed by 5 (27.8%) who had an acute need or want for alcohol when they were in a place where they had previously obtained alcohol always. The third biggest group consisted of 3 (16.7%) respondents aged thirty-three to thirty-nine who testified that they had an acute want or drive for alcohol when they were in a setting where they previously obtained alcohol sometimes. A small number of 2(11.1%) respondents aged thirty-three to thirty-nine years old reported having an acute want or drive for alcohol while they were in a setting where they had previously obtained alcohol a few times.

While the smallest percentage of respondents¹ (15.6%), aged thirty-three to thirty-nine years old, testified that they had an extreme want or drive for alcohol when they were in an environment where they had previously obtained alcohol very few times.

Kharb et al. (2018) conducted a study to examine the correlation between desire and the onset of relapse in individuals with alcoholism, the findings testified that desire for alcohol and other substances seems to be a leading feature associated to relapse among alcohol dependent recovering clients.

Table 33 *They failed to accomplish their main social, academic or official responsibilities*

	Vft		Ft		sometimes		Mot		A		Total	%
	N	%	N	%	N	%	N	%	N	%		
19-25	2	25.0	1	12.5	2	25.0	2	25.0	1	12.5	8	100
26-32	2	16.7	0	0.0	7	58.3	2	16.7	1	8.7	12	100
33-39	2	11.1	0	0.0	8	44.4	6	33.3	2	11.1	18	100
40-46	1	8.3	2	16.7	6	50.0	0	0.0	3	25.0	12	100
47-53	0	0.0	0	0.0	1	100	0	0.0	0	0.0	1	100
54>	0	0.0	1	50.0	1	50	0	0.0	0	0.0	2	100
Total	7	13.2	4	7.5	25	47.2	10	18.9	7	13.2	53	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, Al for always

Table 33 above captures the findings on respondents' fulfilment on their major obligations at home, work, school, or community. According to the data, a significant proportion of the 25 participants (47.2%) were in the process of recuperating from AUD occasionally failed to fulfil their key duties at home, job, school, or community sometimes.

This was followed by the second highest number of respondents¹⁰ (18.9%) who frequently failed to fulfill their key commitments at family, job, school, or community most of the times. A lower proportion 7(13.2%) failed to fulfill their key commitments at home, job, school, or community always, while a comparable proportion 7 (13.2%) failed to fulfill their primary obligations at home, work, school, or community very few times.

The smallest proportion of respondents 4 (7.5%), failed to fulfil their key commitments at home, job, school, or community on a few occasions.

When analysing data by age, it was discovered that nearly equal proportions of respondents aged nineteen to twenty-five reported failing to meet their key duties at home, job, school, or community. Out of the total number of respondents, 2(25.0%) did not fulfill their major responsibilities at home, work, school, or community on very few occasions, while another 2(25.0%) failed to do so sometimes. Additionally, 2(25.0%) of those surveyed failed to fulfill their primary responsibilities at home, work, school, or community for the majority of the time. One (12.5%) responder failed to meet significant duties at home, work, school, or in the community only a few times, whereas another failed every time.

Table 34 They continued the use of alcohol despite having persistent or recurrent social or interpersonal problems caused by the effect of alcohol

	Vft		Ft		sometimes		Mot		A		Total	%
	N	%	N	%	N	%	N	%	N	%		
19-25	1	12.5	2	25.0	2	25.0	1	12.5	2	25.0	8	100
26-32	1	8.3	0	0.0	4	33.3	5	41.7	2	16.7	12	100
33-39	2	11.1	1	5.6	7	38.9	6	33.3	2	11.1	18	100
40-46	0	0.0	0	0.0	6	50.0	4	33.3	2	16.7	12	100
47-53	0	0.0	0	0.0	0	0.0	1	100	0	0.0	1	100
54>	0	0.0	0	0.0	1	50.0	1	50.0	0	0.0	2	100
Total	4	7.5	3	5.7	20	37.7	18	34.0	8	15.1	53	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, A for always

One of the diagnostic criteria for alcohol use disorder, as outlined in the DSM-5, is the persistent or recurring social or interpersonal problems (PRSIP) resulting from the effects of alcohol, despite continued use of the substance. The present investigation revealed that a significant proportion of, specifically 20 individuals (37.7%), persisted in their alcohol

consumption despite facing PRSIP that were attributed to the effects of alcohol on occasion. Subsequently, a total of 18 participants (34.0%) persisted in their alcohol consumption despite facing PRSIP attributed to alcohol consumption on a frequent basis. The third cohort comprised of 8 individuals, accounting for 15.1% of the sample, who exhibited PRSIP due to their alcohol consumption, yet continued to consume alcohol. A minority of respondents, specifically 4 individuals (7.5%), persisted in consuming alcohol despite experiencing PRSIP resulting from its effects. An even smaller subset of respondents, comprising 3 individuals (5.7%), continued to use alcohol despite PRSIP caused by its effects, albeit on a limited basis.

The present study examined the persistent use of alcohol in spite of PRSIP caused by alcohol consumption and age. Results indicated that a small proportion of respondents aged 19-25, specifically 1 (12.5%) continued to consume alcohol despite experiencing persistent or frequent social or relationship issues caused by alcohol, with a similar number reporting such behaviour occurring most of the time. Despite experiencing PRSIP resulting from occasional alcohol consumption, two participants 2(25%) between the ages of nineteen and twenty-five continued to engage in alcohol consumption on a limited basis. In a similar vein, 50% of the participants persisted in consuming alcohol despite experiencing PRSIP resulting from its effects. Specifically, 25% of the participants reported experiencing such problems occasionally, while the remaining 25% reported experiencing them consistently.

The findings of a survey conducted on individuals aged between twenty-six to thirty-two years old indicate that a significant proportion of the respondents, comprising 41.7%, continued to engage in alcohol consumption despite experiencing PRSIP resulting from the use of alcohol. Subsequently, the second cohort of four individuals (33.3%) reported a pattern of PRSIP resulting from alcohol use, yet continued to consume alcohol on

occasion. Among the respondents aged between twenty-six to thirty-two years old, the third group consisted of two individuals (16.7%) who reported PRSIP resulting from alcohol consumption, yet continued to consume alcohol. One participant between the ages of 26 and 32 reported that they persisted in consuming alcohol regardless of going through PRSIP resulting from its influence, albeit on very few instances.

A study was conducted to examine the behaviour of individuals aged 33 to 39 who continue to consume alcohol despite experiencing PRIP caused by its effects. The findings indicate that a majority of the respondents (38.9%) reported occasional continuation of alcohol use despite such problems. The second most sizable cohort consisted of six, comprising 33.3% of the sample, who reported PRSIP stemming from alcohol consumption, yet continued to imbibe on a regular basis.

On several occasions, a pair of smaller groups, each comprising 11.1% of the sample, indicated that they persisted in consuming alcohol despite experiencing PRSIP attributable to alcohol. Conversely, the remaining group reported that they continued to consume alcohol despite experiencing PRSIP caused by alcohol on only a few occasions. The present investigation examined the alcohol consumption patterns of participants between the ages of forty and forty-six, despite experiencing post-acute withdrawal symptoms (PAWS) resulting from alcohol use. The findings indicate that a significant proportion of respondents, specifically 50%, persisted in their alcohol consumption despite experiencing PRSIP stemming from the effects of alcohol.

The most substantial cohort comprised of four respondents, accounting for 33.3% of the sample, who reported persistent consumption of alcohol despite experiencing PRSIP stemming from the effects of alcohol. A minority of two participants (16.7%) reported to

the researcher that they persisted in alcohol consumption despite experiencing PRSIP resulting from the effects of alcohol. The study revealed a noteworthy social concern pertaining to the age group of 40-46 years, wherein the respondents exhibited a higher inclination towards persistent alcohol consumption despite the adverse social implications. It was observed that none of the participants reported discontinuing alcohol use despite experiencing PRSIP caused by alcohol, with only a negligible proportion reporting such instances.

The subsequent cohort of participants examined in the present investigation fell within the age range of forty-seven to fifty-three. Notably, a solitary respondent reported persistent alcohol use despite experiencing PRSIP as a consequence of alcohol consumption on the majority of occasions. Subsequently, a cohort consisting of two individuals who were aged fifty-four years or older provided their response. One participant, representing 50% of the sample, reported persistent use of alcohol despite experiencing PRSIP on occasion. The other participant reported continued alcohol use despite experiencing chronic or intermittent PRSIP caused by its effects.

According to the DSM-5, PRSIP caused by the effect of alcohol regardless of its continual consumption is a defining criterion for AUD is more common among the recovering clients aged forty years and above as compared to the recovering clients younger than forty years of age in rehabilitation Centers in Nairobi County Kenya.

Table 35 *They needed increased amount of alcohol to experience the previous intoxication*

	Vft		Ft		sometimes		Mot		A		Total	%
	N	%	N	%	N	%	N	%	N	%		
19-25	4	50.0	2	25.0	2	25.0	0	0.0	0	0.0	8	100
26-32	1	8.3	4	33.3	3	25.0	1	8.3	3	25.0	12	100
33-39	2	11.1	1	5.6	6	33.3	7	38.9	2	11.1	12	100
40-46	2	16.7	1	8.3	4	33.3	2	16.7	3	25.0	12	100
47-53	0	0.0	0	0.0	0	0.0	1	100	0	0.0	1	100

54>	0	0.0	0	0.0	1	50.0	0	0.0	1	50.0	2	100
Total	9	17.0	8	15.1	16	30.2	11	20.8	9	17.0	53	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, Al for always

This study also looked at the need for more alcohol to feel the prior drunkenness. The findings revealed that the majority of respondents 16 (30.2%) need a higher amount of alcohol to experience the prior drunkenness sometimes. This was followed by 11 (20.8%) respondents who stated that they needed more alcohol to feel the prior intoxication the most of the times. The third biggest group of respondents 9 (17.0%) claimed that they constantly needed more alcohol to experience the prior drunkenness always. A comparable set of respondents 9 (17.0%) claimed that they needed more alcohol to experience the prior drunkenness very few times. While the lowest group of 8 (15.1%) respondents indicated needing more alcohol to relive past drunkenness a few times.

An examination of the respondents' demand for more alcohol to experience past drunkenness and their age was also undertaken, with the findings shown in table 35 above. According to reports from respondents aged nineteen to twenty-five years, most 4 (50%) of the respondents need an increased amount of alcohol to experience the prior intoxication very few times. While 2(25%) of respondents required an increased quantity of alcohol to experience the previous intoxication a few times, an equal percentage 2(25%) required an increased amount of alcohol to experience the previous intoxication sometimes. It is worth mentioning that none of the respondents aged nineteen to twenty-five need more alcohol to feel the prior drunkenness most of the time or always.

The observations from respondents aged twenty-six to thirty-two years old revealed that the majority of respondents 4(33.3%) need an increasing amount of alcohol to experience the previous intoxication a few times. The second biggest group of respondents, 3(25%), claimed that they required more alcohol to experience the previous intoxication

sometimes, while a comparable group, 3(25%), reported that they needed more alcohol to relive the prior intoxication always. a minor proportion with a comparable percentage, 1(8.3%) said that they needed an increasing amount of alcohol to experience the prior intoxication very few occasions. Most of the time, 1 (8.3%) said that they needed more alcohol to feel the prior drunkenness.

The descriptions from respondents aged thirty-three to thirty-nine years old suggested that the majority of respondents 7(38.9%) need an increasing amount of alcohol to experience the prior drunkenness most of the time. The second highest percentage 6(33.3%) said that they needed more alcohol to feel the previous drunkenness sometimes. A lesser proportion of respondents 2(11.1%) claimed that they needed more alcohol to feel the prior intoxication very few times, with a similar proportion 2(11.1%) reporting that they needed more alcohol to feel the prior intoxication only always. The lowest proportion 1(15.6%) indicated that he/she required more alcohol to experience past drunkenness a few times.

The study additionally looked into the necessity for more alcohol to experience past intoxication in respondents aged forty to forty-six years old. Results indicated that most of the participants 4(33.3%) need an increasing amount of alcohol to experience the previous intoxication sometimes. The second highest percentage 3(25%), claimed that they constantly needed more alcohol to experience the prior intoxication always. The third greatest percentage 2 (16.7%) indicated that they needed more alcohol to experience the prior intoxication most of the time, while a comparable percentage 2 (16.7%) indicated that they needed more alcohol to experience the previous intoxication relatively few times The smallest proportion 1(8.3%) stated that he or she need an increased amount of alcohol was required to experience the prior drunkenness a few times.

The only respondent aged forty-seven to fifty-three years old reported that he or she required an increasing amount of alcohol to feel the prior drunkenness the majority of the time. Half of the respondents 1 (50%) aged fifty-four years and older stated that they needed more alcohol to feel the prior drunkenness on occasion, while the other half answered that an increasing amount of alcohol was required to feel the previous drunkenness on always.

Table 36 presents information on whether the respondents reduced or did not take alcohol and whether they experienced withdrawal symptoms

Table 36 *If they reduce or did not take alcohol, they experienced the withdraw symptoms*

	Vft		Ft		sometimes		Mot		A		Total	%
	N	%	N	%	N	%	N	%	N	%		
19-25	3	42.9	0	0.0	3	42.9	1	14.3	0	0.0	7	100
26-32	5	41.7	0	0.0	3	25.0	0	0.0	4	33.3	12	100
33-39	3	16.7	2	11.1	6	33.3	2	11.1	5	27.8	18	100
40-46	4	33.3	3	25.0	3	25.0	0	0.0	2	16.7	12	100
47-53	0	0.0	1	100	0	0.0	0	0.0	0	0.0	1	100
54>	0	0.0	1	50.0	0	0.0	0	0.0	1	50.0	2	100
Total	15	28.8	7	13.5	15	28.8	3	5.8	12	23.1	52	100

Source: Author, 2024.

Key;

Vft for very few times, Ft for few times, Mot for most of the times, A for always

Experiencing withdraw symptoms if they reduce or did not take alcohol, was another criterion for AUD according to the DSM-5. The study found that 15 (28.8%) of respondents experienced withdrawal symptoms if they reduced or stopped drinking alcohol very few times. A similar percentage 15 (28.8%) of respondents reported feeling withdrawal symptoms if they reduced or stopped drinking alcohol sometimes. A lower proportion 12 (23.1%) of respondents reported suffering withdrawal symptoms if they reduced or stopped drinking alcohol always. However, a smaller proportion 7(13.5%) of

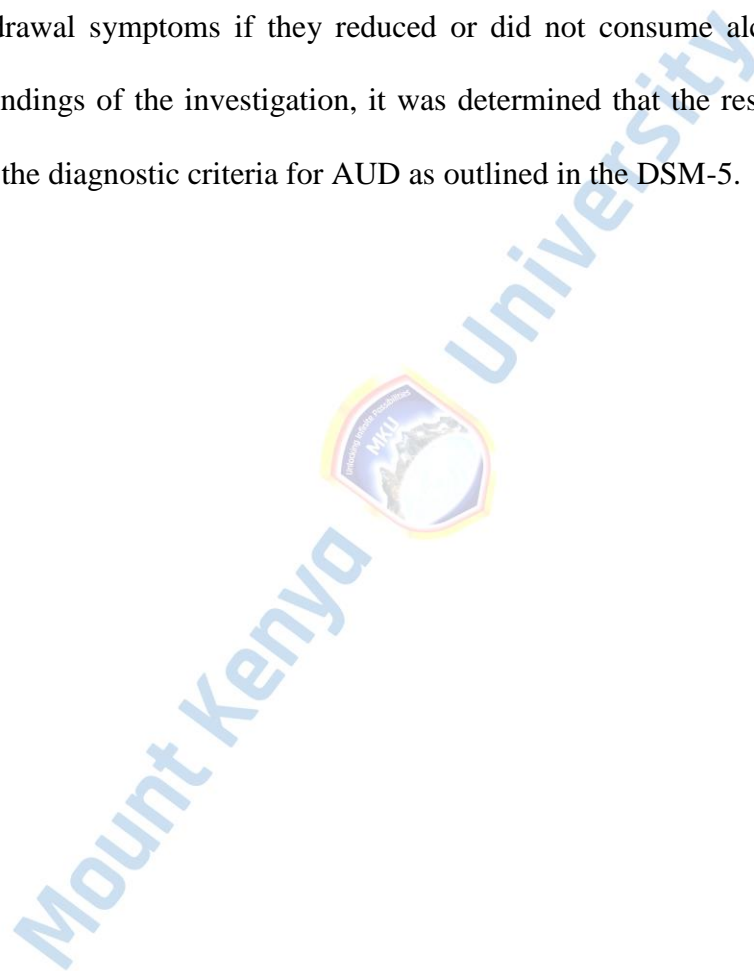
respondents reported having withdrawal symptoms if they reduced or stopped drinking alcohol very few times. The smallest percentage 3(5.8%) of respondents indicated experiencing withdraw symptoms if they reduce or did not take alcohol most of the times. A study was undertaken to see if respondents experienced withdrawal symptoms when they lowered or stopped drinking alcohol, and the results are shown in above. Three (42.9%) respondents between the ages of nineteen and twenty-five reported feeling withdrawal symptoms if they reduced or stopped drinking alcohol very few times. A similar percentage3 (42.9%) reported having withdrawal symptoms if they reduced or stopped drinking alcohol sometimes. The least percentage 1 (14.3%) reported withdrawal symptoms if they reduced or avoided drinking most of the time.

An examination of the responses of respondents aged twenty-six to thirty-two revealed that the majority of respondents 5(41.7%) had withdrawal symptoms if they reduced or did not consume alcohol on a very few times. This was followed by 4 (33.3%) individuals who said they always suffered withdrawal symptoms whenever they reduced or stopped drinking alcohol. However, the least percentage 3 (25.0%) reported experiencing withdrawal symptoms when they reduced or stopped drinking alcohol.

The responses of respondents aged thirty-three to thirty-nine years old were examined and analysed. The majority 6(33.3%) reported experiencing withdrawal symptoms if they reduced or did not consume alcohol sometimes. While 5 (27.8%) reported experiencing withdrawal symptoms if they reduced or stopped drinking alcohol always. A lesser percentage 3(16.7%) reported experiencing withdrawal symptoms if they reduced or stopped drinking alcohol very few times. Two respondents (11.1%) reported experiencing withdrawal symptoms if they reduced or did not consume alcohol a few times, with a

similar number reporting experiencing withdrawal symptoms if they reduced or did not use alcohol the most of the time.

The study also found that one responder aged forty-seven to fifty-three years reported withdrawal symptoms if they reduced or stopped drinking alcohol for a few times. Another group of people aged fifty-four and up experienced withdrawal symptoms if they reduced or did not use alcohol few times, but another group of people of the same age exhibited withdrawal symptoms if they reduced or did not consume alcohol always. Based on the findings of the investigation, it was determined that the respondents had exhibited all of the diagnostic criteria for AUD as outlined in the DSM-5.



CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The present chapter comprises of four distinct sections. The initial segment presents a concise overview of the main results, while the subsequent segments delineates the implications of the research outcomes. The third section of the study presents the conclusions drawn from the observations made during the research. The last section outlines the recommendations made by the researcher in light of the study's objectives and findings.

5.2 Summary of the Study

This study assessed the influence of family attributes on alcohol use disorder (AUD) among recovering clients in selected rehabilitation Centers in Nairobi County, Kenya.

The study investigations were guided by the following objectives;

- i. To find out the influence of family culture on AUD among recovering clients in selected rehabilitation Centers in Nairobi county Kenya.
- ii. To examine the extent to which family socioeconomic status influence AUD among recovering clients in selected rehabilitation Centers in Nairobi county Kenya.
- iii. To find out the influence of parenting styles on AUD among recovering clients in selected rehabilitation Centers in Nairobi county Kenya.
- iv. To find out the influence of family alcohol use on alcohol use disorder among recovering clients in selected rehabilitation Centers in Nairobi county Kenya.

In summary, according to the first objective most of the participants indicated that there was a positive family environment, a family emotional support, and an expression of emotions in the family. This was demonstrated by 16 (41.0 %) male and 3 (75%) female who indicated that their older sibling took time to deliberate with them their emotional

experiences and 21 (47.7 %) male and 1 (25%) female who agreed that their fathers took time to discuss their emotional experiences. A larger percentage 35 (73%) male and 3 (60%) female also agreed that their mother took time to deliberate with them their emotional experiences. Expression of emotions was demonstrated by most of the participants 26 (49.2%) male and 3(50%) female who were allowed to express their feelings by their fathers. Similarly, majority 36 (66.7%) male 3 (50%) respondents specified that they were allowed to express their feelings by their mothers.

Comparable observations were made among the siblings where majority 28 (58.3%) male were allowed to express their feelings by their siblings. Majority, (43.3%) male and half (50%) female reported that their fathers discussed with them different coping strategies in different situations covering concrete ways to cope with stress and challenges. Similarly, a positive family environment was indicated by majority of clients 38 (74.8%) male and more than half (66.6%) female who reported that their mothers emphasized on productive use of time. These findings indicated that there is need for more studies to unearth other factors linked with emergence of AUD other than family culture.

The second study findings indicated that socio-economic status was not a major factor in the development of alcohol use disorder as indicated by education levels and income. Half of the participants earned a maximum of Thirty-four thousand Kenyan shillings (34,000) and their highest level of education completed was tertiary. However, 10 (18.2%) were earning more than one hundred thousand per month. This finding is consistent with the results of the focus group discussion, wherein certain participants reported persistent use of the substance due to insufficient income to meet their financial requirements, while the majority continued to use due to habitual tendencies until the onset of alcohol use disorder.

The third study objective descriptive results indicate that most of the respondents were brought up by authoritative parents as demonstrated by 29 (64.4%) male and (50%) female who confirmed that they were shown warmth or friendliness, love or encouraging feelings by their fathers. 22(48.9%) of the participants' opinions and choices to upgrade their freedom and thinking, were listened to by their fathers who also set limits and responsibilities with an understanding of the penalties or consequences of their behaviour. The use of authoritative parenting style among the participants was also demonstrated by 21 (65.3%) male and 3 (60%) female who agreed that their mothers appreciated them, had fun being with them, was happy with their little or big determinations, achievement and communicated the same through different kinds such as physical contacts, laughter, good tones of voice, playful teasing, facial expressions, and encouragement among others.

The fourth objective descriptive analysis results specified that there was an alcohol user in every family represented by the respondent. Most of the respondents, 35 (76.1%) male, 3 (60%) female started using alcohol when their mothers were non-users and 10 (23.8%) male and 1 (25%) female started using alcohol when their fathers were non-users. These findings indicate that most of the recovering clients acquired the alcohol use behaviour which developed to alcohol use disorder from other internal or external environments but not the parents. However, 11 (28.2%) male and 1 (33.3%) female started using alcohol when their older brothers were social users.

The fifth study objective results indicated that most of the respondents, to manage alcohol use disorder was both preventive and curative. Psycho-education in the community especially among family members, in learning institutions, places of worship and other places of gathering was reported to be a preventive strategy by ensuring the community understand how alcohol use develop to AUD. The community need to join hands in order

to keep their youth positively and productively engaged to reduce idleness which is a risk factor in alcohol use and the emergence of AUD. The respondents also emphasized on the need for abstinence from alcohol use and especially if there is a family member suffering from alcohol use disorder. This could be an indication that the family might be predisposed to alcohol hence making the development alcohol use disorder a very likely possibility.

Individuals and family members need to realize the fact that alcohol use disorder is a disease that is difficult to treat and heal from, so members ought not to start the use of alcohol and especially so if there is a member recovering from problematic alcohol use in the family. Families should organize activities for fun among the members free from alcohol use while parents should practice good parenting approach that are protective to the emergence of AUD.

Policies on brewing, selling, and use of cheap liquor, alcohol use or purchase need to be adhered to by all. The acceptable age for purchasing and use of alcohol should be review from the 18 to 24 years. This gives the youth time to learn how to manage their freedom and early adulthood responsibility without alcohol. Advertisements of alcohol need to be controlled and the warning message well communicated. Adults and leaders should be good role models and not encourage their young adults to get into alcohol use and especially so at young age. Access to alcohol and cheap liquor need to be reduced by reducing the outlets and particularly with in the residential areas.

Individuals experiencing alcohol use disorder should be taken to rehabilitation Centers with professional personnel. The treatment environment should be conducive to enhance proper learning and recovery. Family members need to be involved in the recovery process and be sensitized on the importance of adherence to family and ethical values of

living by all family members. Higher institutions of learning should take responsibility to sensitize their population on the harmful issues related to alcohol use.

Both the national and county governments should establish rehabilitation Centers that are affordable to many and the recovering clients need to adhere to the recommendation of recovery process including the Alcoholic Anonymous (AA). Individuals should take personal responsibility, learning new skills and hobbies, develop personal slogan or group slogans that will help to distract them from using alcohol and adherence to the religious teachings and practice. The national government and local government should support the increase of the number of religious places of worship.

Each person should work towards personal development and get a job or create one while making sure they are busy earning a living positively. The society should also be sensitized on the need for treatment of those suffering from alcohol related problem including alcohol use disorder and to reduce stigmatization. Psycho-education on the effects of addiction and how it is identified should be the responsibility of the society and not just a few members of the society. Assistance and support from home, work place, places of worship, learning institutions and other productive groupings should be encouraged.

Both national and county government should enact strict and punitive laws to manage the advertisements, sell, and use of alcohol. Further, the two governments should employ and deploy trained counsellors to offer free counselling services to the society, in order to create self-awareness to the society in relation to alcohol consumption, misuse and emergence of AUD. The recovering individuals should ensure that they are busy and have personal goals, choose friends to keep, and places to visit in order to avoid relapse.

5.3 Conclusions

The study findings have revealed that family attributes were factors that influence the emergence of AUD. The specific finding of this study exhibited that there was statistical significant relationship between family culture and AUD. These findings communicate that family culture contributed to the onset of AUD among the recovering clients in selected rehabilitation Centers in Nairobi County. However, there is a need for more studies to establish other factors in a family that contribute to the onset of AUD in the society.

An observation of family socio-economic status and AUD revealed that the development of AUD occurs to both those in the high as well as low socio-economic status. This creates a need for intensive psych education on the development of alcohol use disorder in the society. Different parenting styles and alcohol use disorder were also evaluated and the relationship for the specific parenting styles were different from each other. Pearson product moment correlation coefficient (PPMCC) for different parenting styles communicated different messages. The negative PPMCC for permissive parenting indicated that as permissive parenting style increased the alcohol use disorder decreased. On the contrarily, authoritarian, authoritative and neglectful parenting styles all had a positive PPMCC. This communicated that when their characteristics increased, AUD alcohol use disorder among the recovering clients in selected Centers also increased. However, an observation on the four parenting styles indicated that there was no statistical significant correlation between parenting styles and AUD among the recovering clients in selected Centers located within Nairobi County.

The investigation on family alcohol use and alcohol use disorder observed that there was no statistical significant relationship between family alcohol use and alcohol Use Disorder among the recovering clients in selected rehabilitation Centers in Nairobi

County. Conversely, family member taking alcohol is such a risk of other family members to develop alcohol use disorder.

5.4 Recommendations for the Authorities for Implementation

The study recommends both National and County government to enact strict and punitive laws to manage the advertisements, sell, and use of alcohol and employ trained counsellors to offer free counselling services to the society.

The government through the ministry of health should train and empower more mental health practitioners to offer psycho social support and professional help to families and society at large. They should establish rehabilitation Centers that are affordable to all beneficiaries. The acceptable age for purchasing and use of alcohol should be review from the 18 to 24 years.

5.5 Service Users or Beneficiaries.

The beneficiaries of this study include the recovering clients and the society at large. The researcher recommends the need for abstinence from alcohol use and especially if there is a family member suffering from alcohol use disorder.

The recovering clients and their families should be educated on productive ways of managing their finances.

The study recommends that the counsellors and other mental health practitioners should initiate psycho-education in the community particularly among family members, on parenting styles in order to mitigate the development of alcohol use disorders.

learning institutions, places of worship and other places of gathering was also recommended.

5.6 Other Stakeholders

The community need to join hands in order to keep their youth positively and productively engaged to reduce idleness. Individuals experiencing alcohol use disorder

should be taken to rehabilitation Centers with professional personnel and family members need to be involved in the recovery process.

The study recommends that the community should be sensitized on positive strategies to minimize or eradicate stigma against the recovering clients. This will help them not to relapse.

5.7 Further Research

According to the finding of this study the researcher recommends more studies to establish:

- (i) Personal factors that contribute to the development of AUD in the Society.
- (ii) The specific characteristics of different parenting styles that contribute to continued alcohol use.
- (iii) The role of alcohol predisposition in the development of AUD.
- (iii) The protective and risk factors in the development of AUD in the society.

REFERENCES

A.T., G. (2013). Construct Validity. In: Gellman M.D., Turner J.R. (eds). *Encyclopedia of Behavioral Medicine*. .

- Abdu-Raheem, B. O. (2013). Sociological Factors To Drug Abuse And The Effects On Secondary School Academic Performance. *Contemporary Issues In Education Research – Second Quarter 2013 Volume 6, Number 2*, 1-10. Retrieved from <https://files.eric.ed.gov/fulltext/EJ1073210.pdf>
- Achwal, A., & Prakash, R. (2021, 01). *Permissive Parenting Style – Characteristics, Effects & more*. Retrieved from Firstcry: <https://parenting.firstcry.com/articles/permissive-parenting-style-characteristics-effects-and-more/>
- activecampaign. (2021). The 4 Types of Validity in Research Design (+3 More to Consider). *validity-in-research-design*.
- Agostinelli, G., & Grube, J. (2005). Effects of presenting heavy drinking norms on adolescents' prevalence estimates, evaluative judgments, and perceived standards. *Prevention science : the official journal of the Society for Prevention Research*, , 89-99.
- Aiken, A., Clare, P. J., Wadolowski, M., Hutchinson, D., Najman, J. M., Slade, T., . . . Mattick, R. P. (2018, 01 24). Age of Alcohol Initiation and Progression to Binge Drinking in Adolescence: A Prospective Cohort Study. *Alcoholism, clinical and experimental research*, 42(1), 100-1110. doi:<https://doi.org/10.1111/acer.13525>
- Aiken, C. H. (2018). Age of Alcohol Initiation and Progression to Binge Drinking in Adolescence: A Prospective Cohort Study. *Alcohol Clin Exp Res*, 100-110.
- Arthur, J. L. (2005, 11). *Family size and its socio-economic implications in the Sunyani Municipality of the Brong Ahafo region of Ghana, West Africa*. New York: Center for International Earth Science Information Network. Retrieved from Center for International Earth Science Information Network (CIESIN): <http://www.ciesin.org/documents/arthurjl.pdf>
- Arya. (2021). Parenting Styles and Its Impact on Alcoholism and Psychological Distress among College Students. *International Journal of Research Publication and Reviews*, 2582-7421.
- Association, A. P. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®). In A. P. Association, *Diagonistic and Statistical Manual of Mental Disorders Fifth Edition* (pp. 490-503). Washington ,DC: American Psychiatric Publishers.
- Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001, 11 18). *AUDIT : the Alcohol Use Disorders Identification Test : guidelines for use in primary health care*. Retrieved from World Health Organization: https://apps.who.int/iris/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6-a-eng.pdf?sequence=1&isAllowed=y
- Bandura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. New Jersey: Prentice-Hall.
- Bandura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. New Jersey: Prentice-Hall.
- Bandura, A. (1986). *Social Foundations of Thought and Action: A Social Cognitive Theory*. New Jersey, USA: Prentice-Hall.
- Bear, J. S. (2002). Student Factors: Understanding Individual Variation.
- Becoña, E., Martínez, Ú., Calafat, A., Juan, M., Fernández-Hermida, J. R., & Secades-Villa, R. (2011, 12 01). Parental styles and drug use: A review. *Drugs: Education, Prevention and Policy*, 1-10. doi:<https://doi.org/10.3109/09687637.2011.631060>
- Berge, S. . (2016). Role of parenting styles in adolescent substance use: results from a Swedish longitudinal cohort study. *BMJ Open* .

- Bergland. (2015). What Are the Eleven Symptoms of Alcohol Use Disorder? *Psychology today*.
- Birech, K. K. (2013). Alcohol Abuse and the Family: A Case Study of the Nandi Community of Kenya. *International Journal of Humanities and Social Science Vol. 3 No. 15*.
- Bowen. (1999). Bowen's family systems theory. *Journal of Family Therapy (ANZJFT) Vol.20 No.2*, 94-103.
- Bratek, A., Beil, J., Jarzabek, K., Banach, M., Krysta, K., & Krupka-Matuszczyk, I. (2013, 09 25). Association of early drinking onset with subsequent alcohol abuse. *Psychiatr Danub*, 99-101. Retrieved from <https://pubmed.ncbi.nlm.nih.gov/23995154/>
- Britannica. (2019, 03 01). *Encyclopaedia*. Retrieved from Nairobi. Encyclopedia Britannica.: <https://www.britannica.com/place/Nairobi>
- Brown, J. (2013, 06 18). Bowen Family Systems Theory and Practice: Illustration and Critique. *Australian and New Zealand Journal of Family Therapy*, 94-103. doi:<https://doi.org/10.1002/j.1467-8438.1999.tb00363.x>
- Buist, D. M. (2012, 10 31). *Sibling Relationship Quality and Psychopathology of Children and Adolescents: A Meta-Analysis*. Retrieved from National Center for Biotechnology Information: <https://doi.org/10.1016/j.cpr.2012.10.007>
- Calafat, A., García, F., Juan , M., Becoña, E., & Fernández-Hermida, J. R. (2014, 05 01). Which parenting style is more protective against adolescent substance use? Evidence within the European. *Drug and alcohol dependence*, 138, 185-192. doi:10.1016/j.drugalcdep.2014.02.705
- Calling, S., Ohlsson, H., Sundquist, J., Sundquist, K., & Kendler, K. S. (2019, 10 19). Socioeconomic status and alcohol use disorders across the lifespan: A co-relative control study. *plos one*, 1,5,11. doi:<https://doi.org/10.1371/journal.pone.0224127>
- Carter, A. C., Brandon, K. O., & Goldman , M. S. (2015, 01 21). The College and Noncollege Experience: A Review of the Factors That Influence Drinking Behavior in Young Adulthood. *Journal of Studies on Alcohol and Drugs*, 71(5), 742–750 (2010), 3-10. doi:<https://doi.org/10.15288/jsad.2010.71.742>
- Chen, Q., Kong, Y., Gao, W., & Mo, L. (2018, 07 25). Effects of Socioeconomic Status, Parent–Child Relationship, and Learning Motivation on Reading Ability. *Frontiers in psychology*, 9, 1297. doi:<https://doi.org/10.3389%2Ffpsyg.2018.01297>
- Cherry, k. (2019). What Is Classical Conditioning?A Step-by-Step Guide to How Classical Conditioning Really Works. *Very Well Mind*.
- Cherry, K., & Gans, S. (2023, 05 01). *What Is Classical Conditioning in Psychology?How It Works, Terms to Know, and Examples*. Retrieved from Very well mInd: <https://www.verywellmind.com/classical-conditioning-2794859>
- Cherry. (2020). What Is Operant Conditioning and How Does It Work? *Behavioral Psychology*.
- Chweya, M., & Auya, S. (2014, 09 01). Socio- economic effects of alcoholism on families in mukuru slum,Nairobi County. *International Journal of Innovation and Scientific Research*, 9(1), 35-39. Retrieved from <https://oa.mg/work/1505898269>
- Collins, S. E. (2016). Collins SE. Associations Between Socioeconomic Factors and Alcohol Outcomes. *Alcohol research : current reviews vol. 38,1 (2016)*, 83-94.
- Corey, G. (2016). *Theory and Practice of Counseling and Psychotherapy*. Massachusetts: Cengage Learning.

- Courtney, K. E., & Polich, J. (2009, 01). Binge Drinking in Young Adults: Data, Definitions, and Determinants. *Psychological Bulletin*, 135(1), 142-156. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2748736/>
- Creswell. (2014). Research Design: Qualitative, Quantitative and Mixed Methods Approaches(4th ed.). *Scientific Research*.
- Desai, R., Ruiters, R. A., Magan, A., Reddy, P. S., & Mercken, L. A. (2020, 10 20). Social network determinants of alcohol and tobacco use: A qualitative study among out of school youth in South Africa. *PloS one*. doi:<https://doi.org/10.1371/journal.pone.0240690>
- Deza, C. a. (2018, May). The Effect of Parental Education on Children's Drug and Alcohol Use. *American Economic Association*, 108, 373-378. doi:10.1257/pandp.20181105
- Dryden, J. (2022, 03 17). *In U.S., alcohol use disorder linked to 232 million missed workdays annually*. Retrieved from Washington University in St. Louis: <https://rb.gy/u51yl>
- Eeuwijk. (2017). Society_and_Health/Focus_Group_Discussion_Manual. *SwissTPH*, 1-16.
- Ewing, B. A., Osilla, K. C., Pedersen, E. R., Hunter, S. B., Miles, J. N., & D'Amico, E. J. (2015, 02). Longitudinal family effects on substance use among an at-risk adolescent sample. *Addictive Behaviors Volume 41, February 2015*, 185-191. doi:<https://doi.org/10.1016/j.addbeh.2014.10.017>
- Fernandez-Hermida, J. R., Calafat, A., Becoña, E., Tsertsvadze, A., & Foxcroft, D. R. (2022, 02 28). Assessment of generalizability, applicability and predictability (GAP) for evaluating external validity in studies of universal family-based prevention of alcohol misuse in young people: systematic methodological review of randomized controlled trials. *Society for the Study of Addiction*, 107(9). doi:<https://doi.org/10.1111/j.1360-0443.2012.03867.x>
- Ferreira-Borges, C., Parry, C. D., & Babor, T. F. (2017, 03 27). Harmful Use of Alcohol: A Shadow over Sub-Saharan Africa in Need of Workable Solutions. *International journal of environmental research and public health*, 14(4). doi:<https://doi.org/10.3390/ijerph14040346>
- Ginty. (2013). *Construct Validity*. In: Gellman M.D., Turner J.R. (eds). New York, NY: Springer.
- Gitatui, M., Kimani, S., Muniu, S., & Okube, O. (2019, 12). Determinants of harmful use of alcohol among urban slum dwelling adults in Kenya. *African health sciences*, 19(4), 2906-2925. doi:<https://dx.doi.org/10.4314/ahs.v19i4.12>
- Githui, D. M. (2011). Drinking Culture and Alcohol Management in Kenya: An Ethical Perspective. *European Journal of Business and Management*, 3(4). Retrieved from <https://www.iiste.org/Journals/index.php/EJBM/article/view/301/188>
- Glasser, W. (2017, 10 25). *Reality Therapy*. Retrieved from GoodTherapy: <https://www.goodtherapy.org/learn-about-therapy/types/reality-therapy>
- Gossage, S. P. (2014). Alcohol Use, Working Conditions, Job Benefits, and the Legacy of the “Dop” System among Farm Workers in the Western Cape Province, South Africa: Hope Despite High Levels of Risky Drinking. *Int. J. Environ. Res. Public Health*, 7406-7424.
- Grant, B. F., Chou, P. S., Saha, T. D., Pickering, R. P., Kerridge, B. T., Ruan, J. W., . . . Hasin, D. S. (2017). Prevalence of 12-Month Alcohol Use, High-Risk Drinking, and DSM-IV Alcohol Use Disorder in the United States, 2001-2002 to 2012-2013: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. *JAMA Psychiatry*. 2017;74(9):, 911-923.

- Grube, A. &. (2005, 6). *National Library of Medicine, National Center for Biotechnology Information*. Retrieved from Effects of Presenting Heavy Drinking Norms on Adolescents' Prevalence Estimates, Evaluative Judgments, and Perceived Standards. *Prev Sci* 6, 89–99 (2005):
<https://doi.org/10.1007/s11121-005-3408-1>
- Hamed, T. (2016). Validity and Reliability of the Research Instrument; How to Test the Validation of a Questionnaire/Survey in a Research. *International Journal of Academic Research in Management*.
- Hanlon, A. F. (2007). African Journal of Drug and Alcohol Studies. *African Journal of Drug and Alcohol Studies* vol.6, 39--53.
- Hassan, M. N. (2013). Factors Associated With Alcohol Abuse among.
<https://pdfs.semanticscholar.org/9d57/4a7a6a2e8e3756587508fc44fc7cc43e0abb.pdf>, 1-10.
- Hlomani-Nyawasha, T. J., Meyer-Weitz, A., & Egbe, C. O. (2020). Factors influencing alcohol use among female in-school adolescents in the Western Cape, South Africa. *South African Journal of Psychology*, 50(4), 574-586.
 doi:<https://doi.org/10.1177/0081246320946298>
- Hoffmann, J. P., & Bahr, S. J. (2014, 03 7). Parenting style, religiosity, peer alcohol use, and adolescent heavy drinking. *Journal of Studies on Alcohol and Drugs*, 75(2). doi:<https://doi.org/10.15288/jsad.2014.75.222>
- Hoque, M., & Ghuman, S. (2012, 01 04). Do Parents Still Matter Regarding Adolescents' Alcohol Drinking? Experience from South Africa. *International Journal of Environmental Research and Public Health*, 9(1), 110-122.
 doi:<https://doi.org/10.3390%2Fijerph9010110>
- Hoque, M. a. (2012). Do parents still matter regarding adolescents alcohol drinking. *International Journal of Environmental Research and Public Health*, 9, 110-122., 110-122.
- Horsman, E. N. (2018). Predicting the Effects of Underage Drinking on Concomitant Alcohol Use Disorder and Poor Educational Attainment. *Contemporary Research in Disability and Rehabilitation*, 1(1). Retrieved from <https://crdr-ojs-utrgv.tdl.org/crdr/article/view/30/9>
- Hutchinson, M. B. (2014). THE IMPACT OF ALCOHOL USE DISORDERS ON FAMILY LIFE:A REVIEW OF THE EMPIRICAL LITERATURE. *National Drug and Alcohol Research Centre*.
- Hutchinson, M. B. (2014). *THE IMPACT OF ALCOHOL USE DISORDERS ON FAMILY LIFE:A REVIEW OF THE EMPIRICAL LITERATURE*. SYDNEY: NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE, UNIVERSITY OF NEW SOUTH WALES.
- Jacques Philip, T. F. (2016). Relationship of Social Network to Protective Factors in Suicide and Alcohol Use Disorder Intervention for Rural Yup'ik Alaska Native Youth,. *Psychosocial Intervention*,, 45-54.
- Jessica Pui Kei Leung, A. B. (2016). Adverse Childhood Experiences and Alcohol Consumption in Midlife and Early Old-Age. *Alcohol and Alcoholism*, Volume 51, Issue 3, , 331–338,.
- Johnson, B. E., & Ray, W. A. (2016, 03 21). Family Systems Theory. *Research gate*. doi:<https://doi.org/10.1002/9781119085621.wbefs130>
- Joutsenniemi, K., Martelin, T., Kestilä, L., Martikainen, P., Pirkola, S., & Koskinen, S. (2007, 03 16). Living arrangements, heavy drinking and alcohol dependence. *Alcohol and Alcoholism*, Volume 42, Issue 5, 480 -491.
 doi:<https://doi.org/10.1093/alcalc/agm011>

- K.J. Mathew, M. B. (June 2018). Role of Family in Addictive Disorders. *International Journal of Psychosocial Rehabilitation*, 65-75.
- Kabwama, N. M. (2016). Kabwama, S. N., Ndyababangi, S., Mutungi, G., Wesonga, R., Bahendeka, S. K., & Guwatudde, D. (2016). Alcohol use among adults in Uganda: findings from the countrywide non-communicable diseases risk factor cross-sectional survey. *Global Health Action*, 9, 3. *Global Health Action* 9,31302, 1-8.
- Kamende, M. O. (2016). Status of Drugs and Substance Abuse among the General Population in Kenya. *African Journal of Alcohol & Drug Abuse : Edition 1*.
- Kamender, M., Muteti, J., Kiman, S., & Okioma, V. (2022, 06 30). Alcohol Use Disorders and Associated Determinants among Public Sector Employees in Kenya National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), Kenya. *African Journal of Alcohol & Drug Abuse*, 7. Retrieved from <https://t.ly/P-fy>
- Kamenderi, M. K. (2022). Alcohol Use Disorders and Associated Determinants among Public Sector Employees in Kenya. *African Journal of Alcohol & Drug Abuse*.
- Kamer, L. (2022, 11 22). *Extreme poverty rate in Kenya from 2016 to 2025*. Retrieved from statista: <https://www.statista.com/statistics/1229710/number-of-people-living-in-extreme-poverty-in-kenya/>
- Kariuki, D. K., Misaro, J., Kabiru, J., & Birech, J. (2013, 08 15). Alcohol Abuse and the Family: A Case Study of the Nandi Community of Kenya. *International Journal of Humanities and Social Science*, 3(15), 1-8. Retrieved from http://erepository.uonbi.ac.ke/bitstream/handle/11295/81792/Misaro_Alcohol%20Abuse%20and%20the%20Family.pdf?sequence=1&isAllowed=y
- Katembu, S. M., & Odiemo, L. O. (2017). *Relationship Between Alcohol Use Disorder, Cognitive Reappraisal and Expression Suppression Among Youth Seeking Help in Rehabilitation Centers in Kiambu County, Kenya*. Nairobi: University of Nairobi Library. Retrieved from <https://shorturl.at/egxX0>
- Keiko, H. (2019). Associations of education and income with heavy drinking and problem drinking among men: evidence from a population-based study in Japan. *BMC Public Health*.
- Kendagor, A., Gathecha, G., Ntakuka, M. W., Nyakundi, P., Gather, S., Kiptui, D., . . . Ngaruiya, C. (2018, 11 07). Prevalence and determinants of heavy episodic drinking among adults in Kenya: Analysis of the STEPwise survey, 2015. *BMC Public Health*. doi:<https://doi.org/10.1186/s12889-018-6057-6>
- KENPRO. (2012). Sample Size Determination Using Krejcie and Morgan Table. *African Research Journal of Education and Social Sciences*.
- Kharb, R., Shekhawat, L. S., Deshpande, S. N., Beniwal, R. P., Bhatia, T., & Deshpande, S. N. (2018, August). Relationship between Craving and Early Relapse in Alcohol Dependence: A Short-Term Follow-up Study. *Indian J Psychol Med*, 40(4), 315-321. doi:10.4103/IJPSYM.IJPSYM_558_17
- Kimani, S. W. (2019). *Examining perceived ethical parenting styles in relation to alcohol abuse among the youths: a case study of Kibera slum, Kibera constituency*. Nairobi: Strathmore University. Retrieved from <http://hdl.handle.net/11071/6659>
- Kimani, S. (2019). Examining perceived ethical parenting styles in relation to alcohol abuse among the youths: a case study of Kibera slum, Kibera constituency. *School of Humanities and Social Studies (SHSS) Strathmore University*.

- Kimani. (2019). Examining perceived ethical parenting styles in relation to alcohol abuse among the youths: a case study of Kibera slum, Kibra constituency. *Thesis, Strathmore*.
- Kiplagat, A. B., Ngunu, C., Oyugi, E., & Ransom, J. (2020, 02 02). Epidemiology of HIV Infection Among HIV-Exposed Infants, Nairobi County, Kenya, 2015. *Infectious Diseases: Research and Treatment*, 13. doi:<https://doi.org/10.1177/1178633720948863>
- Korio, A. A., & Nyavanga, E. J. (2019, 03 21). Alcoholic Beverage Use Among Somali Youth Living in Eastleigh, an Urban Suburb in Nairobi, Kenya. *European Journal of Preventive Medicine*, 7(1), 23-28. doi: doi: 10.11648/j.ejpm.20190701.15
- Krejcie, R. V. (1970). Determining sample size for research activities. . *Educational and psychological measurement*, 30(3), , 601-610.
- kuria, m. (2020). psychology testing. *counselling practice*, 62-66.
- Lauckner, C., Warnock, C. A., McLaughlin, S., Marie, A., Lambert, D. N., & Muilenburg, J. L. (2020). The relationship between perceived parental leniency, access to alcohol at home, and alcohol consumption and consequences among rural adolescents. *Journal of Rural Mental Health*, 44(1), 26-38. doi:<https://psycnet.apa.org/doi/10.1037/rmh0000128>
- Leech, N. L., Barrett , K. C., & Morgan, G. A. (2014). *IBM SPSS for Intermediate Statistics Use and Interpretation, 5th Edition*. Oxfordshire: Routledge.
- Lepper, L. E., Lluca, A., Mayer, A., Patel, N., Salas, J., Xaverius, P. K., & Kramer, B. (2016, 01 17). Socioeconomic Status, Alcohol Use, and Pregnancy Intention in a National Sample of Women. *the official journal of the Society for Prevention Research*, 17(1), 24-31. doi:<https://doi.org/10.1007/s11121-015-0578-3>
- Leung, J. P., Britton, A., & Bell, S. (2016, 05 01). Adverse Childhood Experiences and Alcohol Consumption in Midlife and Early Old-Age. *Alcohol and Alcoholism*, 51(3), 331-338. doi:<https://doi.org/10.1093/alcalc/agg125>
- Li, & G. (2023). The effect of the time parents spend with children on children's well-being. *Frontiers in psychology*.
- Luczak, S. E., Prescott, C. A., Dalais, C., Raine, A., Venables, P. H., & Mednick, S. A. (2014, 02 01). Religious Factors Associated with Alcohol Involvement: Results from the Mauritian Joint Child Health Project. *Drug and Alcohol Dependence Volume 135, 1 February 2014*, 37-44. doi:<https://doi.org/10.1016%2Fj.drugalcdep.2013.10.028>
- Machin, C. &. (2018). Sample sizes for clinical, laboratory and epidemiology studies. In J. W. & Sons, *An authoritative resource that offers the statistical tools and software needed to design and plan valid clinical studies* (p. 416). John Wiley & Sons LTD.
- Maithya, R., & Cheloti, S. (2021, 01 27). Parental Involvement in the Management of Drug Abuse Crisis among Children and Youth in Kenya. *African Journal of Alcohol & Drug Abuse*, 2, 1-6. Retrieved from <https://shorturl.at/knvB2>
- Martínez-Loredo, V., Fernández-Artamendi, S., Weidberg, S., Pericot, I., López-Núñez, C., Fernández-Hermida, J. R., & Secades, R. (2015, 12 15). Parenting styles and alcohol use among adolescents: A longitudinal study. *European Journal of Investigation in Health, Psychology and Education* , 6(1), 27-36. doi:<https://doi.org/10.3390/ejihpe6010003>
- Masaba, B. B. (2017, 02 27). Alcohol Abuse Practices Among Residents of Busia Town, in Kenya. *American Journal of Health Research*, 5(1), 11-18. Retrieved

- from
<https://article.sciencepublishinggroup.com/pdf/10.11648.j.ajhr.20170501.13.pdf>
- Massawe, A. E., Ruheza, S., & Msambila, A. A. (2022, 04 28). The Significance of Culture and Regulations on Alcohol Abuse Among Youths in Rombo District Council. *European Journal of Development Studies*, 2(2), 5.
doi:10.24018/ejdevelop.2022.2.2.72
- Mclead, S., & Evans, O. G. (2023, 05 09). *Albert Bandura's Social Learning Theory*. Retrieved from Simply Psychology: <https://shorturl.at/DIKMR>
- McLeod, S. (2016, 2 5). *Albert Bandura - Social Learning Theory*. Retrieved from simply psychology: <https://www.simplypsychology.org/bandura.html>
- McLeod, S. (2023, 03 08). *Classical Conditioning: How It Works With Examples*. Retrieved from Simply Psychology: <https://www.simplypsychology.org/classical-conditioning.html>
- Mosel. (2022). What are the Effects of an Alcoholic Mother on Children? *American Addiction Centers*.
- Muchiri, d. S. (2018). . Family management risk and protective factors for adolescent substance use in South Africa. *Subst Abuse Treat Prev Policy* 13, 24.
- Mungai, D., & Midigo, R. (2019, 12 29). Social and cultural determinants of health; understanding the persisting Alcohol Use Disorder (AUD) in the rural populations in central Kenya. *AMIS Press*, 600-611.
doi:<https://doi.org/10.3934/publichealth.2019.4.600>
- Murakami , K., & Hashimoto, H. (2019, 04 23). Associations of education and income with heavy drinking and problem drinking among men: evidence from a population-based study in Japan. *BMC public health*, 19(1). doi:doi: 10.1186/s12889-019-6790-5.
- Murakami, H. (2019). Associations of education and income with heavy drinking and problem drinking among men: . *BMC Public Health*.
- Murakami, H. (2019). Associations of education and income with heavy drinking and problem drinking among men: evidence from a population-based study in Japan. *BMC Public Health*.
- Mwania, J. M., & Njagi, S. N. (2017). Parenting styles as predictors of drug abuse among selected public secondary school students in Embu county, Kenya. *European Journal of Education Studies*, 3(11).
doi:<http://dx.doi.org/10.5281/zenodo.1067272>
- Mwanza, E. (2019, 3 7). *Top 7 Regions With Highest Number of Alcoholics*. Retrieved from Kenyans: <https://www.kenyans.co.ke/news/37627-top-7-regions-highest-number-alcoholics>
- MWANZA, E. (2019, March 7). Top 7 Regions With Highest Number of Alcoholics. <https://www.kenyans.co.ke/news/37627>, pp. 1-3.
- NACADA. (2011). *The Role of Parents in Prevention and Control of Alcohol and Drug Abuse among their Children in Nairobi*. Nairobi: NACADA.
- NACADA. (2020). *List of NACADA Accredited Rehabilitation Centers In Kenya*. Nairobi: victormatara.com.
- NACADA. (2022). *Accredited Treatment and Rehabilitation center in Kiambu County*. Nairobi: National Authority for the Campaign Against Alcohol and Drug Abuse. Retrieved from <https://nacada.go.ke/rehabilitation-Centers>
- NACADA. (sep 2018). *National Alcohol and Drug Abuse Policy*. Nairobi: NACADA.
- Nadkarni, A., Dabholkar, H., McCambridge, J., Bhat, B., Kumar, S., Mohanraj, R., . . . Patel, V. (2013, 06 20). The explanatory models and coping strategies for

- alcohol use disorders: an exploratory qualitative study from India. *Asian journal of Psychiatry*, 6(6), 521-527. doi:<https://doi.org/10.1016/j.ajp.2013.06.010>
- National Institute on Alcohol Abuse and Alcoholism. (2021). Parenting to Prevent Childhood. *Turning Discovery into Health*, 301-443.
- Necho, B. &. (2020). The prevalence and factors associated with alcohol use disorder among people living with HIV/AIDS in Africa: a systematic review and meta-analysis. *Subst Abuse Treat Prev Policy* 15, 63, 1-6.
- Nicolas, A. (2023, 04 10). Reliability and Validity – Definitions, Steps & Examples. *Research Prospect*. Retrieved from <https://shorturl.at/hpuDV>
- Njeru, L. W. (2015). *The impact of alcohol abuse on the welfare of rural households: a case study of Mbeti-north Ward, Embu County*. Nairobi: University of Nairobi. Retrieved from <http://erepository.uonbi.ac.ke/handle/11295/93080#.ZFpqr8QwEi0.whatsapp>
- Njoki, M. K. (2013). *Drug and Substance Abuse in Secondary Schools in Kenya. A Case Study of Kiambu County*. University of Nairobi. Nairobi: University of Nairobi. Retrieved from <http://erepository.uonbi.ac.ke:8080/xmlui/handle/123456789/59377>
- Nkurunungi, C. A. (2019, 01 09). Authoritarian Parenting Style, Substance Abuse and Externalized Problem Behaviour among secondary school students. *Makerere University*. Retrieved from <http://hdl.handle.net/10570/7104>
- Nyawasha, M.-W. &. (2020). Factors influencing alcohol use among female in-school adolescents in the Western Cape, South Africa. *South African Journal of Psychology*, 50(4), , 574-586.
- Obiol, R. .. (2021). How People in Recovery Manage the Stigma of Being an Alcoholic. *Health Communication*.
- Odhiambo, O. D., Sifuna, D. S., & Kombo, D. K. (2020). Influence of Parenting Style on Drug Abuse among Girls in Secondary Schools in Nakuru County. *Journal Of Humanities And Social Science (IOSR-JHSS)*, 25(1), 26-35. doi:DOI: 10.9790/0837-2501062635
- Oshi, A. (2018). Single Parent Family Structure as a Predictor of Alcohol Use among Secondary School Students: Evidence from Jamaica. *Single Parent Family Structure as a Predictor of Alcohol Use among Secondary School Students: Evidence from Jamaica*.
- Pedersen, W., & Soest, T. v. (2013). Socialization to binge drinking: A population-based, longitudinal study with emphasis on parental influences. *Drug and Alcohol Dependence*, 135(2), 587-592. doi:<https://doi.org/10.1016/j.drugalcdep.2013.07.028>
- Philip, J., Ford, T., Henry, D., Rasmus, S., & Allen, J. (2016). Relationship of Social Network to Protective Factors in Suicide and Alcohol Use Disorder Intervention for Rural Yup'ik Alaska Native Youth. *Psychosocial Intervention*, Vol. 25. (Num. 1.), 45-54. doi:<https://doi.org/10.1016/j.psi.2015.08.002>
- Prasad, M., & Garcia, C. (2017, 09 11). *How to Conduct a Successful Focus Group Discussion*. Retrieved from Humans of data: <https://humansofdata.atlan.com/2017/09/conduct-successful-focus-group-discussion/>
- Probst, C., Parry, C. D., Wittchen, H.-U., & Rehm, J. (2018, 06 25). The socioeconomic profile of alcohol-attributable mortality in South Africa: a modelling study. *BMC Medicine*, 97(16). doi:<https://doi.org/10.1186/s12916-018-1080-0>
- Pui Kei Leung, B. B. (2016). Adverse Childhood Experiences and Alcohol Consumption in Midlife and Early Old-Age. *Alcohol and Alcoholism*, 331-338.

- Pullen, C. (2017, 11 7). *National Center for Family Philanthropy*. (Pullen Consulting Group) Retrieved from 10 Habits of a Healthy Family Culture: <https://www.ncfp.org/2017/11/07/10-habits-of-a-healthy-family-culture/>
- Ramsoomar, L. (2015). *Risk and protection: alcohol use among urban Youth within the birth to twenty (bt20) cohort*. Johannesburg: University of the Witwatersrand. Retrieved from <https://core.ac.uk/download/pdf/188775529.pdf>
- Roemer, W. (2014). Where you live matters: The roles of living arrangement and self-esteem on college students' hazardous drinking behaviors. *Addiction Research & Theory*, 474-480.
- Rosoff, D. B., Clarke, T.-K., Adams, M. J., McIntosh, A. M., Smith, G. D., Jung, J., & Lohoff, F. W. (2019, 04 26). Educational attainment impacts drinking behaviors and risk for alcohol dependence: results from a two-sample Mendelian randomization study with ~780,000 participants. *Molecular psychiatry*, 26(4), 1119-1132. doi:<https://doi.org/10.1038/s41380-019-0535-9>
- Rosoff, D. B., Clarke, T.-K., Adams, M. J., McIntosh, A. M., Smith, G. D., Jung, J., & Lohoff, F. W. (2019). Educational attainment impacts drinking behaviors and risk for alcohol dependence: results from a two-sample Mendelian randomization study with ~780,000 participants. *Molecular Psychiatry*, 26, 1119–1132. Retrieved from <https://www.nature.com/articles/s41380-019-0535-9#citeas>
- Satir, V. (1983). *Conjoint Family Therapy* (3 ed.). Palo Alto, USA: Science and Behavior Books.
- Schmengler, P. (2022). Educational level and alcohol use in adolescence and early adulthood—The role of social causation and health-related selection—The TRAILS Study. *PLOS ONE*.
- Sharma, S. (2019, 05). *Experimental and Ex Post Facto Designs*. Berlin: Research Gate. Retrieved from https://www.researchgate.net/publication/333220493_Experimental_and_Ex_Post_Facto_Designs
- Solis, S. (2012). Understanding the children whose parent abuse alcohol. *Current drug abuse review*, 135-147.
- Soundararajan, N. A. (2017). Relation between age at first alcohol drink & adult life drinking patterns in alcohol-dependent patients. *The Indian journal of medical research*, 146(5), 606-611.
- Stephen, K., & Odiemo, O. L. (2018, 07 25). Relationship between Alcohol Use Disorder and Cognitive Reappraisal Among Youth Seeking Help in Rehabilitation Centers in Kiambu County, Kenya. *Triple A Research Journal of Social Science and Humanity (ISSN: 2636-5472)vol.2, 8(3)*, 67-78. doi:<https://doi.org/10.5296/ijld.v8i3.13417>
- Sudhinaraset, M., Wigglesworth, C., & Takeuchi, D. T. (2016). Social and Cultural Contexts of Alcohol Use: Influences in a Social-Ecological Framework. *Alcohol research : current reviews*, 38(1), 35-45. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4872611/pdf/arcr-38-1-35.pdf>
- Susman, D. (2022, 10 14). *How Social Learning Theory Works*. Retrieved from Dotdash Media: <https://www.verywellmind.com/social-learning-theory-2795074>
- Taherdoost, H. (2016, 7 31). Validity and Reliability of the Research Instrument; How to Test the Validation of a Questionnaire/Survey in a Research. *International Journal of Academic Research in Management*, 5(3), 28-36. Retrieved from https://papers.ssrn.com/sol3/Delivery.cfm/SSRN_ID3205040_code2177801.pdf?abstractid=3205040&mirid=1

- Teijlingen, E. v., & Hundley, V. (2001). The importance of pilot studies. *Nursing standard (Royal College of Nursing (Great Britain))*, 16(40). doi:<https://doi.org/10.7748/ns2002.06.16.40.33.c3214>
- The recovery village. (2022). Alcohol Relapse Rates & Abstinence Statistics.
- Thomas, L. (2022, 12 05). *Simple Random Sampling | Definition, Steps & Examples*. Retrieved from scribbr: <https://www.scribbr.com/methodology/simple-random-sampling/>
- Tsamparli-Kitsara, A., & Frrokaj, E. (2016, 03). Quality of Sibling Relationship and Substance Misuse: A Comparative Study. *The European Journal of Counselling Psychology*, 123-147. doi:DOI: 10.5964/ejcop.v4i1.78
- Viechtbauer, W., Smits, L., Kotz, D., Budé, L., Spigt, M., Serroyen, J., & Crutzen, R. (2015, 06 06). A simple formula for the calculation of sample size in pilot studies. *Journal of Clinical Epidemiology*, 68(11), 1375-1379. doi:<https://doi.org/10.1016/j.jclinepi.2015.04.014>
- Wangari, N. (2017, 10 23). Measuring Socioeconomic Status: Applying Living Standard Measurement Questions in Mobile Research. *Mobile Research Development, Survey Guide*. Retrieved from <https://www.geopoll.com/blog/applying-lsm-questions-in-mobile-research/>
- Wangechi, M. T. (2016). *Patterns and effects of women's alcohol consumption on family cohesiveness in Kirinyaga county, Kenya*. University of Nairobi, Nairobi. Retrieved from <http://bitly.ws/EcF8>
- Wangui, W. C., Mariene, J., & Wamalwa, B. (2017, 7). Effects of parental alcoholism on students' education in public Secondary schools-a case of Kangema sub-county, Murang'a County-Kenya. *International Journal of Education and Research Vol. 5 No. 7, 5(7)*. Retrieved from <https://www.ijern.com/journal/2017/July-2017/08.pdf>
- Wells, L., & Östberg, V. (2018, 12). Parental education differentially predicts young adults' frequency and quantity of alcohol use in a longitudinal Swedish sample. *SSM - population health*, 91-97. doi:<https://doi.org/10.1016/j.ssmph.2018.09.001>
- Wells, Ö. (2018). Parental education differentially predicts young adults' frequency and quantity of alcohol use in a longitudinal Swedish sample. *population health*, 6, 91-97. doi:<https://doi.org/10.1016/j.ssmph.2018.09.001>
- Whitehead, A. L., Julious, S. A., Cooper, C. L., & Campbell, M. J. (2015, 06 19). Estimating the sample size for a pilot randomised trial to minimise the overall trial sample size for the external pilot and main trial for a continuous outcome variable. *Statistical Methods in Medical Research*, 25(3), 1057-1073. doi:<https://doi.org/10.1177/0962280215588241>
- WHO. (2018). Global status report on alcohol and health 2018. *Management of substance abuse*, 1-24.
- WHO. (2014). Global status report on alcohol and health. *World Health Organization*, 28-32.

Appendices

Appendix 1: NACADA Accredited Rehabilitation Centers in Kiambu County

	Name	Contact	Email
1	New Hope Rehabilitation Centers	0722659743/0780659743	info@nuevarehab.com
2	Genesis Sober Community	0720884024/0202500061	genesssober@gmail.com
3	Sober living &Recover Community based Org	0720059363/0765159363	soberlivingrg@gmail.com
4	Eden Village Rehab Centers	0722867693/0726051995	Justin.farrar@yahoo.com
5	Nueva Esparanza Treatment & Rehabilitation Centers	07222655974	wmucare@g mail.com
6	Jorgs Trust	0723692848/0721712968	Jorgstrust @yahoo.com
7	The Raphaelites	0722714300/0722837627	theraphaelites@wanaichi.com
8	Teen Challenge- Female rehab	– 0711627087	info@kenyac.com
9	Blessed Talbot	0722341452	concernmissionCenters @yahoo.com
10	Wonder peace Rehabilitation Centers	0722807882/0706312696	wonderpeace@live.com
11	Caretech Medical and rehabilitation Centers	0720419499.0720419440	caretechmedical@gmail.com

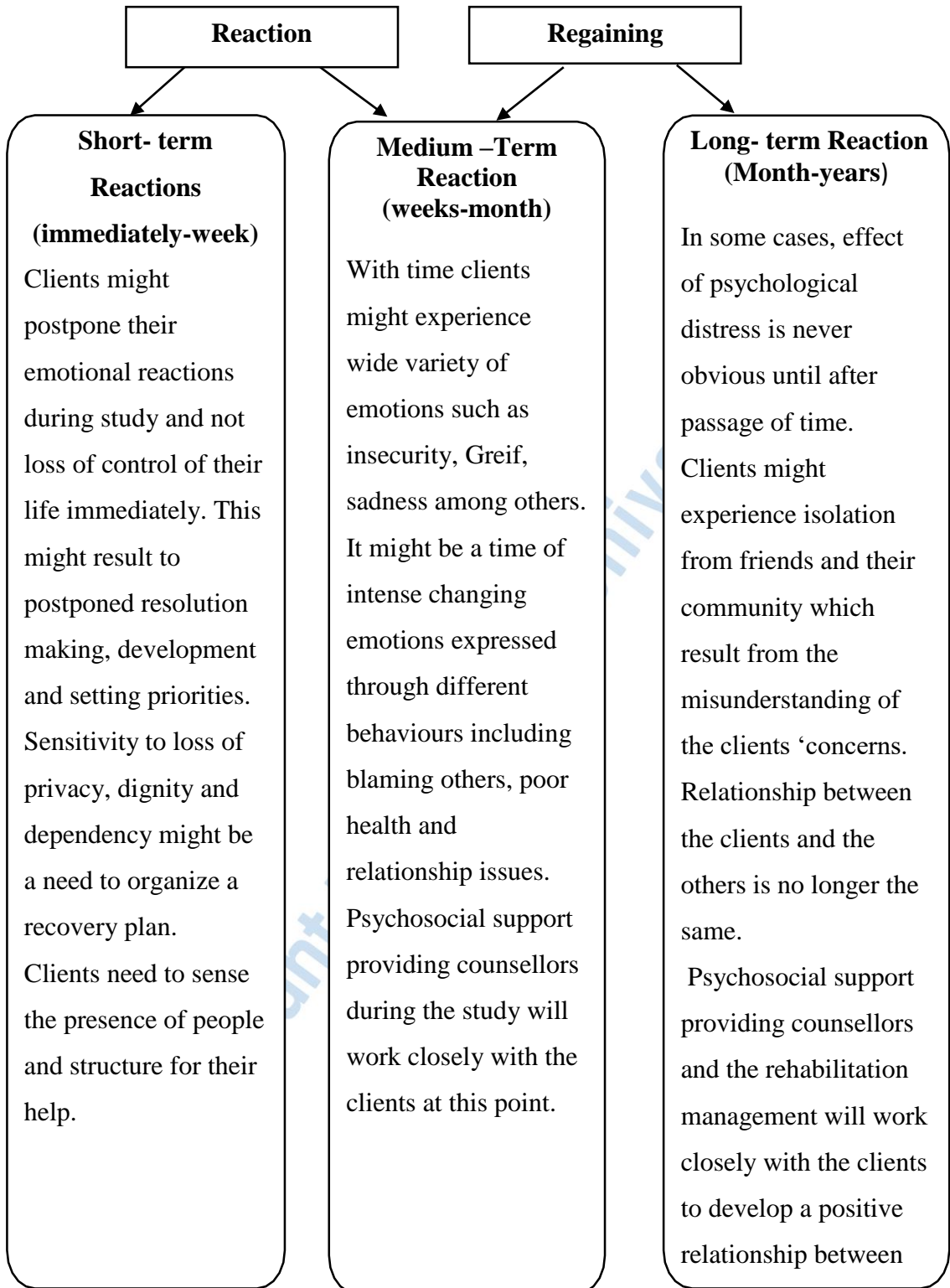
12	Dove International Treatment & Training Centers	0726983045	clintosho@yahoo.com
13	Thika Counselling Centers	0702103841	info@psychocare.gmail.com
14	Sober Living and Recovery	0720059363	soberliving@gmail.com
15	Lifetime Wellness Centers	0721415729	njorogemwati@gmail.com
16	Canopy of Hope Treatment Centers	0722365643/0732771888	info@canopyofhope.com
17	Mediva Wellness Centers	0711228904	info@medivawellness.org
18	Athena Rehabilitation Centers	0722297088	athenarehabilitationCenters@gmail.com
19	Genesis Sober Community	0710420041/0788112631	Genesiscommunity2015@gmail.com
20	Zawena Treatment Centers	0734755591/0797621103	zawenatreatment@gmail.com
21	Mama Care Recovery Centre	0763671244/0714721123/0791508633	omkiambuwomanrep@gmail.com
22	Nobility House Treatment and	0791825044	info@nobolityhouse.com

Rehabilitation
Centers



Appendix 2: Psychosocial Support Plan

Source: Adapted from Taranaki District Health Board



Appendix 3: Questionnaire for the Alcohol Recovering Clients

This study is being conducted by a PhD student from Mount Kenya University Thika, on:
An investigation of family attributes on alcohol use disorder among addicts in selected
Rehabilitation Centers in Nairobi County, Kenya

I humbly request you to honestly and diligently answer all the items following the given
instructions. Kindly remain anonymous by not giving any identification. I give my
commitment that all the provided information will be used for academic purpose.

Thank you for your participation.

Yours faithfully

Marypiah Kuria

To observe the COVID-19 Health protocol, please use the provided google forms to
provide the data. Below is the link to access the google form.

https://docs.google.com/forms/d/e/1FAIpQLScQMlmsLfBOeu5Pk5VF4vUB46LA7TX1Jqg_hxGpt_qskTEXvg/viewform

Section A: Items to collect Biographic Data

Q1

Gender

Male Female

Q.2 Indicate using a tick (✓) your current age bracket

Below 18 years Between 19yrs and 25 yrs.

Between 26yrs and 32 years. Between 33yrs and 39yrs

Between 40yrs and 46 years Between 47yrs and 53yrs

Above 54 years.

Q.3

Tick (✓) to indicate the age you started using alcohol.

Below 10 years [] Between 11 years and 17 years. []

Between 18yrs and 24 years. [] Between 25 years and 31 years. []

Between 32yrs and 38yrs [] Between 39 years and 45 years. []

Above 46 years. []

Q.4

Tick (✓) to indicate your living arrangement before you were 18 years old.

I lived with my grandparents only []

I lived with my parents only []

I lived with my brothers and sisters only []

I lived with my father and my siblings only []

I lived in our nuclear family []

I lived with my mother and my siblings only []

Objective One: Items to collect data on Family Culture and Alcohol Use Disorder

SECTION B. ITEMS ON FAMILY CULTURE AND ALCOHOL

USE DISORDER

Q.5

On a scale of 1 – 5, rate the statements listed below concerning your family members;

Your father

A scale of 1-5.	Strongly disagreed	Disagreed (2)	Neither agreed or	Agreed (4)	Strongly Agreed
He discussed with you different coping strategies in					
He trained you on how to use money (spending					
He emphasized on productive use of time					

He allowed you to express your feelings					
You could depend on your father for help in times of					
He rewarded your positive behaviours either with kind					
He was committed to ensure you do not miss school					

Your mother

A scale of 1-5.	Strongly disagreed	Disagreed (2)	Neither agreed or	Agreed (4)	Strongly Agreed
She discussed with you different coping strategies in					
She trained you on how to use money (spending					
She emphasized on productive use of time					
She allowed you to express your feelings					
You could depend on your mother for help in times of					
She rewarded your positive behaviours either with kind					
She was committed to ensure you do not miss school					

Your siblings (brothers and sisters)

A scale of 1-5.	Strongly disagreed	Disagreed (2)	Neither agreed or	Agreed (4)	Strongly Agreed
They discussed with you different coping strategies in					

They trained you on how to spend money(spending					
They emphasized on productive use of time					
They allowed you to express your feelings					
You could depend on your brothers and sisters for help					
They rewarded your positive behaviours either with kind					
They were committed to ensure you do not miss school					

Q.6

On a scale of 1- 5 rate your commitment and adherence (obedience) to the family values listed below.

A scale of 1-5	Almost never (1)	Few times	Sometimes (3)	Most of the times	Almost always
Trustworthiness					
Compassion					
Courage and persistence					
Integrity					
Family quality time together					
Attendance to your place of worship					
Adherence to religious teaching					
Commitment to excellence					
Satisfaction in your achievements					
Spending philosophy(how to					

Academic performance and time Productive use of time					
Cooperation with others					
Respect for law, order and patriotism					
Volunteer work and kindness to others					

Q.7

Using the given key: Never, Very few times, sometimes, many times or always. Tick (✓) how much your family encouraged you do the following.

Statement	Never	Very few times	Sometimes	Many times	Always
Being happy sharing what you have with others					
Volunteering to serve others and co-operating with others by being a team player.					
Value owning your personal properties and working hard for success					
Treat others as you would like to be treated and always work towards improving spiritual					
To always do the best you could in everything and they appreciated your achievements					
Save a portion of your income and valued your contribution in the community					

Take available opportunities to share your ideas feelings and creativity					
Creating unstructured time to have fun like going for vacation with all family members					
Having quality time as a family without fun					

SECTION C. Items on socio economic status and alcohol use disorder

Q.8

Tick (✓) against your highest level of education completed

Education level completed	
Primary level	
Secondary level	
Tertiary level	
University degree	
Master's degree	
Doctoral degree	

Tick (✓) against your parents' or guardian highest level of education completed.

Education level completed	Father	mother
Primary level		
Secondary level		
Tertiary level		
University degree		
Master's degree		
Doctoral degree		

Q.9

Please tick against () your main source/s of income

Agriculture	Construction	Transport	Real estates	Employment	Other Business (Specify	Not applicable

Q.10

Please tick against () your range of Monthly income

Ksh. less than 24,000		Between ksh 24,000-34,000
Between Ksh 35,000-45,000		Betweenksh46,000-56,000
Between Ksh 57,000-77,000		Between ksh 78,000-88,000
Between Ksh 89,000-99,000		Over ksh 100,000

Q.11

Please tick against () your living settlement structures before you were 18 years old.

living settlement structures	Family-owned house	Rented house	Institution given house
Semi-permanent			
Permanent(blocks/stones)			
Gated community residence			
Gated family residence			
Gated and Guarded community residence			
Gated and Guarded Family residence			

Q.12

Organise these economic activities starting from the most popular to the least popular among your parents or guardian before you were 18 years old.

(Construction, Transport, Real estates, Employment, Agriculture, Other business)

Economic activities	most popular	second	third	fourth	fifth	least popular
Father/male guardian						
Mother/female guardian						

Q.13

Organise these economic activities starting from the most popular to the least popular that you engaged in after you were 18 years old.

(Construction, Transport, Real estates, Employment, Agriculture, Other business)

Economic activities	most popular	second	third	fourth	fifth	least popular
Father/male guardian						
Mother/female guardian						

SECTION D. ITEMS ON PARENTING STYLE AND ALCOHOL

USE DISORDER

Q.14

On a scale of 1-5 indicate how you agreed with the statements listed below concerning your family members

Your father or a male guardian

	Strongly disagreed (1)	Disagreed (2)	Neither agreed or disagreed (3)	Agreed (4)	Strongly disagreed (5)
My father had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken					
My father nagged, yelled and demanded discipline from me more than he					

encouraged, listened or praised me					
He did not show me warmth or friendliness, love or encouraging feelings					
My father used physical punishment, such as canning and gave no choices, options or room for negotiation it was always his way.					
He never allowed me to make choices instead they chose items for me					
My father never explained reasons to avoid definite behaviours but they presumed I should just know					
Always expected more and never acknowledged the achievements made					
Never explained or gave me an opportunity to give my opinion when making family rules.					
He was never involved in my academic work meeting my personal targets and emotional development					

<p>My father appreciated and had fun being with me. He was happy with my little or big determinations and achievement and communicated the same through different kinds such as physical contacts, laughter, nice voice tones, playful teasing, facial expressions, encouragement among others.</p>					
<p>My father listened to my opinions and choices to upgrade my freedom and thinking, he also set limits and responsibilities with an understanding of the penalties or consequences of my behaviour.</p>					
<p>My father were too caring, prizing and cherishing to me, he valued my opinions on major family decisions</p>					
<p>My father Put emphasis on my choice as compared to answerability and responsibility</p>					
<p>My father is able to modify and adjust our relationship according to the circumstance in relation to</p>					

needs at the moment and Punishment accordingly.					
There are very few family rules or the expected principles of conduct, and the few rules that were set were changeable					
My father at times used enticement inform of gifts, food, money and other promises to make as behave in the expected manner. He behaved more like a friend or peers than an authority and never imposed any kind of penalties					
He never made program or plans to be followed when he were absent					
I had limited interaction with my father because he were either too busy with their work, problems or he had nothing to share with me.					
My father had very few expectations or demands for behaviour from me and my siblings and Offer very little supervision					

He communicated very little friendliness, love, and care towards me					
My father was never interested in my school work, school activities and missed all or most the school events					
My father neither cared nor responded to my feeling or emotions					

Q.15

(b) On a scale of 1-4 indicate how you agreed with the statements listed below concerning your mother

Your mother or the female guardian

	Strongly disagreed (1)	Disagreed (2)	Neither agreed or disagreed	Agreed (4)	Strongly disagreed (5)
My mother had a lot of both written and unwritten rules to be followed always and react swiftly and harshly whenever the rules were broken					
My mother nagged, yelled and demanded discipline from me more than she encouraged, listened or praised me					

She did not show me warmth or friendliness, love or encouraging feelings					
My mother used physical punishment, such as canning and gave no choices, options or room for negotiation it was always her way.					
She never allowed me to make choices instead she chose items for me					
My mother never explained reasons to avoid definite behaviours but they presumed I should just					
Always expected more and never acknowledged the achievements made					
Never explained or gave me an opportunity to give my opinion when making family rules.					
She was never involved in my academic work meeting my personal targets and emotional development					
My mother appreciated and had fun being with me. She was happy with my little or					

My mother listened to my opinions and choices to upgrade my freedom and thinking, she also set limits					
My mother was too caring, prizing and cherishing to me, she valued my opinions on major family decisions					
My mother Put emphasis on my choice as compared to answerability and responsibility					
My mother is able to modify and adjust our relationship according to the circumstance in relation to needs at the moment and Punishment accordingly.					
My mother at times used enticement in form of gifts, food, money and other promises to make as behave in the expected manner.					
She never made program or plans to be followed when she were absent					
I had limited interaction with my mother because she was either too busy with their work, problems or she had nothing to share with me.					

My mother had very few expectations or demands for behaviour from me and my siblings and Offer very little supervision					
He communicated very little friendliness, love, and care towards me					
My mother was never interested in my school work, school activities and missed all or most the school events					
My mother neither cared nor responded to my feeling or emotions					

Q.16

On a scale of 1 – 5, rate if these family members took time to discuss your emotional experiences (When you were hurting, stressed, happy, or anxious)

	Strongly disagreed (1)	Disagreed (2)	Neither agreed or disagreed (3)	Agreed (4)	Strongly agreed (5)
Father					
Mother					
First born sibling					
Second born sibling					

Third born sibling					
--------------------	--	--	--	--	--

Others specify

SECTION E. ITEMS ON FAMILY ALCOHOL USE AND ALCOHOL USE DISORDER

Q.17

Using the key given below rate your family alcohol use at the time you started using alcohol.

Key

Non user – does not take alcohol at all

Social user – only takes alcohol in social functions

Regular user – takes alcohol once in a while

Heavy user – takes alcohol and gets dysfunctional

Binge user – takes a lot of alcohol at a time

	Non user	Social user	Regular user	Heavy user	Binge user
Father					
Mother					
1st Brother					
2nd Brother					
3rd Brother					
1st Sister					
2nd Sister					
3rd Sister					

Q.18

Tick (✓) which family member(s) has alcohol problems?

Father	Mother	First born	Second born	Third born	Forth born	Fifth born

Others specify

Section Six: Items to correct data on alcohol use disorder among recovering clients in rehabilitation.

SECTION E; ITEMS TO COLLECT INFORMATION ON THE LEVEL OF AUD

Q.19

Using the scale provided indicate by ticking (✓) the level of alcohol dependence.

Level of Alcohol dependency scale

Statement	Very few times	Few times	Sometimes	Most of the times	Always
I took larger amounts of alcohol than I intended					
I persistently desired to cut down or regulate alcohol use but still went back to alcohol					
I spent a great deal of time obtaining alcohol, drinking					

or recovering from its effect					
I experienced an intense desire or urge for alcohol when I was in an environment where I previously got alcohol from					
I failed to fulfil my major obligations at home, work, school, or community					
I continued the use of alcohol despite having persistent or recurrent social or interpersonal problems caused by the effect of alcohol.					
I needed increased amount of alcohol to experience the previous intoxication					

<p>If I reduce or do not take alcohol, I experienced The following: sweating, increased heart pulse Hand tremors, lack of sleep</p>					
---	--	--	--	--	--

Focus Group Discussion schedule for recovering clients in selected rehabilitation Centers in Nairobi

In your opinion when is drinking alcohol considered to be harmful, dangerous, or problematic?

According to you, how do the following factors contribute to dangerous or problematic alcohol use;

1. To the best of your knowledge, what were the subjects of discussion during the Family times?
2. Family socio-economic status can influence what happens in a family. Issues to do with, family members' education levels, Income, Family Size, and Location are considered to be family socio-economic factors. How do they play out in your family?
3. Parents and siblings assume or display different behaviours during their parenting. In your family what were the most outstanding experiences?
4. Family members drinking alcohol (Binge drinking, Problem with the law, Domestic violence, Irresponsibility

THANK YOU FOR YOUR COOPERATION

Appendix 4: ERC Certificate



REF: MKU/ERC/1969
TO: MARYPIAH W. G. KURIA

Date: 21 October 2021

REG: PHDCOUNS/2014/62550

Dear Sir/Madam,

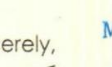
RE: INVESTIGATION OF FAMILY ATTRIBUTES ON ALCOHOL USE DISORDER AMONG RECOVERING CLIENTS IN SELECTED REHABILITATION CENTERS, NAIROBI COUNTY, KENYA

This is to inform you that **Mount Kenya University** has reviewed and approved your above research proposal. Your application approval number is **1042**. The approval period is **21/10/2021 - 20/10/2022**.

This approval is subject to compliance with the following requirements;

- i. Only approved documents including informed consents, study instruments, MTA will be used
- ii. All changes including amendments, deviations and violations are submitted for review and approval by **Mount Kenya University**
- 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 **Mount Kenya University** within 72 hours of notification
- iv. Any changes, anticipated or otherwise that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to **Mount Kenya University** 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 **Mount Kenya University**

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

Yours sincerely,

The Chairman
Mount Kenya University
Ethics Review Committee
P.O. Box 342 - 0100, Thika

Appendix 5: Introduction Letter





Mount Kenya University

DIRECTORATE OF GRADUATE STUDIES

PHDCOUNS/2014/62550

6th December, 2021

*The Director, Research Coordination Division
National Commission for Science, Technology & Innovation
Utalii House, 8th & 9th Floor
P.O Box 30623- 00100
NAIROBI*

Dear Sir/Madam,

RE: MARYPIAH W. G. KURIA - REGISTRATION NO. PHDCOUNS/2014/62550

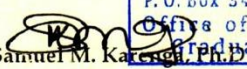
The purpose of this letter is to introduce the above named student who is pursuing Doctor of Philosophy in Counseling Psychology in the Department of Psychology in the School of Social Sciences.

The title of her research is *"Investigation of Family Attributes on Alcohol Use Disorder Among Recovering Clients in Selected Rehabilitation Centers, Nairobi County, Kenya."*

She has been cleared by the University's Ethics Review Committee (Certificate attached) and now has to proceed to the field to collect data for her research between December, 2021 and May, 2022.

Any assistance accorded to her will be highly appreciated.

Thank you.


Dr. Samuel M. Karaga, Ph.D.
Director, Graduate Studies

Mount Kenya University
P.O. Box 342 - 01000, THIKA
Office of the Director
Graduate Studies

Enc.

Main Campus, General Kago Road, P.O. Box 342-01000 Thika. Tel: +254 67 2820 000,
Cell: +254 720 790 796, 0709 153 000
Email: info@mku.ac.ke, Web: www.mku.ac.ke

Appendix 6: Research License





THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013


The Grant of Research Licenses is Guided by the Science, Technology and Innovation (Research Licensing) Regulations, 2014

CONDITIONS

1. The License is valid for the proposed research, location and specified period
2. The License any rights thereunder are non-transferable
3. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research
4. Excavation, filming and collection of specimens are subject to further necessary clearance from relevant Government Agencies
5. The License does not give authority to transfer research materials
6. NACOSTI may monitor and evaluate the licensed research project
7. The Licensee shall submit one hard copy and upload a soft copy of their final report (thesis) within one year of completion of the research
8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice

National Commission for Science, Technology and Innovation
off Waiyaki Way, Upper Kabete,
P. O. Box 30623, 00100 Nairobi, KENYA
Land line: 020 4007000, 020 2241349, 020 3310571, 020 8001077
Mobile: 0713 788 787 / 0735 404 245
E-mail: dg@nacosti.go.ke / registry@nacosti.go.ke
Website: www.nacosti.go.ke

Appendix 7: Authority for data collection at Precision Counselling & Rehabilitation Home



Kahawa Sukari
From Thika Road Exit 10
Kahawa Sukari Area
Nyahururu Rd, 3rd North Area

Telephone:
Cell: 0702 378314 (Safaricom)
Office: 0780 378314 (Airtel)
Email: info@precisioncounseling.org
Website: www.precisioncounseling.org
Postal Address: P.O Box 48418-00100
Nairobi, Kenya

Precision Counseling & Rehabilitation Home
...Anchored for Empowerment...

Marypiah Wairimu Gatura Kuria
PhD COUNS/2014/62550
P. O. Box 106 – Uthuru
Tel: +254 720 902 366
Nairobi

28th March, 2022

Dear Marypiah,

RE: DATA COLLECTION

Following your application for data collection in Precision Counseling and Rehabilitation Home, we are happy to inform you that your application has been approved. However all ethical consideration related to data collection **MUST** be observed.

Welcome to Precision Counseling and Rehabilitation Home.

For and on behalf of;
Precision Counseling and Rehabilitation Home


Mary Njoroge
DIRECTOR



...Anchored for Empowerment...

Appendix 8: Introduction Letter from the Researcher to the Respondents

Department of Counselling Psychology,
School of Social Sciences,
Mount Kenya University.
P.O. Box 342-01000,
Thika.

Dear participant,

RE: Study Data Collection

My name is Marypiah Wairimu Guttural Kuria, A Doctorate of Philosophy (PhD) in Counselling Psychology student from Mount Kenya University. To fulfil all the requirements of the course for the conferment of the degree, I am conducting a study on: An investigation of family attributes on alcohol use disorder among addicts in selected rehabilitation Centers in Nairobi County, Kenya.

Sampling result indicated that you are a participant in this study. I humbly request you to receive the attached questionnaire and honestly respond to all the items as required. All the information you provide will be treated with maximum ethical confidentiality and only for the Academic purposes. Your participation and cooperation is extremely treasured.

Yours Sincerely,

Marypiah Kuria.

Appendix 9: Consent Form for Recovering Clients in Selected Rehabilitation Centers

Dear Respondent,

My name is Marypiah wairimu Gatura Kuria, A Doctorate of Philosophy (PhD) in Counselling Psychology student of Mount Kenya University. To fulfil all the requirements of the course for the conferment of the degree, I am conducting a study on: An Assessment of family attributes on alcohol use disorder among addicts in selected Rehabilitation Centers in Nairobi County, Kenya.

Sampling result indicates that you are a participant in this study. I humbly request you to receive the attached questionnaire and honestly respond to all the items as required. Any interpretation about this study will be provided and if by any chance you are convinced to drop from the study you are free to do so

The researcher will adhere to all research ethics during and after the study. Complete copy of this study will be submitted to Mount Kenya University. Your participation in this study will be extremely valued.

Respondent's acknowledgment

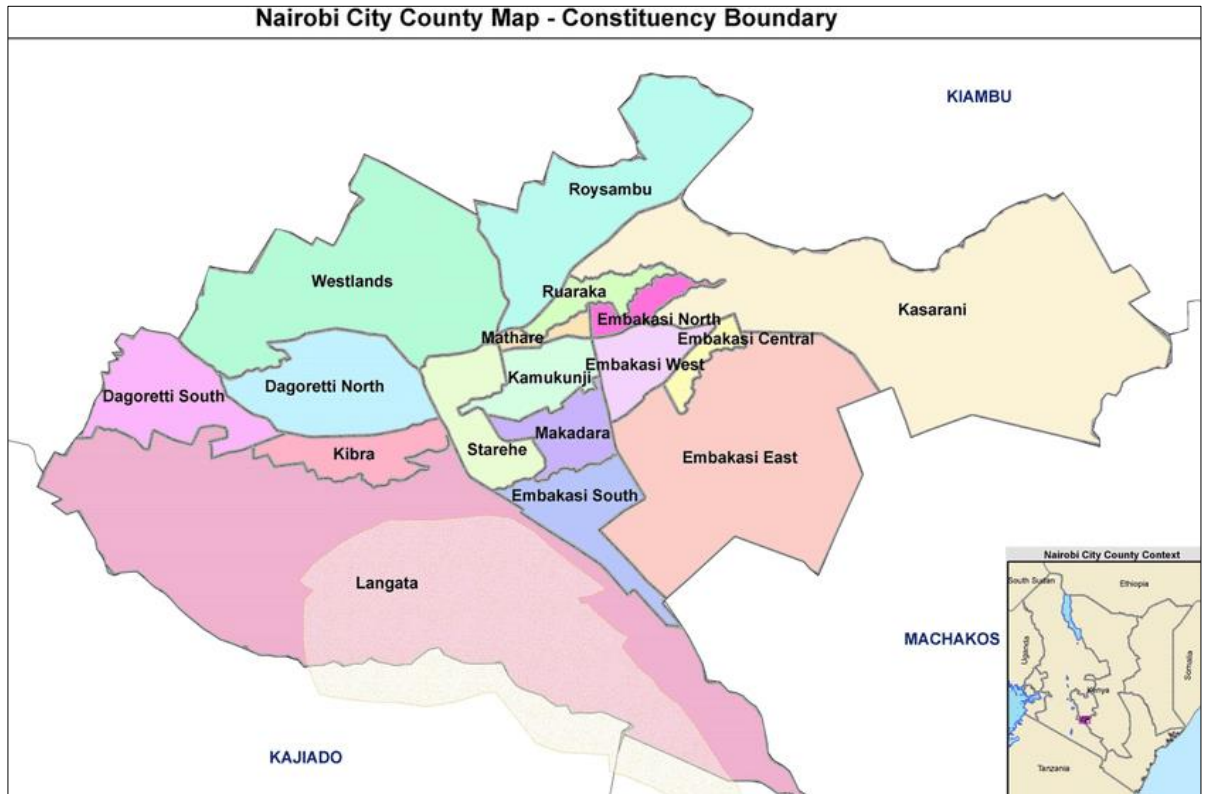
Kindly sign on the provided space to communicate your commitment to participate in this study as a respondent.

Name-----

Sign-----

Date-----

Appendix 10: Map of Nairobi County



Source; Kiplagat, Ngunu, Oyugi, & Ransom (2020)

Appendix 11: Similarity Index

**FAMILY ATTRIBUTES ON
ALCOHOL USE-DISORDER
AMONG RECOVERING CLIENTS
IN SELECTED REHABILITATION
CENTERS WITHIN NAIROBI CITY
COUNTY, KENYA**

by MARYPIAH KURIA

Submission date: 12-Apr-2024 07:51PM (UTC+0300)

Submission ID: 2347741799

File name: 12_MARCH_2024_MARYPIAH_KURIA_FINAL_COPY_FOR_GRADUATION.docx (2.9M)

Word count: 50341

Character count: 274547

FAMILY ATTRIBUTES ON ALCOHOL USE-DISORDER AMONG RECOVERING CLIENTS IN SELECTED REHABILITATION CENTERS WITHIN NAIROBI CITY COUNTY, KENYA

ORIGINALITY REPORT

19%

SIMILARITY INDEX

18%

INTERNET SOURCES

8%

PUBLICATIONS

9%

STUDENT PAPERS

PRIMARY SOURCES

1

[mail.iosrjournals.org](mailto:iosrjournals.org)

Internet Source

2%

2

www.ajol.info

Internet Source

1%

3

www.researchgate.net

Internet Source

1%

4

erepository.uonbi.ac.ke

Internet Source

<1%

5

www.elivapress.com

Internet Source

<1%

6

su-plus.strathmore.edu

Internet Source

<1%

7

nacada.go.ke

Internet Source

<1%

8

repository.kemu.ac.ke:8080

Internet Source

<1%

repository.daystar.ac.ke

303 "Prevention of Substance Use", Springer Science and Business Media LLC, 2019
Publication <1%

304 Katembu Stephen, Okunya Luke Odiemo. "Relationship between Alcohol Use Disorder and Cognitive Reappraisal Among Youth Seeking Help in Rehabilitation Centers in Kiambu County, Kenya", International Journal of Learning and Development, 2018
Publication <1%

305 Keiko Murakami, Hideki Hashimoto. "Associations of education and income with heavy drinking and problem drinking among men: evidence from a population-based study in Japan", BMC Public Health, 2019
Publication <1%

306 Marc H. Bornstein. "Children's Parents", Wiley, 2015
Publication <1%

Exclude quotes Off
Exclude bibliography Off

Exclude matches Off